Local Safeguarding Children Board

Hammersmith & Fulham | Kensington and Chelsea | Westminster

ANNUAL REPORT 2018-2019

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Introduction from the LSCB Independent Chair

Independent Chair

Jenny Pearce

Welcome to this year's Local Safeguarding Children Board (LSCB) annual report for 2018-2019.
This was an important year as changes in legislation and related statutory guidance for safeguarding children set out the need to develop the new safeguarding children partnership arrangements that must be in place from October 2019.

We have worked to consult with key stakeholders to consolidate the work of the LSCB, and to ensure that we are ready to implement the new changes.
The legislation requires the Police, local Authority and Health Commissioners to lead safeguarding children arrangements which will then be scrutinised by an independent scrutineer. This means that the title of my role will change from Independent Chair to Independent Scrutineer.

Addressing these changes has been a productive exercise and plans are in place to build on the strong partnerships that already exist to safeguard children. With the LSCB becoming the Local Safeguarding Children Partnership (LSCP), we will retain quarterly partnership meetings with the wide body of agencies holding responsibility for safeguarding children, ensuring that this shared responsibility is embedded in practice across all agencies.

In my role as Independent Chair, I have noted and am encouraged that all our local partners want to keep hold of the strong partnership relationships so that information sharing and regular updating on safeguarding concerns can continue.

Over the year our work has addressed a number of safeguarding concerns, including the continued recognition of the impact of the tragedy of the fire at Grenfell Tower. We have worked to our three safeguarding children priorities, addressing peer on peer abuse, the impact of domestic abuse and engaging with children and young people. Examples of this work are outlined within the report. Very sadly we have worked with a number of cases involving knife crime and will be following up on some through learning events and case reviews. As across the country, knife crime, peer on peer violence and the criminal exploitation of children is a significant problem, raising the need for strong multi-agency partnership working. To facilitate this we have set up an LSCB subgroup looking specifically at 'Safeguarding Adolescents'. This, alongside other subgroups, reports to the quarterly safeguarding children board meetings, ensuring that all partners learn from and engage with the ongoing safeguarding concerns across the three boroughs. The work of the LSCB will continue as we transition into the new arrangements and I look forward to continuing to work with colleagues to work towards safeguarding children now and in the future.

The local picture

Hammersmith and Fulham

Approximately **35,150** children and young people aged 0 to 19 years live in Hammersmith and Fulham. This is **19%** of the total population in the area.

Kensington and Chelsea

Approximately **29,801** children and young people aged 0 to 18 years live in Kensington and Chelsea. This is less than **19%** of the total population in the area.

Westminster

Approximately **44,465** children and young people aged 0 to 19 years live in Westminster. This is less than **19%** of the total population in the area.

Local Safeguarding Data 2018/2019

6141 Referrals to Children's Social Care (**1668** LBHF / **2234*** RBKC / **2239** WCC)

271 Children were subject to a Child Protection Plan (**159** LBHF / **51** RBKC / **61** WCC)

Neglect and **Emotional Abuse** are the most frequent reason for children being placed on a Child Protection Plan in 2018-2019

Domestic Abuse continued to be the main parental risk factor leading to children becoming subject of a Child Protection Plan, and Neglect, Mental Health, Alcohol and Substance Misuse are also significant factors.

553 children were Looked After (**251** LBHF / **93** RBKC / **209** WCC)

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

1 serious incident notification made to the National Child Safeguarding Practice Review Panel, which will be a **Serious Case Review** in Hammersmith and Fulham

106 face to face multi-agency safeguarding children training workshops attended by **1760** delegates

5 Designated Safeguarding Lead for Schools Training Sessions

5 Designated Safeguarding Lead for Schools Networking Forums

3 Safeguarding Training workshops for School Governors

1 Safeguarding Training workshop for Tri-Borough Music Hub, attended by **55** music tutors attending schools in all three boroughs.

61 schools in Hammersmith and Fulham, **97%** were rated Good or better

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

59 schools in Westminster, **93%** 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 and the revised statutory guidance in 'Working Together to Safeguard Children 2018', which was published in July 2018.

Our LSCB is chaired by an Independent Chair, Jenny Pearce. 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) were 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.

Development of the new Local Safeguarding Children Partnership

The future of the multi-agency safeguarding partnership was 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 the Safeguarding Partners were required to publish in June 2019, ahead of implementation by October 2019.

