Local Safeguarding Children Board

Hammersmith & Fulham | Kensington and Chelsea | Westminster

ANNUAL REPORT 2017-2018

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Introduction from the LSCB Independent Chair

Independent Chair

Jenny Pearce

Welcome to this year's Local Safeguarding Children Board annual report. This report covers my first full year as chair of the LSCB. I have been impressed by the dedicated commitment to safeguarding children demonstrated by the full range of LSCB partners. The essential element of the success of an LSCB is its partnership arrangements: where emerging issues of concern can be identified, appropriate information can be shared and colleagues can work together towards common aims. Our LSCB achieves this through its quarterly board meetings, its range of sub-groups and by its capacity to respond to emerging issues of concern if and when they arise.

We have three shared priorities that we are all working towards together and we have had regular updates from partners on particular areas of work in progress and under development. This collaboration means that the safeguarding of children remains up to date, becomes a genuinely multi agency endeavour and that support and appropriate challenge between partners on ongoing practice is facilitated.

It is not possible for this annual report to reflect on the year without noting the impact of the tragic fire at Grenfell Tower which happened shortly after I first came into post. Following an internal assessment to ensure that all children directly impacted by the fire were receiving appropriate support, we have continued to have updates at each LSCB meeting to inform partners about ongoing activities with families, communities, schools, health and all other partners impacted by the tragedy. We have received updates on the re-housing of families and children, on the support input for local schools and community groups and have facilitated time for partners to ask questions about any safeguarding concerns they may have about children affected. This work is, and will continue to be, ongoing and of essential priority to the work of the LSCB.

Over and above this essential priority, we have worked together to implement our three safeguarding children priorities that were identified in early 2017 to ensure that:

(1) the LSCB are responsive to the needs of children witnessing/experiencing domestic abuse and coercive control and minimizing the impact of this on children and young people;

(2) that children and young people are kept safe from peer on peer abuse (including during transition into and out of adolescence);

(3) the work of the LSCB is informed by the voice of children and young people resident in the three boroughs. In response we have held a 'No Knife, One Life' event at a local college and, drawing on the learning, are planning a second further event.

While we are moving forward to work on these and other emerging priorities, we have also looked forward to ensure that we are assessing our strengths and identifying areas for improvement. It has been timely that the Children and Social Work Act 2017, supported by 'Working together to safeguard children 2018' (DfE 2018) has created a new platform for arrangements for safeguarding children. Leads from three partners: The Local Authority, Police and Health commissioners will become the three identified

safeguarding partners responsible for funding and overseeing safeguarding arrangements.

The change gives us an opportunity to assess our strengths and identify any existing challenges. To this end we have had focused discussions with the LSCB and targeted meetings on management arrangements and the number, role and focus of LSCB subgroups. I have met with the representative leads of the three partnerships, all of whom are keen to build on the existing strengths of the partnerships in place. There has been agreement that we assess the necessary number of subgroups and the potential strategic role that subgroup chairs could play in directing safeguarding arrangements of the future. These suggestions are under final consideration and will be submitted to central government during 2019.

Central to our developing ideas is the knowledge that any abuse, neglect and/or harm caused to children are intolerable. Numerous reviews, inspections and evaluations have identified that working together, sharing ideas, resources and skills is at the heart of safeguarding children. I hope that this report gives you an overview of the work that we are doing to achieve this.

The local picture

Hammersmith and Fulham

Approximately **33,777** children and young people aged 0 to 17 years live in Hammersmith and Fulham. This is **19%** of the total population in the area.

Approximately **29.7%** of the local authority's children are living in poverty (London average – 24%, national average 20%)

The three most deprived wards with large child populations are Wormholt & White City, College Park & Old Oak, Shepherds Bush Green.

There are **2,900** (15%) workless households in the area with dependent children aged 0 to 19 years compared to London average of 5%.

The proportion of children entitled to free school meals:

- In primary schools is **22.4%** (the national average is **14%**)
- In secondary schools is **19.6%** (the national average is **12.9%**)

Children and young people from minority ethnic groups account for **46%** of all children living in the area, compared with **21. 5%** in the country as a whole.

The largest minority ethnic groups of children and young people in the area are Black and Black British and Mixed.

The proportion of children and young people with English as an additional language:

- In primary schools is **49.9%** (the national average is **20%**)
- In secondary schools is **43%** (the national average is **16%**)

At 31 March 2018, **230** children are being looked after by the local authority. There were **125** children subject of a child protection plan, and **1496** children in need.

Kensington and Chelsea

Information about Children and Young People in Kensington and Chelsea March 2018

Approximately **28,890** children and young people aged 0 to 17 years live in Kensington and Chelsea. This is **18%** of the total population in the area.

Approximately **24.8%** of the local authority's children are living in poverty.

There are **1,890** workless households in the area with dependent children aged 0 to 19 years.

The proportion of children entitled to free school meals:

- In primary schools is **23%** (the national average is **14%**)
- In secondary schools is **16%** (the national average is **12.9%**)

Children and young people from minority ethnic groups account for **38.5%** of all children living in the area, compared with **21. 5%** in the country as a whole.

The largest minority ethnic groups of children and young people in the area are Mixed and Black and Black British.

The proportion of children and young people with English as an additional language:

- In primary schools is **53.8%** (the national average is **20%**)
- In secondary schools is **46.7%** (the national average is **16%**)

At 31 March 2018, **87** children are being looked after by the local authority There were **78** children subject of a child protection plan, and **765** children in need.

Westminster

Approximately **44,465** children and young people aged 0 to 17 years live in Westminster. This is **18%** of the total population in the area.

Approximately **34%** of the local authority's children are living in poverty, compared to the London rate of 24% and the national rate of 20%.

The three most deprived wards with large child populations are Queens Park, Westbourne and Church Street.

There are **3,830** workless households in the area with dependent children aged 0 to 19 years.

The proportion of children entitled to free school meals:

- In primary schools is **22%** (the national average is **14%**)
- In secondary schools is **26%** (the national average is **12.9%**)

Children and young people from minority ethnic groups account for **57%** of all children living in the area, compared with **21. 5%** in the country as a whole.

The largest minority ethnic groups of children and young people in the area are Mixed and Black and Black British.

The proportion of children and young people with English as an additional language:

- In primary schools is **69%** (the national average is **20%**)
- In secondary schools is **62%** (the national average is **16%**)

At 31 March 2018, **204** children are being looked after by the local authority. There were **80** children subject of a child protection plan, and **606** children in need.

Local Safeguarding Data 2017/2018

5785 Referrals to Children's Social Care (**1651** LBHF / **2460*** RBKC / **1674** WCC)

283 Children were subject to a Child Protection Plan (**125** LBHF / **78** RBKC / **80** WCC)

The percentage of Child Protection Plans that ended but had lasted two years or more is **7.3%** LBHF / **3.3%** RBKC / **7%** WCC

Children on a Child Protection Plan for a second or subsequent time, **22.4%** LBHF / **13.1%** RBKC / **4%** WCC

Neglect was the most frequent reason for children being placed on a Child Protection Plan in 2017-2018

Domestic Abuse continued to be the main parental risk factor leading to children becoming subject of a Child Protection Plan

Neglect, Mental Health, Alcohol and Substance Misuse are also significant factors.

521 children were Looked After (**230** LBHF / **87** RBKC / **204** WCC)

20 Children were in Private Fostering Arrangements (**5** LBHF / **5** RBKC / **10** WCC)

Peer on peer is most common model of CSE but **online grooming and exploitation is a growing concern.**

3 actions identified from Section 11 audits

0 active Serious Case Reviews but 1 LSCB Conference to share the learning from the recent **Clare and Ann Serious Case Review**

100 face to face multi-agency safeguarding training workshops attended by **1753** delegates

6 Designated Safeguarding Lead for Schools Training Sessions

3 Designated Safeguarding Lead for Schools Networking Forums

3 Safeguarding Training workshops for School Governors, accessed by **66** Governors from **50** schools **61** schools in Hammersmith and Fulham, **93%** were rated Good or better

39 schools in Kensington and Chelsea, **100%** rated Good or better

59 schools in Westminster, **97%** rated Good or better

*The children's services bespoke case management system in RBKC records all contacts and referrals about children so the referrals data appears higher. The case management systems in LBHF and WCC are able to distinguish between contacts and referrals.

Governance and Structure

All local authority areas were required by law to have a Local Safeguarding Children Board and ours spans the three local authorities of Hammersmith & Fulham, Kensington and Chelsea and Westminster. This is a statutory partnership established following the Children Act 2004, and follows the 'Working Together to Safeguard Children 2015' statutory guidance.

Our LSCB is chaired by an Independent Chair, Jenny Pearce, who joined us in April 2017. The Board meetings take place quarterly, as do the subgroup meetings.

