

1

Information sharing and communication

Local and national case reviews have repeatedly found that a child was not adequately safeguarded because professionals did not share crucial information about the child or their circumstances. Government [guidance](#) makes it very clear that GDPR, agency protocols, human rights and lack of consent **MUST NOT** be a barrier to sharing information – the safety and welfare of the child is paramount and must take precedence above all. Find out more information on the [SSCP website](#) and the [Greater Manchester Multi-agency Safeguarding Children Procedures](#).

2

Roles of males in families

Learning from [local](#) and [national case reviews](#) tells us that often there is a male who is part of the family network that the child comes into contact with but is not known about by agencies working with the family. This could be a father, grandfather, uncle, stepfather, partner of the mother or any carer, babysitter, childminder, a neighbour or an acquaintance. Fathers and father figures can have a [positive impact](#) on a child's life and anyone coming into regular contact with a child needs to be known about so that any potential risks can be assessed. Find out more in this [7 Minute Briefing](#).

3

Strategy meetings

Learning from case reviews has highlighted opportunities where we can strengthen our [multi agency strategy meeting](#) process. It is important that all relevant professionals are invited to attend a strategy meeting, to support information sharing. Actions should be SMART (specific, measurable, achievable, realistic and timely), and should be shared promptly with partners to ensure a collective understanding of the risk management plan.

4

Escalation and professional challenge

Learning from local and national case reviews tells us that professionals sometimes feel unable to challenge other professionals about decisions they have made regarding the safeguarding and protection of a child. The SSCP encourages and enables ALL professionals to have confidence to disagree, to [respectfully challenge](#) and openly discuss concerns about decisions affecting a child. Read more in this [7 Minute Briefing](#).

7

Cultural consciousness and professional curiosity

Learning from several case reviews in Salford tells us that we as practitioners need to really try and understand the daily lived experience of each child, no matter what their background or culture is, and especially if different from our own. This involves being professionally curious, which is another recurring theme from case reviews. Find out more about how to develop culturally conscious and reflective practice in this [Cultural Consciousness guidance](#) produced by the SSCP.

**6**

Safeguarding Babies under 1 and water safety

Research tells us that [babies](#) under the age of 12 months are especially vulnerable, and several babies were harmed in Salford during the [lockdown](#) period. Babies and young children are not only harmed by physical abuse but also by neglect when leaving them [unattended in the bath](#). This can also apply to older children who have disabilities. Adolescents are at risk from swimming in open water. Read more in this [7 Minute Briefing](#).

5

Knife crime /Adolescents

In recent years there have been several incidents involving young people and serious violence, often involving knives. Learning from these case reviews told us of the importance of sharing key information about [young people](#) with partners, and of trying to understand what's really going on for young people in their day to day lives. Find out more in the [Adolescent Strategy](#) and in this [7MB](#).