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 held a number of meetings with the local authority Chief Executives, Directors of Children's Services, Police and Clinical Commissioning Group, as well as wider partners to develop the new model. This development work continued through to October 2019, when the new Local Safeguarding Children Partnership held its inaugural meeting. The agreed structure for the LSCP can be found on p11.

The new Local Safeguarding Children Partnership will retain the three key priorities from the Local Safeguarding Children Board which can be found on page 10.

In addition, the new partnership aims to build stronger relationships and joint working opportunities with other strategic partnerships across the three local authorities, including:

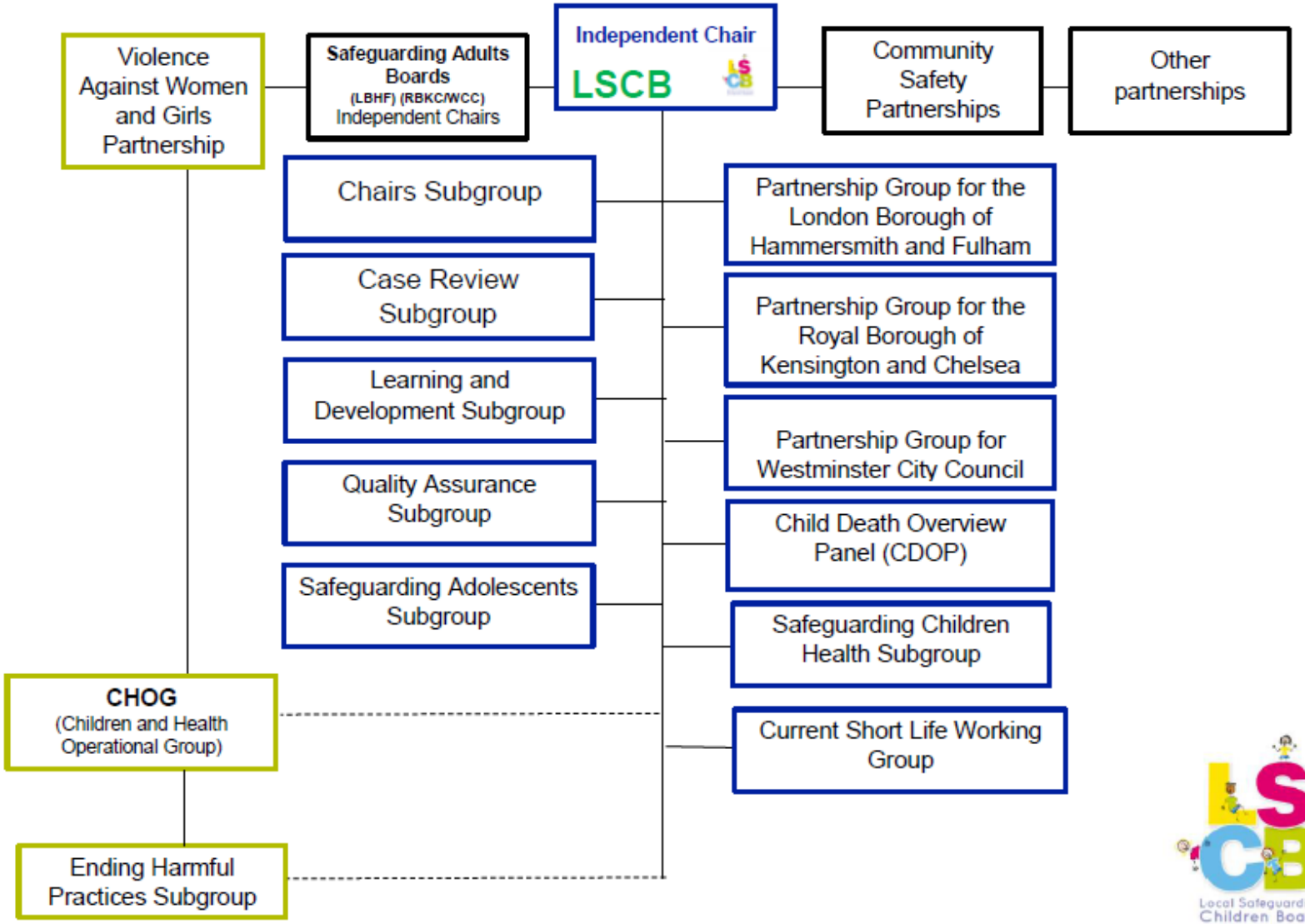
- the Community Safety Partnerships – tackling serious youth violence and knife crime and sharing the learning from Domestic Homicide Reviews (DHRs).