The main functions of the LSCB (as per Working Together to Safeguard Children 2015) are to:

- Develop policies and procedures for safeguarding and promoting the welfare of children in the local area
- Communicate the need to safeguard and promote the welfare of children, raising awareness of how this can be best done and encouraging all to do so
- Monitoring and evaluating the effectiveness of what is done by the local authorities and their Board partners individually and collectively to safeguard and promote the welfare of children
- Participating in the planning of services for children in the local area
- Undertaking reviews of serious cases and sharing the lessons learnt.

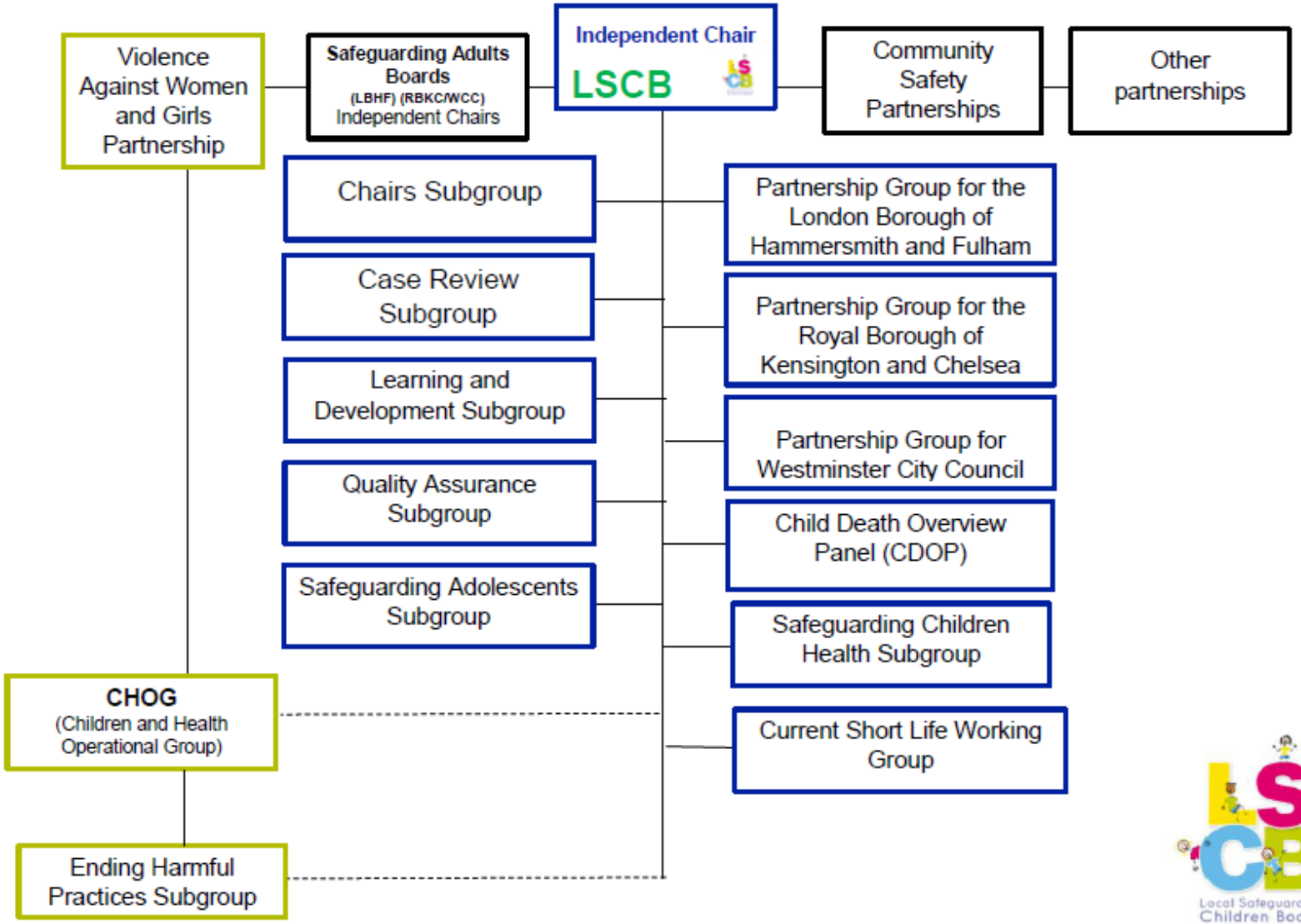
Future of the LSCB

It is important to note that the future of the multi-agency safeguarding partnership is currently being reviewed by the Board, in light of the revised statutory guidance 'Working Together to Safeguard Children 2018', published in July 2018 following the new Children and Social Work Act that received Royal Assent in 2017. This sets out the new framework for the delivery of multi-agency safeguarding arrangements which will come into effect no later than July 2019. These arrangements must be agreed by the Safeguarding Partners (as named in Working Together to Safeguard Children 2018).

Safeguarding partners
A *safeguarding partner* in relation to a local authority area in England is defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as:
(a) the local authority
(b) a clinical commissioning group for an area any part of which falls within the local authority area
(c) the chief officer of police for an area any part of which falls within the local authority area

The Independent Chair has held meetings with the local authority Chief Executives, Directors of Children's Services, Police and Clinical Commissioning Group to begin to develop the new model and this work continues in 2018-2019.

LSCB structure



LSCB Priorities 2017-2018

The new LSCB Chair challenged Board members to agree three key priorities for our work across the partnership.

These include:

Priority 1 – Reducing the Harm of Domestic Abuse and Coercive Control

What is Domestic Abuse?

Any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial, emotional.

Controlling behaviour is a range of acts performed by the abuser and designed to make their victim subordinate and/or dependent.

Coercive behaviour is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used by the abuser to harm, punish or frighten their victim.

A lot of our work on tackling domestic abuse and coercive control is co-ordinated by the Children and Health Operational Group (CHOG), a shared subgroup of the LSCB and the Violence Against Women and Girls Partnership. Its role is to encourage the implementation of the Co-ordinated Community Response (CCR) model in children and health agencies, both statutory and non-statutory, to improve organisational responses to domestic abuse through both formal and ad-hoc training, advocacy of best practice through various safeguarding and health meetings and forums, representation of survivor's and their children's voices and domestic abuse policy development and implementation.

The Children and Health Operational Group meets on a quarterly basis. Four meetings took place the last year, during which the following themes were explored: Trauma & Adverse Childhood Experiences (ACEs), Coercive Control & Perpetrator Accountability, Engaging / Working with

Perpetrators, Family Support Services & Domestic Homicide Reviews.

The Standing Together Against Domestic Violence (STADV or Standing Together) Children and Health Co-ordinator (who co-ordinates the CHOG) has engaged with a variety of stakeholders such as GP practices, sexual health services, substance misuse services, health visitors, Children's Services, early years' providers, and front-line domestic abuse service providers in the boroughs of Hammersmith & Fulham, Kensington and Chelsea and Westminster. In the last year, one of the main priorities was to enhance the knowledge and skills of professionals working in GP practices, to respond to and prevent further domestic abuse by identifying it, screening patients safely and understanding the risk factors in relation to domestic abuse and referring to MARAC and domestic abuse services.

Key successes include:

- 217 professionals working in GP practices were trained in 2017-2018
- 20 GPs received half-day Domestic Abuse Leads / Champions training
- 160 Domestic Abuse Leads trained up at Chelsea & Westminster Hospital and 90 trained at Imperial Healthcare Trust.
- Health professionals working in GP surgeries reported an increase in their knowledge of domestic abuse and confidence in handling the disclosures because of the training they received
- Domestic abuse briefings were delivered to 57 additional health professionals such as SASH (Support & Advice for Sexual Health) Workers.
- Our Safeguarding Children Health Subgroup received a briefing on the domestic abuse risk assessment tools available.
- The LSCB training programme has signposted to the regular MARAC workshops available once a term and delivered six training sessions on Domestic Abuse and Safeguarding Children
- Challenge raised by the RBKC MARAC co-ordinator about the number of outstanding actions for partners to complete was amplified in the LSCB RBKC Partnership Group.
- Learning from Luton Child J Serious Case Review disseminated through all three Local Partnership Groups and
- Development of co-located IDVAs and DVIP practitioners with Children's Social Care in Hammersmith & Fulham leading to effective partnership working and positive impact on engaging families.
- In Kensington and Chelsea, social workers are consulting with embedded domestic abuse workers and systemic clinicians to think about how best to engage with perpetrators.

Planned work for 2018-2019

The LSCB is keen to explore how we could roll out Operation Encompass, a scheme whereby the Police in the Multi-Agency Safeguarding Hub (MASH) contact schools to notify them of specific domestic abuse concerns that may have arisen overnight. This would allow the schools to provide the appropriate pastoral care for children following an incident that they may have witnessed or heard at home.
The LSCB Learning and Development Subgroup will continue to explore how we can deliver training around working with perpetrators of domestic abuse.