- the Violence Against Women and Girls Partnership – tackling domestic abuse and harmful practices

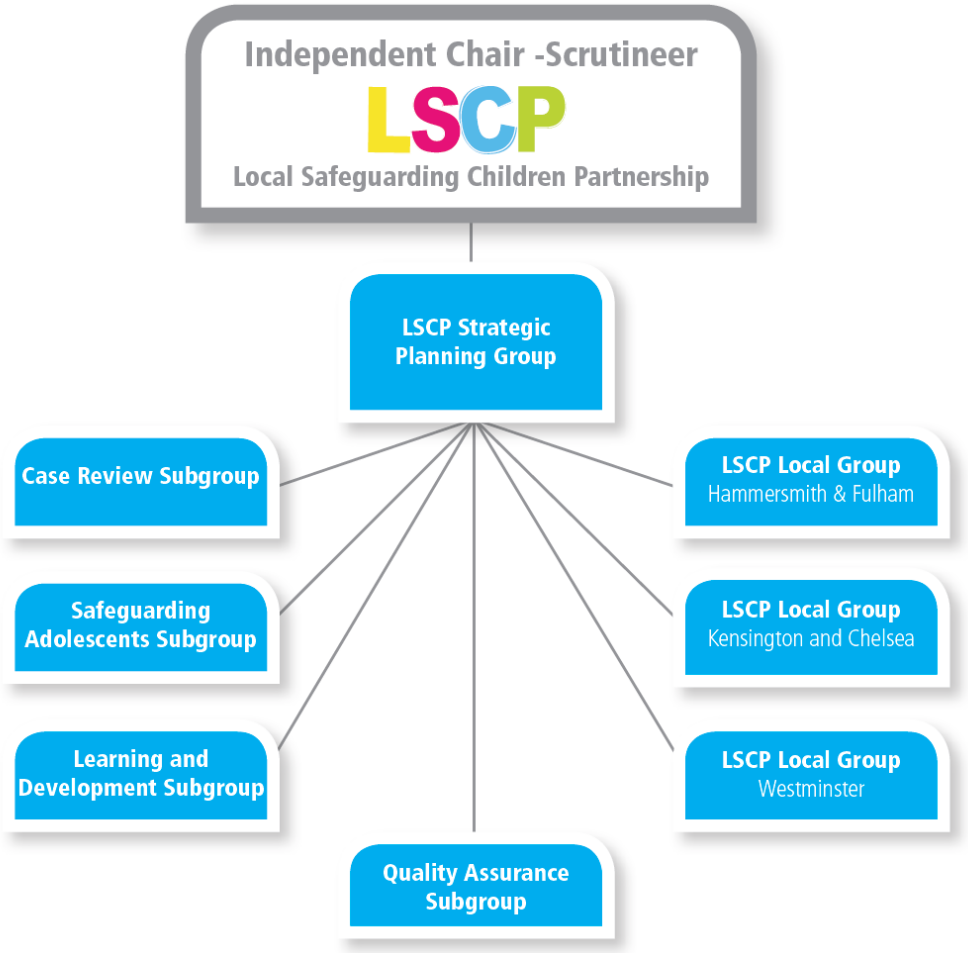
- the Health and Wellbeing Boards

- the two Safeguarding Adults Boards – developing a 'Think Family' approach, and work around transitional safeguarding as we know that young people can still be vulnerable when they turn 18.
  We plan to host some joint learning events between the Local Safeguarding Children Partnership and the two Safeguarding Adult Boards on these two topics.

LSCB structure until September 2019



LSCP Structure from October 2019



Other strategic partnerships the LSCP will liase with

- **Safeguarding Adults Board** Hammersmith & Fulham
- **Safeguarding Adults Executive Board** Kensington and Chelsea, Westminster
- **Community Safety Partnership** Hammersmith & Fulham
- **Safer K&C Partnership** Kensington and Chelsea
- **Safer Westminster Partnership** Westminster
- **Violence Against Women and Girls Partnership (VAWG)** Hammersmith & Fulham, Kensington and Chelsea, Westminster
- **Health & Wellbeing Board** Hammersmith & Fulham
- **Health & Wellbeing Board** Kensington and Chelsea
- **Health & Wellbeing Board** Westminster

LSCB Priorities 2018-2019

The new LSCB Chair and Board members agreed to retain the current 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.