Priority 2 – Tackling Peer on Peer Abuse (including Child Sexual Exploitation)

What is Peer on Peer Abuse?
Peer on peer abuse occurs when a young person is exploited, bullied and / or harmed by their peers who are the same or similar age; everyone directly involved in peer on peer abuse is under the age of 18. 'Peer-on-peer' abuse can relate to various forms of abuse (not just sexual abuse and exploitation), and it is important to note the fact that the behaviour in question is harmful to the child perpetrator as well as the victim. There is no clear definition of what peer on peer abuse entails. However it can be captured in a range of different definitions:

Domestic Abuse: relates to young people aged 16 and 17 who experience physical, emotional, sexual and / or financial abuse, and coercive control in their intimate relationships;

Child Sexual Exploitation: captures young people aged under-18 who are sexually abused in the context of exploitative relationships, contexts and situations by a person of any age - including another young person;

Harmful Sexual Behaviour: refers to any young person, under the age of 18, who demonstrates behaviour outside of their normative parameters of development (this includes, but is not exclusive to abusive behaviours);

Serious Youth Crime / Violence: reference to offences (as opposed to relationships / contexts) and captures all those of the most serious in nature including murder, rape and GBH between young people under-18.

What is Child Sexual Exploitation?
Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate, or deceive a child or young person under the age of 18 into sexual activity a) in exchange for something the victim needs or wants and/or b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact. It can also occur through the use of technology.

The MASE (Multi-Agency Sexual Exploitation) Panel covering the three boroughs meets monthly, chaired jointly by the Police and Local Authorities. This is attended by the Local Authority CSE Leads and multi-agency partners. MASE meetings focus on victims, perpetrators and locations of concern and themes as per the London CSE Protocol published in June 2017.

Mapping has been used to try and identify trends, associates and look at the broader picture across various groups of young people to identify and disrupt harmful behaviour. Mapping exercises were also undertaken to help develop our understanding of the both the victim and

offender profile. This has included looking at associates and networks as well as those known to be at risk and cross border mapping across the three boroughs.

There continued to be strong collaboration between the three CSE leads in each borough, who in turn liaise with key services such as sexual health, safer schools officers and community safety.

The CSE leads, along with specialist practitioners and partners collaborated to deliver CSE training and awareness raising sessions to Family Services staff and key partners, as well as taking part in Operation Songtroop, a Police-led initiative to test CSE awareness in hotels.

A short life working group met to consider the needs of young people displaying harmful sexual behaviours. Linked to this, the three local authorities have been successful in obtaining funding via MOPAC to deliver a trauma informed service (Barnardos TAITH model) with perpetrators of harmful sexual behaviour.

An engagement event was held in February 2018 with parents and carers in RBKC to discuss knife crime.

Case Study

In February 2018, the Local Safeguarding Children Board co-hosted an event alongside the Community Safety Partnership and the Police to help support parents and carers to keep young people safe from knife crime. Broadly, the aims of the event were to:

- To help parents/carers understand the risks young people face
- To help parents/carers understand the signs and indicators that their children/young people may be carrying knives
- To help parents/carers understand the impact of social media and the language that young people use to talk about knives
- To help parents/carers understand the breadth of local services available to engage young people in positive activities
- To help parents/carers understand who they can come to for advice and guidance on this issue
- To help local services hear directly from parents/carers about their concerns and what they need from us

We invited parents/carers from across the Royal Borough of Kensington and Chelsea to attend an evening at a local college, where a number of guest speakers gave brief talks, followed by a question and answer panel. The speakers included the LSCB Independent Chair, the Police Borough Commander, a parent who runs a parents' support group in Hackney, a parent whose child was previously involved in knife crime and a young person who was a former gang member.

Local Councillors and faith leaders were also invited to attend. In addition, there were information staffs available from the Early Help Service and EPIC (youth service provider).

Feedback from the audience included concerns about school exclusions, the availability of alternative educational provision, and positive aspirations for young people.

Feedback also suggested that future events may need to be run on a small scale in order to allow for deeper discussions and for all voices to be heard.

One Life, No Knife

This is an initiative that began in Kensington and Chelsea but it is hoped that elements can be replicated in both Hammersmith & Fulham and Westminster.

The Local Safeguarding Children Board, together with the Safer K&C Partnership and Police collaborated to host an evening event for parents and carers in the borough to come and hear from colleagues in Police and voluntary sector services about the challenging subject of knife crime and how to help keep children and young people safe.

The event was also an opportunity for local services to begin a conversation with residents about how we can work in partnership to reduce the risk of harm to our young people.

London Needs You Alive Campaign - MOPAC

Supporting parents and carers to keep young people safe

Hosted by the Safer K&C Partnership, the Local Safeguarding Children Board and the Met Police.

Tuesday 20 February 2018
6pm to 8:30pm

St Charles Sixth Form College, St Charles Square, London W10 6EY

To find out more and to register, visit www.rbkc.gov.uk/knifesafetyevent

This is a free event for parents and carers to hear from those whose lives have been directly affected by knife crime.

You will also hear from the police, community support services and experts suggesting practical steps parents and carers can take to help keep children and young people safe.

We are keen to hear from you about how we can work in partnership together to minimise the risk to our young people.

METROPOLITAN POLICE
TOTAL POLICING

LSCB Local Safeguarding Children Board

PARTNERSHIP

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Case Study

Operation Songtroop

Operation Songtroop (Part of Operation Makesafe) was a Police-led operation to target child sexual exploitation (CSE) within the boroughs of Hammersmith & Fulham, Kensington and Chelsea and Westminster.

It was specifically implemented as a proactive method to address criminal offences associated with CSE that were occurring in certain hotels across the LSCB footprint.

The operation took place in early March 2018, ahead of Operation Makesafe talks that took place across the boroughs before National CSE Awareness Day, also in March 2018. Police worked closely with partner agencies who play an active role in safeguarding children from CSE.

Background:
Hotels have long been recognised as 'hotspots' for child sexual exploitation nationally. It is known that the use of local (national chain) hotels for sex parties remains a feature of the CSE profile across London.

A total of 60 local hotels were selected as part of Operation Songtroop (part of Operation Makesafe), following a review of data gathered from the Multi-Agency Sexual Exploitation Panel (MASE) and other local intelligence.

Our aims:
The key objectives of the operation were:
- to test local hotels' understanding, recognition and response to possible CSE situations from the Operation Makesafe training that they had previously received.
- to share the findings with the hotels themselves as well as partner agencies to identify opportunities for learning, identify patterns and behaviours and to develop intelligence about CSE in order to inform further work in this area.

How we did it:
Each hotel was visited twice, after school, with different pairings of adult and child. The adults took in a clear plastic bag which contained multiple bottles of alcohol that was clearly displayed for the hotel staff to view. The primary objective of the adult was to try and book a hotel room for them and the child and to pay for this using cash.

The adults were encouraged to give other indicators of CSE during the booking process if the opportunity arose, such as being reluctant to provide ID, asking if the room would be available for only a few hours, and to talk for the child if they were spoken to by staff. All of the above indicators are highlighted within the Operation Makesafe training previously delivered to hotels and should have been recognised by hotel staff.

Once each pairing had visited the hotels, they were met by a 'feedback team' who took notes about each scenario. Following this, the hotel staff and general manager were debriefed by Police CSE officers.

Considerations:
Special consideration was given to the appropriate selection of young people who had been trained and prepared for this

operation. The young people were police cadets and were selected because of their previous involvement in 'test purchase' operations with other Police teams. The cadets were of an appropriate age to fully understand the reasons for the operation and all were fully briefed and appropriate consent was sought from parents and carers. After each day, the cadets were de-briefed by the officers from the Police CSE teams to ensure that they felt comfortable during the operation, to see if any follow up support was needed, and to see if they had any suggestions for how it could be improved.

Another key element of Operation Songtroop was that it was a joint piece of work with the partner agencies who work with Police to tackle CSE. This was essential in order to benefit from the expertise of colleagues who make up the MASE Panel. A co-ordinated approach also meant that any safeguarding matters relation to the children participating could be acted on immediately, as well as for any children found to be at risk during the operation.

Results:
A total of 60 local hotels were visited as part of Operation Songtroop. Whilst bookings were not successful in all the hotels (if for example a hotel was fully booked), the adults were not challenged in all but two of the hotels visited, in terms of any of the following indicators:

- Relationship between the adult and child presenting
- The purpose of their visit
- That alcohol was clearly visible
- Why the child was not in school

Only two hotels took proactive steps to challenge the situation or to ensure the child was safe, with one making a call to Police.

The results highlighted the evident lack of awareness of CSE, despite the previous work done by the Police and partners specifically tailored towards these businesses. The fact that bookings were accepted at hotels highlights that children are still at risk of CSE within the three boroughs when entering hotels.

The results of the operation show that the Operation Makesafe training previously delivered to the hotels is not always disseminated by the hotels to their staff as part of routine induction training or regularly enough for it to be familiar to long term staff.