The Police and the Local Authority Safeguarding Leads for Schools worked together to begin planning the roll out of Operation Encompass. This is 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 formally endorsed the roll out of Operation Encompass in January 2019.

The Children and Health Operational Group (CHOG), a shared subgroup of the LSCB and the Violence Against Women and Girls Partnership has led on the awareness raising of domestic abuse across the partnership. Its role is to encourage the implementation of the Co-ordinated Community Response (CCR) model in children and health agencies.

The CHOG Coordinator left on 31.03.2018 and there was a gap whilst recruitment decisions were made. The new coordinator started in October 2018 and since then, key successes include:

- the subgroup meetings have been revised and well attended
- the subgroup has agreed a theory of change and a data set to review.
- the subgroup has also reviewed the new Pathfinder project across the three boroughs.
- Domestic abuse training was provided to 49 staff at Royal Brompton Hospital
- The CHOG coordinator has attended the Westminster Early Help Strategy Launch
- The CHOG coordinator has co-delivered a workshop on domestic abuse and children at the Hammersmith & Fulham Partnership Group
- Supported the planning for the potential launch of the Safe and Together Model across the partnership

In addition, the VAWG partnership was successful in a bid to be part of the National Pathfinder project, leading innovative approaches to tackling violence against women and girls in the health economy, in acute health trusts, mental health trusts and community based IRIS programmes in GP practices. The Pathfinder project will help to identify good practice and develop guidance in the form of a 'toolkit' which will enable others to achieve a model response to domestic abuse in health settings.

Planned work for 2019-2020

The Safeguarding Children Partnership will continue to monitor the roll out of Operation Encompass across schools, including schools in the independent sector.

The Safeguarding Children Partnership will explore the possibility of using the Safe and Together Model. This child-centred model provides a framework for multi-agency practitioners to work alongside survivors of domestic abuse, and better intervene with perpetrators, in order to keep the child/ren safe and together with the non-abusing parent.

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: refers 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.

Contextual Safeguarding Learning Event for the LSCB: At the July LSCB Board meeting, Dr Carlene Firmin from the Contextual Safeguarding Network and the University of Bedfordshire was invited to share her presentation on contextual safeguarding to the partnership. Contextual safeguarding is an approach to understanding and being able to respond to young people's experiences of significant harm outside of their families, for example within their peer groups, in schools, online and in their neighbourhoods. Additional spaces were made available so that key practitioners from across the partnership could also attend to learn more about this approach.

Following this, the local authorities convened a contextual safeguarding working group to review and pilot tools to promote a contextual safeguarding approach to their work.

Safeguarding Adolescents Subgroup:
This year, the LSCB convened a new Safeguarding Adolescents Subgroup. Over the past year, the subgroup has considered the following:

- a mapping exercise to understand the different forums across the three local authorities where children and young people are discussed and whether there is a way to rationalise these.
- A bid to the Contextual Safeguarding Network for support in developing our approach to Contextual Safeguarding. Ultimately, this expression of interest was not successful, however, it did lead to our involvement in the Beyond Referrals Project, working with four schools to develop appropriate responses to harmful sexual behaviours.
- A thematic Learning Review from Croydon LSCB on vulnerable adolescents
- A report from the National Working Group for Sexually Exploited Children and Young People report on sexual exploitation and the transition between children's and adults' services.
- Feedback from young residents about local youth services

Operation Makesafe:
In February 2019, the Police and CSE leads, along with Designated Nurses, health and voluntary sector partners collaborated to deliver CSE training and awareness raising sessions at two conferences for local hotels across the three local authorities, as well as taking part in Operation Makesafe, a Police-led initiative to test CSE awareness in hotels which was run for the third time in March 2019.

Taith Project:
The three local authorities and partners have worked to roll out the Taith project, in partnership with Barnardo's. This is a trauma informed service that aims to work with young perpetrators of harmful sexual behaviour, to reduce offending behaviours and provide opportunities for therapeutic support. Referrals to the Taith project in all three boroughs have increased over the past year.

MASE (Multi-agency Sexual Exploitation Panel): The MASE 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. This year, planning began to extend the remit of MASE to include child exploitation and gang involvement, and multi-agency partners were consulted on how this might work effectively, to aid in mapping trends and disrupting harmful behaviour.

Safeguarding Adolescents at Risk Panel (SARP): SARP was launched in June 2019 to merge all panels of at-risk young people to one comprehensive multi-agency panel. SARP aims to streamline our current safeguarding practices and support better identification of risk and information sharing for some of our most vulnerable children and young people in Hammersmith and Fulham.

One Life No Knife Projects:
Planning began for an engagement event for parents and carers to discuss knife

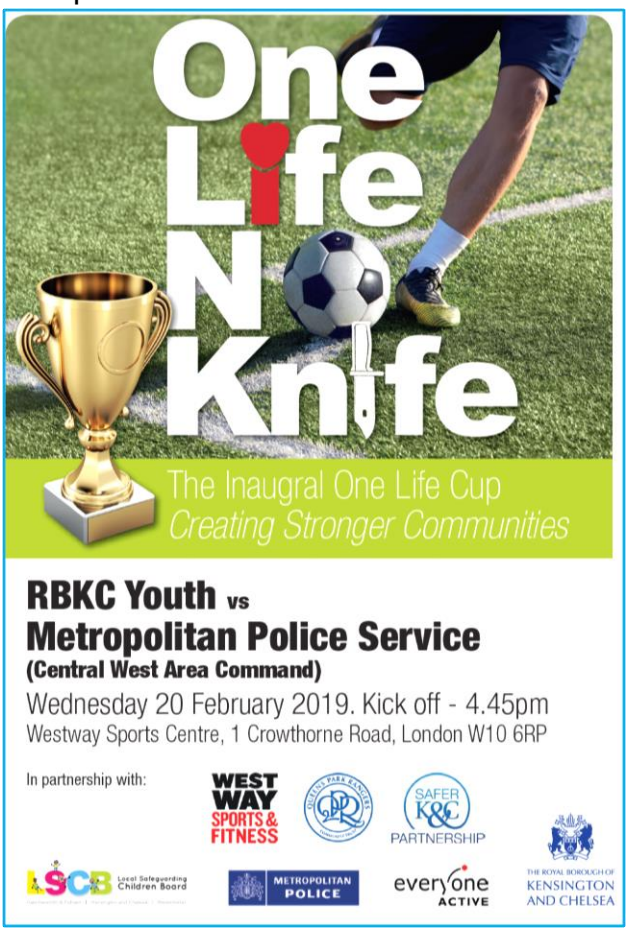
crime and serious youth violence in Hammersmith and Fulham, in preparation for an event that we aimed to host in the summer of 2019. Regrettably, difficulties in securing a suitable venue and date to accommodate key stakeholders led to a delay and we are now hoping to host this in 2020.