Next steps:
It is anticipated that this operation will be repeated in 18-19 across all three local authorities and that a wider learning event for hotels and licensed premises will be convened so that local businesses can learn more about child sexual exploitation and how to raise concerns locally with Police and Children's Services.

Operation Makesafe

Operation Makesafe has been developed by the Metropolitan Police in partnership with London's boroughs to raise awareness of child sexual exploitation in the business community, such as hotel groups, taxi companies and licensed premises.

The aims
The purpose of the campaign is to help business owners and their employees identify potential victims of child sexual exploitation and, where necessary, alert police officers to intervene prior to any young person coming to harm.

What's involved
Businesses such as hotels, licensed premises and taxi companies are being provided with awareness training to help them recognise the signs of child sexual exploitation. They are directed to call 101, quoting 'Operation Makesafe', should they suspect suspicious behaviour or activity on their premises or in their vehicles.

Met Police call handlers have received specialist training to identify calls relating to child sexual exploitation and provide the appropriate advice and police response.

Online Safety Working Group Case Study

Online Safety

We know that children and young people are increasingly spending time online. The Internet can be a fantastic resource for young people, but can also expose children to harm.

The LSCB is keen to raise awareness of online safety matters with parents / carers and young people as well as the professionals and volunteers that work with them.

A small working group was developed following an emerging concern about keeping children safe online in the Westminster LSCB Partnership Group.

The group wanted to produce some helpful information for parents and carers about keeping their children safe online and ensure this was widely distributed, to coincide with the annual Safer Internet Day which was due to be celebrated on the 06th February 2018. Safer Internet Day is celebrated globally in February each year to promote the safe and positive use of digital technology for children and young people and inspire a national conversation.

Coordinated in the UK by the **UK Safer Internet Centre** the celebration sees hundreds of organisations get involved to help promote the safe, responsible and positive use of digital technology for children and young people.

The day offers the opportunity to highlight positive uses of technology and to explore the role we all play in helping to create a better and safer online community. It calls upon young people, parents, carers, teachers, social workers, law enforcement, companies, policymakers, and wider, to join together in helping to create a better internet.

The working group decided to produce a flyer for parents and carers to help signpost them to already existing resources. The completed flyer was distributed to schools, colleges and early years providers (electronically and in hard copy where requested), as well as to local libraries and children centres. The flyer was also circulated to GP practices across the three local authorities and shared with colleagues in the Police who in turn were able to share it with parents/carers. Copies were also circulated to partner agencies to share with practitioners.

The flyer was then adapted to remove reference to the Safer Internet Day so that it could be used all year round and featured on the LSCB website alongside other helpful resources for parents/carers.

The flyer was also translated into Arabic following a request

from the LSCB Lay Member in Westminster who had recognised that some parents/carers may not be able to engage with the flyers in English.
In 2018-2019, this working group has been expanded to include practitioners from across all three boroughs and we are working on developing further awareness raising sessions and training.

Planned work for 2018-2019

LSCB Partners are keen to develop a greater understanding about Contextual Safeguarding, and will launch a new subgroup for Safeguarding Adolescents that will work to create proactive, preventative multi agency engagement with the social, economic and environmental 'context' within which adolescent risk, harm and vulnerability occur. It will safeguard adolescents through multi agency partnerships to address the diverse, changing and multiple forms of risk and harm impacting on their lives. It will bring assessment of the various safeguarding concerns together, preventing siloed responses to needs artificially separated from each other.

A learning event regarding Contextual Safeguarding for Board members is planned for July 2018 with a speaker from the Contextual Safeguarding Network. Further training will be added via the LSCB training programme and across Children's Services in Hammersmith & Fulham a series of Contextual Safeguarding training workshops have been planned.

It is anticipated that we will develop the role of the MASE panel to also include other forms of harm, including criminal exploitation.

In Hammersmith & Fulham, an integrated and multi-disciplinary Adolescent Service will be developed.

The LSCB will make more enquiries about school exclusions.

The LSCB will seek to collate data on the number of and effectiveness of Adolescent at Risk Meetings.

Priority 3 – Hearing the voice of children and young people

The LSCB Chair held two meetings with both a small group of care leavers and a small group of young people known to the Youth Offending Service to ascertain their views about how safe they feel.

All three local authorities have embedded systemic practice within Children's Services and continue to use the Signs of Safety approach in Child Protection Conferences to ensure that children's experiences are the focus of support and interventions.

Local Authority partners have also collaborated with Future Gov to develop a new digital recording system that better captures the child's journey with Children's Services. This will allow practitioners to make decisions that are informed both by data but also the child's experiences.

Planned work for 2018-2019

The LSCB has created the role of Children and Community Engagement Officer and we are in the

process of recruiting to this post following an appointment that fell through earlier in the year. We also want to build on the One Life No Knife events for parents and carers and host events for young people in order to hear their feedback.

Hearing the voice of children and young people is an area of development for the LSCB and a key priority for our work next year.

Quality Assurance

During 17-18, the LSCB conducted two multi-agency audits: one on Neglect and the other on Child Sexual Abuse.

Neglect Multi-Agency Audit for children aged 7-16 years old:

Agencies involved in the audit included School Nursing, Education, GPs, Police, Community Rehabilitation Company & Probation, Youth Offending and CAMHS. A new neglect screening tool was applied to all cases in the audit sample where children and young people were aged between 7-15 years old. Auditors found that where neglect had been identified, as a safeguarding issue, effective interventions lead to improved outcomes for children. In four of the cases, however, auditors found that neglect had not been identified as a key issue but should have been. Emotional neglect was highlighted as a factor in these cases but practitioners found it more difficult to identify that parents were not responding to their children's needs.

The key findings included:

- Legacy of a long history of neglect, which had been managed or improved for period of time, been partially addressed or had not been successfully addressed in the past.
    - When parenting reaches 'good enough' standard less need for professional intervention but often impact of early experiences felt later.
    - General awareness and understanding of the history (positive finding). Potential to lead to frustration and feelings of hopelessness for professionals working with the case/becoming 'stuck'. Whilst some did feel like that, examples of the opposite and workers committed to making a difference now.
    - Is it possible to change the trajectory at this point? What should our expectations be? Identifying an opportunity to make a difference.
    - Dealing with feelings of frustration and hopelessness- what helps? Supervision, strong professional network, use of clinical workers

- A common feature in many of the cases was potential undiagnosed or untreated emotional/mental health or cognitive needs for the parents (including personality disorder). This made it extremely difficult to work with parents and poses a challenge about how we work with them and how we maintain a professional relationship with them, and address some of their underlying needs when there are no formal services in place.

- Education: It can be a challenge for schools and alternative provisions to meet the needs of young people who have experienced persistent neglect.
    - How do we work with young people excluded from education or not attending? What capacity is there to be creative? Where does the responsibility lie?
    - How effectively do social workers and other professionals escalate concerns about the quality of the education being provided?

- A small proportion of the cases involved specific health needs for the children and there was a need to challenge the parents who were not meeting their child's needs.
    - Whose responsibility is it to challenge the parents?
    - Is there a shared understanding of how the needs will affect the child if untreated / what is the significance?

Outcomes and Recommendations

1. Identifying the opportunity to make a difference

- Establishing and maintaining strong professional networks. Making sure it is clear who needs to be involved and why.
- Continue to ensure regular supervision for practitioners (already in place) which offers space to express feelings of frustrations and hopelessness

2. More successful engagement with parents who have complex emotional, learning or personality needs

- Clinical consultations with systemic practitioners with Children's Services to take place in these cases to explore and review approaches. Learning from these consultations to be broadened to include the multi-agency network involved with child or young person. Professional network to share knowledge of 'what works' for that parent.

3. Ensuring education needs are met appropriately

- Attendance and Inclusion workshops have been held to start to explore how we work with children not consistently in education for a range of reasons.

4. The impact of health needs are fully understood

- Where there are concerns that a child's health needs may not be met, multi-agency meeting is convened to include all the relevant health professionals. Creative approaches to be considered including use of skype and telephone conferencing. These meetings will agree who should take the lead and who should undertake any direct work with the parent.

5. Tailored approaches to working with adolescents informed by research and practice

- Adolescent at Risk model - this is currently being reviewed and developed
- Each borough is developing an approach to working specifically with adolescents. These approaches will be informed by practice experience and should take into consideration the issue and impact of neglect

6. Establish a resource bank for working with Adolescents. Collating tools and best practice evidence from across the three boroughs – this will be led by the Safeguarding Adolescents Subgroup established in 18-19.

7. Dip sample neglect screening to be undertaken in Early Help and YOS to evaluate how we are identifying neglect in this age group (7-16 years) – we aim to complete this in 18-19.

Child Sexual Abuse Audit:

The particular focus for this audit was to consider the multi-agency response to cases where there had been questions, indicators and concerns about sexual abuse, as well as cases where sexual abuse has been alleged or investigated. Cases were audited between November 2017 and January 2018.