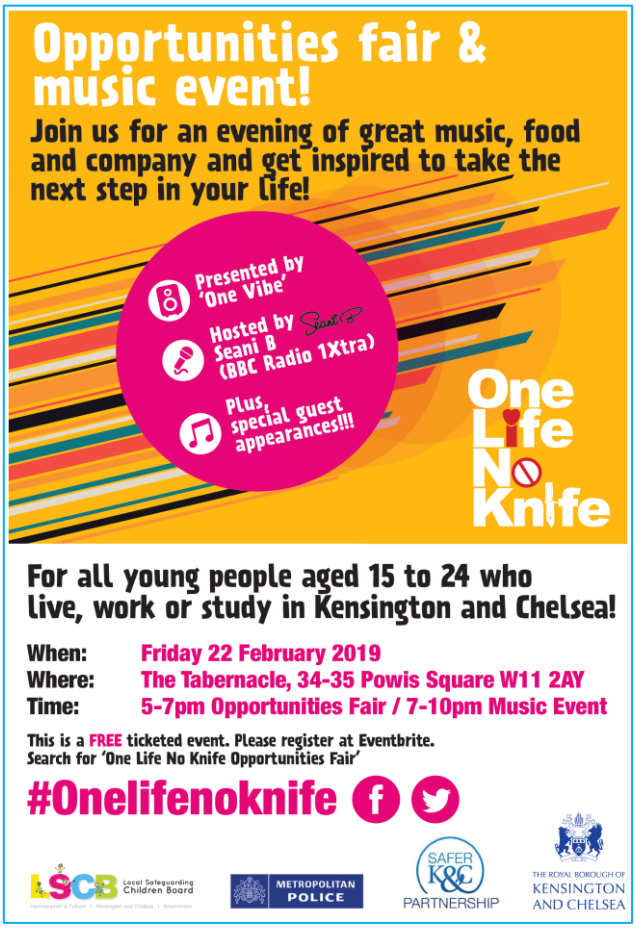
Case Study

In order to build on the One Life, No Knife work that was undertaken in Kensington and Chelsea last year, in February 2019 the police Basic Command Unit hosted a friendly football match between young people in Kensington and Chelsea and officers. The aim was to help build better relationships between young people and a key statutory service and share some important safeguarding messages with our young residents in the borough. The young players beat the police officers with the final score being 14 goals to 2!

Following this, the Safer K&C Partnership, together with the Royal Borough of Kensington and Chelsea and the Police hosted an opportunities fair for young people. This brought together a variety of employers and education providers, to showcase local opportunities for young people to consider. The employers present included British Airways, the British Army, the BBC, Chelsea Football Club, Queens Park Rangers Football Club, the London Fire Brigade and Chelsea and Westminster Hospital. The education providers who attended included Hammersmith & West London College, Imperial College, Thames Valley University and St Charles College. A total of 92 people attended, 60 of whom were young people.

A further engagement event for parents and carers, and young people, is also planned for 2020.





Flyers for the One Life, No Knife events in Kensington and Chelsea.

Case Study

Operation Makesafe

This is a Police-led operation to target child sexual exploitation (CSE) across the three local authorities in order to:

- to test local hotels' recognition and response to possible CSE situations from the Operation Makesafe training that they had previously received.

- to share the findings with the hotels to identify opportunities for learning,

How we did it:
Each hotel was visited after school, with different pairings of adult and child (Police Cadets). The main 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 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.

Following this, the hotel staff and general manager were debriefed by Police CSE officers and multi-agency partners.

The latest operation took place across three evenings in March 2019, following the two CSE awareness conferences for hotels held in February 2019.

This year, we noted an improved response from hotels to CSE concerns, compared to when the Operation was run the previous year.

Background:
Operation Makesafe was a policing test purchasing initiative to identify hotels susceptible to being locations for Child Sexual Exploitation (CSE). The Operation was derived from intelligence that hotel rooms are used by perpetrators.

Raising Awareness of CSE with local hotels:
To ensure the findings were translated into meaningful action and change, two CSE conferences, hosted in a local west end hotel were planned and organised. The Head of Safeguarding in the Metropolitan Police Service at the time, and the Assistant Director of Family Services from Hammersmith & Fulham opened the conferences. Barnardo's Nightwatch Scheme, Local Authority CSE leads, specialist sexual offences investigators and police licensing officers also spoke at the conferences. The events also included very powerful testimony from survivors of CSE.

Around 100 hotel owners, managers and supervisors from hotels across the three local authorities attended the conferences, which took place on the 4th and 11th of February 2019.

The conferences won 'hearts and minds' leading to hotels across the three local authorities being less receptive to perpetrators of CSE.

To end the event, attendees from the hotels were invited to sign a 'Statement of Intent' for their establishment to:

- Challenge guests where signs of CSE were apparent.
- To only accept bookings with official identification.
- To support the Police and report anything suspicious.
- To implement training for their staff to spot signs of exploitation.

Planned work for 2019-2020

Beyond Referrals Project: LSCB Partners are keen to develop a greater understanding about Contextual Safeguarding and hope to pilot some work with four schools in Westminster and Kensington and Chelsea with the Beyond Referrals project, in partnership with the University of Bedfordshire. This pilot aims to support schools to be able to address harmful sexual behaviours in their settings.

Priority 3 – Hearing the voice of children and young people

Our safeguarding self-assessments (Section 11 audits) give some feedback about how partner agencies use opportunities to hear from children and young people.

Multi-agency and single agency audits consider the voice of the child in case work.