Many of the areas of learning and reflection identified during this audit reflect those recognised as part of recent national research. As local multi-agency partners we grapple with similar dilemmas and challenges in our response to sexual abuse. We know that most victims of sexual abuse are abused by someone in their trusted circle and that it can be years before a child is in a position to disclose the abuse to anyone. Yet, often we rely on children to tell us about abuse before we feel able to take action. The majority of cases reviewed as part of this audit involved a disclosure by a child or young person which appropriately triggered an investigatory and safeguarding response. However, these children had contact with various agencies prior to disclosure (at both a voluntary and statutory level). This audit did not find evidence that obvious or overt signs and indicators

were missed, in nearly every case. Instead it prompted reflection about how we are able to be more professionally curious and how we open up opportunities for children (and parents/carers) to talk and feel safe to explore things they feel worried or uncomfortable about.

Some of the ways we can do this include building and promoting relationships (with children, families and within professional networks), seeking to understand the way family networks function (including the significant people in their lives) and by holding the possibility of sexual abuse in mind. When approaching our assessments and investigations we need to remember that criminal investigation is just a small part of the work and should not be the primary focus; the welfare and safety of the child or children involved is much broader than this.

Strengthening communication between social workers and health professionals in the planning and execution of investigations should help us shift the focus. Non-abusing parents/carers have a key role in recognising abuse, increasing safety, helping children talk and supporting children to recover. We need to think about how we promote and support this. Often this means addressing their individual difficulties or support needs. Domestic abuse was a feature in a number of the cases audited and reinforced the importance of recognising the impact of domestic abuse when assessing and supporting the capacity of the non-abusing parent to act protectively.

It is hoped that this audit has raised awareness and prompted reflection in the safeguarding partnership and individual agencies about our responses to sexual abuse.

The Quality Assurance Subgroup has developed an action plan to address the recommendations in the audit. This includes ensuring that Strategy Discussions include meaningful contributions from appropriate health partners and ensuring that all partners are confident in their role and responsibilities to contribute to these meetings. We want to continue to build relationships between health practitioners and social workers and plan to host local networking events to facilitate this. We also plan to review how social workers work alongside Police colleagues for ABE interviews and what training may be required to facilitate this. The LSCB will monitor the progress of the TAITH project that is working to support children who are displaying harmful sexual behaviours, and we will review pathways and access to therapeutic interventions for child victims of sexual abuse.

Section 11 Audit findings:

The section 11 audits are a useful way to check the safeguarding arrangements within agencies and provide the Board with assurance that agencies are doing what they can to ensure the safety and welfare of children.

In 2017-2018, the audits were circulated to maintained schools in all three local authorities, private health providers and one local NHS trust.

An analysis of the audits completed by schools found that schools had a safeguarding children policy in place, and a Designated Safeguarding Lead who had a clear job description that highlighted the breadth of their role. Not all schools reported they had a back-up designated safeguarding lead who could cover the role when required. Most schools were able to report on a clear culture of listening to the voice of children and young people within their setting. Most schools had also been able to access key safeguarding documents and contacts from the LSCB website. One area that the schools were less confident about was on the LSCB priorities, so the Board needs to explore further ways of ensuring this information is cascaded to schools.
A concern that was noted through the audits (and the Designated Safeguarding Leads Forum)

was around communication with key partners, with some schools reporting frustrations at the lack of feedback from Children's Social Care and in some cases schools not being aware that children they work with have an allocated social worker. Schools reported they were able to access appropriate safeguarding training but there were some further requests on training on FGM and Child Sexual Exploitation.

Future audits in 2018-2019 will include the local authorities, and voluntary sector partners.

Learning from Case Reviews

The Case Review Subgroup is made up of multi-agency partners including Police, Health and Local Authorities and was chaired previously by the Director of Family Services in Hammersmith & Fulham. However, following a change in role, the subgroup was subsequently chaired by the LSCB Independent Chair. In 2017-18 the subgroup met and reviewed:

- 5 Serious Case Reviews published by other LSCBs
  Themes explored included suitability of special guardianship orders, effective services to meet the needs of vulnerable adolescents due to neglect, appropriate multi-agency responses to vulnerable adolescents at risk of exploitation through radicalisation, effective supervision to challenge fixed thinking around a case, transitions between children and adults services.
- A challenge to another LSCB on a finding included in a newly published serious case review.
- An unpublished learning review from another LSCB
- 3 local cases not meeting the threshold for serious case review but where learning is applicable
- Changes to the Serious Case Review process due to be implemented following the Government's consultation on Working Together to Safeguard Children 2018.
- 3 action plans from local Serious Case Reviews

The LSCB worked in partnership with two other LSCBs on the Luton Child J Serious Case Review, which was published in June 2017. Child J was a thirteen-month-old boy who had moved with his mother and her new partner to Luton after spending his early life in Hammersmith and Fulham and Ealing. Whilst there was very limited work with the family in Hammersmith and Fulham, we have cascaded the learning from the serious case review to practitioners via our LSCB multi-agency training programme and a local lunch and learn session. In addition, the Cabinet Member for Children's Services in Hammersmith & Fulham wrote to the then Minister with responsibility for child safeguarding, asking that government review and set out guidance so that there is no room for variation between authorities and clarity about what should happen when a 'Child in Need' moves into a new area. This is partially reflected in the revised 'Working Together to Safeguard Children 2018' which now states that 'Where a child in need has moved *permanently* to another local authority area, the original authority should ensure that all relevant information (including the child in need plan) is shared with the receiving local authority as soon as possible. The receiving local authority should consider whether support services are still required and discuss with the child and family what might be needed, based on a timely re-assessment of the child's needs, as set out in this chapter.'

A challenge to one of the findings in the review was raised by a local partner agency (Standing Together) and escalated by the Chair of the LSCB to the Luton LSCB.

Members of the Case Review Subgroup also contributed to the delivery of the LSCB Learning Event for the Clare and Ann Serious Case Review that took place in January 2018 where over 100 practitioners from local services attended.

The LSCB is awaiting the publication of a local Safeguarding Adults Review (SAR) to learn from the case of an adult where practitioners could not gain access, leading to a near miss. This SAR was commissioned by the Safeguarding Adults Board in December 2017 and the LSCB will work in partnership with the Adults Board to disseminate the learning once published.

LSCB Multi-Agency Training

The LSCB training programme is coordinated by our LSCB Multi-Agency Trainer with support from the Learning and Development Subgroup. Between April 2017 and March 2018, the LSCB delivered 100 face to face training workshops through the LSCB training programme. A total of **1753** delegates attended the workshops from a range of agencies across the partnership, including many in the voluntary sector. Across all of our workshops offered, there was an average booking rate of **97.6%**, illustrating the high demand for safeguarding children training, whilst overall attendance at training (across all workshops) was **71.6%**.

The Learning and Development Subgroup approved revised terms and conditions for the LSCB training programme to start in 2018-2019, and it is hoped that this will further reduce the number of delegates not attending training and raise revenue for the development of the LSCB training programme where cancellation fees are applied.

The LSCB training programme is split into three main sections:

Mandatory training: this features our two core training workshops which are the Introduction to Safeguarding Children (1/2 day) and the one day Multi-Agency Safeguarding and Child Protection Workshop.

Specialist training: this features a variety of more specialist topics, including Safeguarding Children and Domestic Abuse, Child Sexual Exploitation, Safeguarding Children and Gang Awareness, Private Fostering Workshops, and a new workshop on Online Safety we have developed.

Managerial training: this features training such as our Meet the LADO workshop and Safer Recruitment and Safer Recruitment Refresher workshops.

Further details about our training offer can be found on the LSCB website: www.rbkc.gov.uk/lscbtraining

The LSCB conducts a training needs analysis every year in order to help inform the design and commissioning of the training. This involves consulting with partners about their training needs, and helps us to understand what the emerging needs may be and if we need to expand on or deliver new training topics.

The LSCB is proud of the collaborative working demonstrated in the delivery of the LSCB training programme. Wherever possible, the LSCB asks key partners to deliver or co-deliver the training workshops so that local knowledge and expertise can be shared and the table on the page 21 demonstrates this.

The LSCB hosted a learning event in January 2018 to highlight the learning from a local Serious Case Review: Clare and Ann. This case involved a mother, who, whilst acutely unwell, killed her partner and eldest daughter, and seriously injured the couple's youngest child. The aims of the event were to explore the key learning points within both the Serious Case Review and the Domestic Homicide Review, and share updates from key partners about the changes that have been implemented since the reviews were first published. 121 local practitioners attended the event and 86.25% of attendees who completed an evaluation rated the event as 'good' or 'excellent'.

The LSCB monitors the feedback from LSCB training workshops, but acknowledges that it is still challenging to monitor the impact of the training we deliver. At every workshop we deliver, we ask delegates to rate the workshop experience, as well as whether the learning outcomes have been

met. Some example feedback from a couple of our mandatory workshops are displayed below:

Delegates are asked to rate their knowledge and understanding of the learning outcomes before the workshop and after. They are also asked to rate the training experience overall.

This is the scale they are asked to use.

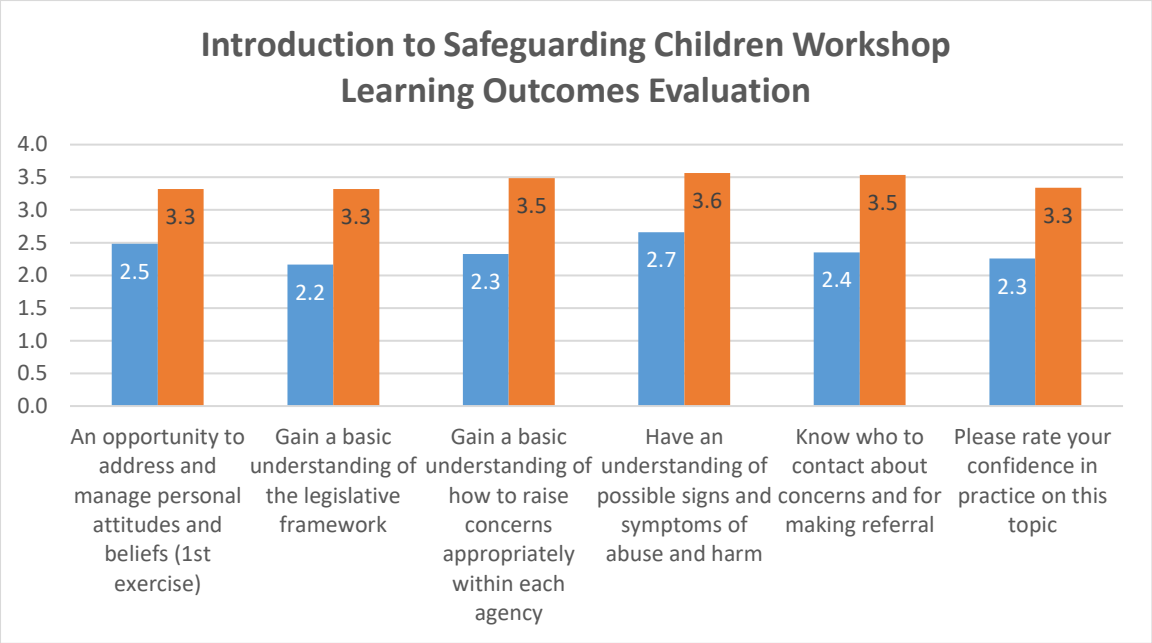
Poor = 1 Satisfactory = 2 Good = 3 Excellent = 4

Legend

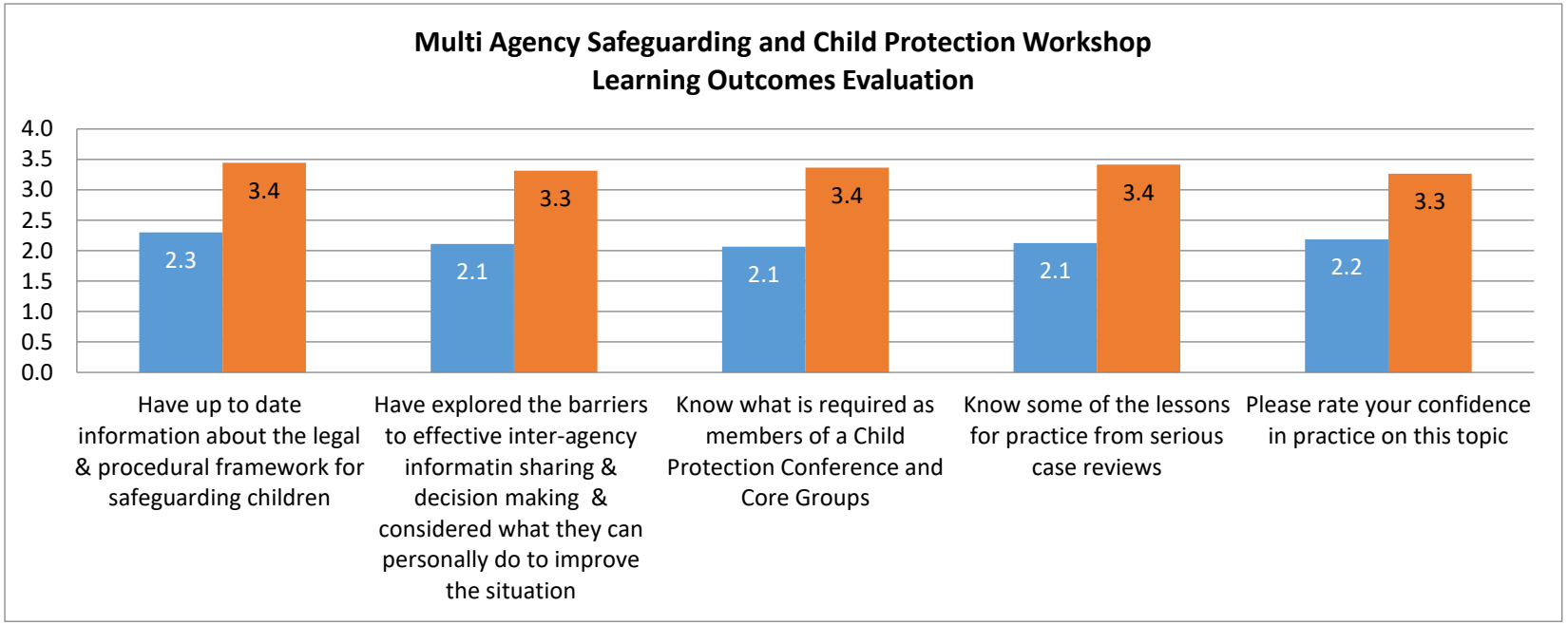
- Before the workshop - After the workshop

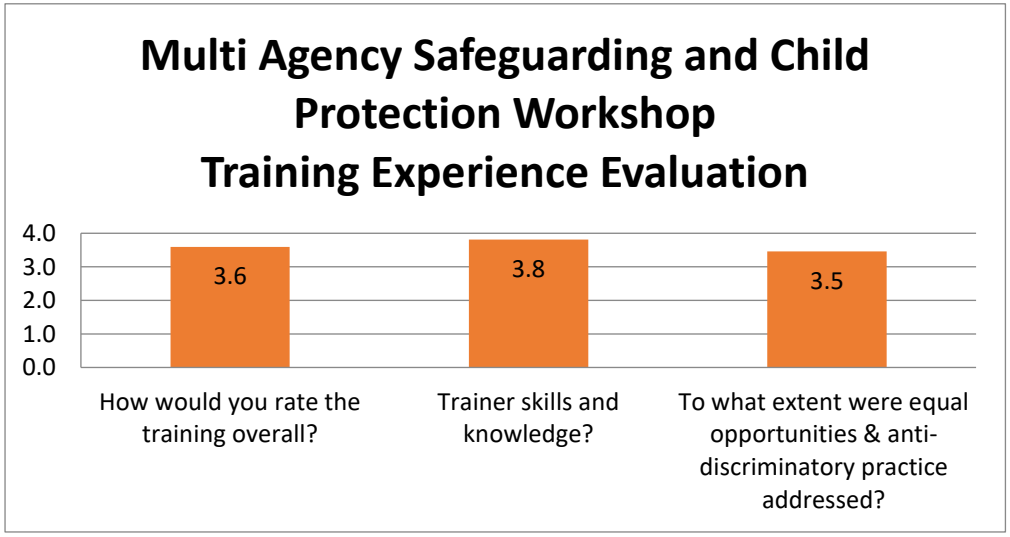
The following charts show the average scores given for learning outcomes and training experience for the Core workshops:

Sessions Delivered: 12 Delegates: 206



Sessions Delivered: 34 **Delegates: 705**





The Learning and Development Subgroup has also tried to monitor the impact of the training course that we deliver via the LSCB training programme. Delegates are asked to share feedback at the end of each workshop about how what they've learnt will impact on their practice. We also send a smaller number of delegates a follow up email survey to check the impact three to six months following their attendance at training. We have noted that only a small percentage of delegates complete this. The LSCB Learning and Development Subgroup will continue to monitor and challenge this in 18-19.

Future plans:

In 2018-2019, the Learning and Development Subgroup are keen to support the workforce to gain a better understanding of contextual safeguarding, in order to build on our work to safeguard adolescents in particular. We are also keen to re-launch our 'Learning from Serious Case Reviews' workshops.

In 2018-2019, the LSCB will also need to launch a new learning management system (LMS) for LSCB training bookings. This is because it is anticipated that the current system used by the Local Authorities is due to be upgraded.

The table below demonstrates the wide range of LSCB partner agencies supporting the delivery of LSCB training workshops.

Programme	Workshop	Trainer Agency											Total no. of sessions
		Health	LBHF	RBKC	WCC	Tri-Borough	LSCB Trainer	External Trainer	Standing Together	IKWRO	Turning Point	WAGN	
Core	Introduction to Safeguarding Children						11						11
Core	Multi-Agency Safeguarding and Child Protection (level 3)	9		7			33		2				51
Core	Multi-Agency Safeguarding and Child Protection (Refresher level 3)						5						5
Managerial	Safer Recruitment					4	4						8
Managerial	Safer Recruitment Refresher (level 6)					3	1						4
Managerial	Meet the LADO					5							5
Specialist	CSE: A Trauma Focused Approach											7	7
Specialist	Safeguarding and Domestic Abuse								6				6
Specialist	MARAC Workshop								8				8
Specialist	Safeguarding and Neglect							1	1				2
Specialist	Safeguarding and Gang Awareness		1		1	1							3
Specialist	Ending Harmful Practices (RBKC only)									2			2
Specialist	Ending Harmful Practices					2							2
Specialist	Private Fostering workshop					3							3
Specialist	Young Carers information session					3							3
Specialist	Parental Substance Misuse										1		1
Specialist	CP conference workshop			4		1							5
Specialist	Safeguarding and Supervision								1				1
Specialist	Missing Children protocol		3			3							6
Specialist	Online Safety						2	2					4
Total number of sessions delivered		9	4	11	1	25	56	3	18	2	1	7	137
% of total sessions delivered		6.6	2.9	8	0.7	18.2	40.8	2.3	13	1.5	0.7	5.1	100

Child Death Overview Panel (CDOP)

The Local Safeguarding Children Board functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Board Regulations 2006, under section 14 of the Children Act 2004. The LSCB is responsible for:

- Collecting and analysing information about each death with a view to identifying:
    - Any case giving rise to the need for a review
    - Any matters of concern affecting the safety and welfare of children in the area of the LSCB
    - Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.
- Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Note: The responsibility for determining the cause of death rests with the Coroner or the doctor who signs the medical certificate of the cause of death and not with the Child Death Overview Panel.

The process for reviewing child deaths includes:

- an overview of all child deaths up to the age of 18 years (excluding those babies that are stillborn and planned terminations of pregnancy carried out within the law)
- A multi-agency rapid response meeting is convened following an unexpected child death in order to make initial enquiries and co-ordinate support to the bereaved family.

This has been a challenging year for CDOP colleagues and partner agencies. We have received an increase in child death notifications related to registration of extremely premature infants born alive, as well as the notifications following the tragedy of the Grenfell Tower Fire.

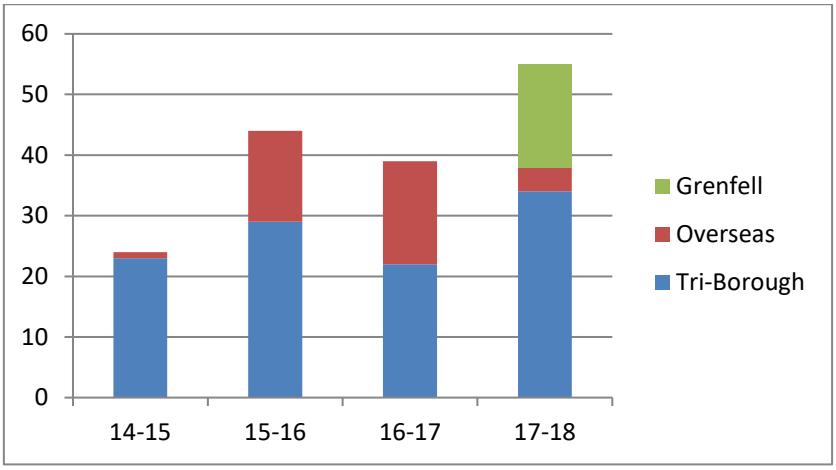
Following an unexpected death, a rapid response meeting is normally held within 5-7 days of the death occurring. This is chaired by the Designated Paediatrician for Child Death.

Modifiable factors are defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

The panel has reviewed child deaths that have occurred across the three local authorities, identifying factors that may have contributed to the deaths along with any modifiable factors. The timing of the reviews is subject to the number of cases relating to a particular theme and other processes such as serious case review, police investigation or an inquest occurring.

In 2017-18, the CDOP Panel received 55 child death notifications in total, including

17 children who were victims of the Grenfell Tower fire and four children who normally resided overseas but who died whilst in the LSCB area.

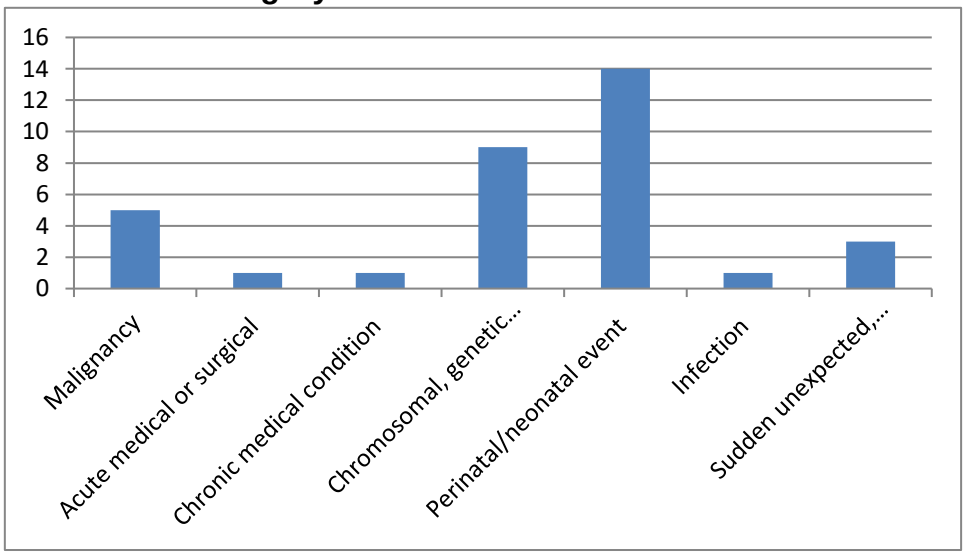


We noted a significant increase in notifications compared with previous years, and whilst the cases associated with the Grenfell Tower fire account for some the increase, there remains an increase of approximately a quarter on the average number of cases notified in the previous three years. This is likely due to an increase in neonatal notifications following the publication of the 'Registration of Stillbirth' briefing paper (House of Commons, 2018) which states 'the birth of a baby who is born alive must be registered, whatever the length of the completed pregnancy. The death of a baby born alive must be registered in the same way as any other death', thus requiring notification to CDOP as well.

Separate to the deaths relating to the Grenfell Fire tragedy, in 2017-18, a total of 12 deaths were unexpected, and required a rapid response meeting to be held. This is similar to 2016-2017 where 32% of the deaths in the LSCB area were unexpected.

The main categories of death for deaths occurring in 2017-18 include perinatal/neonatal events (this is the largest group, and links with the largest age group being neonates under 28 days old), or chromosomal, genetic and congenital and again this relates to this group of six infants under 28 days old.

Provisional category of death for deaths notified in 2017-2018



22 boys and 12 girls died across the LSCB area. The number of boys who have died

is almost double from last year, when 12 boys died and this increase is due to the number of boys under 28 days of age dying in 2017-2018 more than doubling (5 neonatal male deaths in 2016-2017). The majority of the children (74%) were under the age of one and this is similar to last year's figure of 76%.

The CDOP panel was notified of the deaths of four children who normally resided overseas but who died locally. We have seen a significant drop in the number of such children dying as compared to last year. It is unclear why this is, but may be linked to work the CDOP panel has undertaken with private healthcare providers. We convened a themed panel with representatives from the private healthcare sector in order to gain insight into the referral processes, practices and bereavement care, to enable the panel to be assured about the practices undertaken by the specialist nurse for Child Death to review the cases being notified by private providers. No concerns were identified.

Learning from child death reviews:

A number of socioeconomic and economic factors were identified in the deaths reviewed in 17-18, including vulnerable pregnant women with no recourse to public funds, poor housing, chaotic home environment, unsafe sleep environment, temporary housing and knife crime.

A number of parenting and family factors were also identified in the cases reviewed, including parents unable to accept prognosis and wanting to continue active treatment which may not be in the child's best interests, parental mental health issues impacting on their ability to access antenatal care, high maternal BMI and maternal infections associated with increased risk of premature delivery and parental smoking.

The panel also identified an access to healthcare factor in parental access to mental health services during an acute crisis.

The panel identified some service provision and care factors which have been raised with individual providers where appropriate including:

- Increased vulnerability of children following complex surgical and medical interventions
- Appropriateness of transfer to the UK for treatment when the prognosis is very poor
- Appropriateness of extensive invasive treatment in neonates with extremely poor prognosis
- Implantation of multiple embryos during IVF
- Inadequate communication between Health, Social Care and Police, particularly in relation to welfare checks
- Recognition of breech presentation in early labour

Safeguarding factors that the Panel identified included:

- Vulnerability of parents at high risk of suicide following the death of their child
- History of parental alcohol and substance misuse
- History of poor parenting with children's social care involvement, including

known neglect/abuse in the family home
- History of domestic violence in the home
- Young children acting as carers for their younger siblings

Other factors that the Panel identified included:

- Extreme prematurity
- Chorioamnionitis (infection within the womb) and other maternal factors linked with premature delivery
- Congenital complex medical disease

It is important to note that due to relatively low number of deaths, this makes it impossible to provide an accurate statistical interpretation or trend analysis. All unexpected deaths were managed appropriately using the rapid response process.

Relevant learning is cascaded via the health networks in our LSCB area, with the intention that learning from local and national child reviews is incorporated into practice, training and supervision.

Trends and learning identified that may have implications nationally are shared through the national CDOP network.

The future of CDOP and transition to new arrangements

The new 'Working Together to Safeguard Children 2018' was published in July 2018, and alongside this, new guidance for Child death review: statutory and operational guidance (England) was published in October 2018.

The new statutory guidance requires CDOPs to cover a geographical footprint that would enable a minimum of 60 cases to be reviewed per year. In order for our CDOP to meet this requirement, it is anticipated that we will need to merge with at least two neighbouring CDOPs. With that in mind, CDOPs across North West London have been exploring ways in which we could develop a service across this wider footprint.

This guidance sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working Together to Safeguard Children 2018 and clarifies how individual professionals and organisations across all sectors involved in the child death review process should contribute to reviews. The guidance sets out the process in order to:

- improve the experience of bereaved families, and professionals involved in caring for children
  and
- ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths

The new guidance places an emphasis on the Joint Agency Response, which includes home visits by a Child Death Review clinician and senior police officer, as well as bereavement support with the introduction of a new key worker role.

Grenfell Tower Fire

Members of the Local Safeguarding Children Board were deeply saddened by the recent tragedy of the Grenfell Tower Fire and our thoughts rest with the families and friends who lost loved ones in this disaster and the many families who lost their homes.

The Board met shortly after the tragedy in July 2017 and approved the development of the Grenfell Operational Management Group, in conjunction with the Safeguarding Adults Board, to help facilitate information sharing and prioritise actions for partner agencies in their response to the fire.

The Board also received updates on the package of support available to all local schools impacted by the fire, for both the staff and the children and families. An enhanced summer programme 'Summer in the City' was commissioned by the Local Authority and delivered in order to provide local children and families with positive activities to take part in.

Members of the LSCB team supported the staff and volunteers at the Al Manaar Mosque in north Kensington in the immediate few weeks after the fire as well as assisting with outreach work in the community to help promote the local services on offer to support residents in the aftermath of the fire.

Our Child Death Overview Panel (CDOP) team collated the information that was possible to from the Coroner's Court in relation to the very sad deaths of the children as a result of the fire and liaised with the Grenfell Key Workers and Police Family Liaison Officers to ensure that all the bereaved families were signposted to support. As a result of the ongoing Police investigation, Coronial Proceedings and Public Inquiry, the CDOP reviews for the children who died were not able to be completed in full and it is expected that these will be delayed until all other proceedings have concluded.

In the months that followed the fire, the Board received regular updates from colleagues about the work undertaken to re-house families, as well as updates on the delivery of the Grenfell Support Service which allocated dedicated keyworkers to residents affected by the fire, and the development of The Curve facility for residents.
The LSCB facilitated dedicated safeguarding children training sessions for staff and volunteers working at the Curve and we shared advice with the team at the Curve to help them develop their safeguarding children policy.

The Local Authority Safeguarding and Quality Assurance team also assisted the Grenfell Support Team to conduct audits of their casework.

Following the tragedy, the RBKC Early Help service has seen an increase of 13% in early help referrals and as a result a specific team of Early Help practitioners has been set up to respond to Grenfell families. The Local Authority has also set up the Grenfell Education Fund. This provides financial support to schools and is also planning longitudinal studies to understand the longer-term impact on children.

LSCB Website and Social Media

The LSCB website statistics show that the most viewed webpages tend to be the LSCB Training Pages and Safeguarding Contacts Pages. Further development work is needed on the front page of the website, to include a scrolling carousel of news items on the front page, rather than the static image we have currently – we hope that this will enable us to highlight new and refreshed content to visitors.

The LSCB has a social media presence on Twitter (@LSCBx3). We have grown our following to over 500 followers and have used this platform to amplify messages about national safeguarding campaigns led by the DfE and local initiatives such as our One Life, No Knife event for parents and carers. This is something we would like to develop further in 2018-19.

Future priorities

As the LSCB is in transition to our new multi-agency safeguarding arrangements, the priorities will be reviewed with partners again to determine if any updates are required.

Appendix 1 – LSCB Membership and Attendance

LSCB Main Board Attendance 2017-18				
Role	**11th May 2017**	**18th July 2017**	**17th October**	**23rd January 2018**
LSCB Chair	y	y	y	y
Executive Director of Children's Services (Tri-Borough)	y	y	y	n
Director of Family Services (H&F)	y	y	y	y
Director of Family Services (RBKC)	y	y	y	y
Director of Children's Services (WCC)	y	y	x	y
Director of Schools (Asst Director) – Tri-Borough	y	y	y	y
Head of Combined Safeguarding & Quality Assurance (Children's Services)	y	y	y	y
LSCB Business Manager	y	y	y	y
Director of Adults Safeguarding (or rep)	y	y	y	y
Housing	y	y	y	n
Police Borough Commander	y	y	y	n
Police CAIT	y	y	n	n
Probation	y	y	y	y
Community Rehabilitation Company	y	n	n	n
CAFCASS	y	y	y	y
Prisons (Wormwood Scrubs)	y	n	y	n
London Ambulance Service	n	n	n	n
Voluntary Sector (Standing Together)	y	y	y	y
Lay members	y	y	y	y
NHS England	n	y	n	n
Clinical Commissioning Groups	y	y	y	n

Designated Doctor	y	n	y	y
Designated Nurse	y	y	y	y
Head of Safeguarding, CLCH	y	y	y	y
CLCH Director of Nursing	n	y	n	n
Imperial Healthcare Trust, Director of Nursing	y	n	n	y
ChelWest, Director of Nursing	n	n	n	n
WLMHT/West London NHS Trust	n	y	y	y
CNWL	y	y	y	y
Public Health (Tri-borough)	y	n	n	n
Community Safety	y	y	y	n
Policy Team (Commissioning)	y	o	o	o
Head Teachers	y	y	y	y
Cabinet Member for Children's services, H&F	y	n	n	n
Cabinet Member for Family and Children's Services, RBKC	n	n	y	y
Cabinet Member for Children's Services, WCC	y	n	y	n

Appendix 2 – LSCB Budget LSCB Budget

2017/18 Outturn

	2017/18 Outturn				
	LBHF	**RBKC**	**WCC**	**TOTAL**	
CONTRIBUTIONS					
Sovereign Borough General Fund	**-79,169**	**-59,470**	**-77,699**	**-216,338**	*excluding corporate overhead costs*
Metropolitan Police	-5,000	-5,000	-5,000	**-15,000**	
Probation	-2,000	-2,000	-2,000	**-6,000**	
CAFCASS	-550	-550	-550	**-1,650**	
London Fire Brigade	-500	-500	-500	**-1,500**	
CCG (Health)	-20,000	-20,000	-20,000	**-60,000**	
Total Partner Income	**-28,050**	**-28,050**	**-28,050**	**-84,150**	
Total Funding (excluding reserves)	**-107,219**	**-87,520**	**-105,749**	**-300,488**	
EXPENDITURE					
Salary expenditure	58,957	58,957	58,957	**176,871**	
Training	2,750	2,750	2,750	**8,250**	
Other LSCB costs	7,700	7,700	7,700	**23,100**	
2016-17 S113 shared cost adjustment	30,779	-40,848	10,069	**0**	
Total expenditure	**100,186**	**28,559**	**79,476**	**208,221**	
Forecast variance	**-7,033**	**-58,961**	**-26,273**	**-92,267**	
Moved to B/S for partner income					
Final outturn variance	**-7,033**	**-58,961**	**-26,273**	**-92,267**	
BALANCE SHEET					
Reserves Brought Forward	-38,183	-70,689	-55,226	**-164,098**	
Adjustment in year				**0**	
Contribution to LSCB balance sheet accounts	-7,033	-58,961	-26,273	**-92,267**	
Reserves to take forward	**-45,216**	**-129,650**	**-81,499**	**-256,365**	