This year, our Safeguarding Adolescents subgroup considered the voice of children and young people in relation to safety and security. They told us that they wanted to see youth workers visible in their communities, to have access to advice and information regarding personal safety, to have access to safe spaces for young people and help for young people to steer them away from committing crimes.

Planned work for 2019-2020

The Partnership will re-advertise for the role of Children and Community Engagement Officer.

We also want to build on the One Life No Knife events for young people and potentially expand these across all three boroughs.

Other projects:

Review of Child Protection Conferences and options for alternative pathways:

This year, a project began to review the child protection conference system through a systemic lens and to consider whether there are different ways of doing things that would bring greater benefits to families. The review sought to answer the following questions:

- What is the quality of our overall engagement with, and treatment of, families

at the early stages of the child protection process?
- Do families experience our engagement with them as helpful?
- What are families' and professionals' specific experiences of Danger Statements?
- To what extent has the child protection conference system adopted systemic ways of thinking, working and positioning in respect of families?
- Are there alternative pathways to the CP conference route for some families?

Work began to consult with families and multi-agency professionals to help shape proposals. We aim to pilot new approaches in a small number of cases next year.

Quality Assurance

Serious Youth Violence and Exploitation audit:

During 18-19, the LSCB completed a multi-agency audit on Serious Youth Violence and exploitation, looking at our responses to 5 young people in each borough who were considered to be involved in violence or at risk of exploitation.

We held a multi-agency full day workshop took place in October 2019 which was well attended by a range professionals and agencies, in order to discuss the emerging findings and make recommendations for practice.

The recommendations for practice include:

- We need to develop ways of streamlining and effectively managing large professional networks around young people.
- Where young people are in hospital having suffered a serious injury, we should always consider holding the Strategy Meeting at the hospital in order to promote effective information sharing.
- Placement planning for young people aged sixteen plus should consider the full range of vulnerability and risk factors and should address how these will be responded to and mitigated against either by the identified placement or support around the placement.
- When undertaking an assessment or investigation, social workers and their managers should always ask themselves which health professionals or services might be best able to contribute information or help their thinking.
- Where CAMHS have not been able to engage with a family, feedback should be given to the other agencies involved. Where either Early Help or Social Care are already involved, the Team around the Family should review the plan to consider this.
- When working with a young person involved in violence or at risk of exclusion we should always think about younger siblings and future vulnerability or risk.
- Significant information should be fed back to GPs by social workers and other health professionals (e.g. school nursing). This should include the outcomes of any assessment or investigation

Strategic recommendations include:

- The Placements and Fostering and Adoption teams should be included in the strategic groups planning and monitoring our responses to Contextual Safeguarding. This is so that we make sure we are sourcing and using placements with the right expertise where young people are involved in violence and exploitation.
- Forums and panels should be combined wherever possible to consider inter connected risks and vulnerabilities rather than specific issues in isolation (e.g. Missing, Exploitation, Serious Violence etc.)
- CAMHS to consider their approach with families who find it difficult to engage
- The Vulnerable Children's Collaborative (RBKC & WCC) should consider strategies for re-integration to mainstream school for children in alternative education provision so that the Collaborative has oversight and influence of practice in this area.
- Address how we can secure better police involvement in multi-agency auditing

Missing Children audit:

The LSCB also reviewed the single agency audit by Children's Services on Children Missing that was completed in April 2018. This was a review audit to examine practice following a previous audit in October 2017. This audit found that practice had improved around the use of 'grab packs' (which is a two-page document with all the key details of young people who frequently go missing). There was also more consistency around the quality of return home interviews undertaken.

Safeguarding Self-Assessments (Section 11 Audit) findings:

The section 11 audits, a safeguarding self-assessment, 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.

This year, self-assessment audits were requested from private health care providers across the three local authorities. Providers were able to demonstrate having appropriate safeguarding policies, governing structures and safer recruitment procedures in place. Some providers were able to demonstrate some good work in engaging children and young people.

In addition, preparations were started to re-launch the audit using an online survey tool (Survey Monkey), with the ambition to extend the survey beyond safeguarding leads and managers, to front line practitioners in order to give the Partnership more comprehensive feedback from the multi-agency workforce.

Learning from Case Reviews

The Case Review Subgroup is made up of multi-agency partners including Police, Health and Local Authorities and in 2018-19 was chaired by the LSCB Independent Chair. In 2018-19 the subgroup met and reviewed:

- 5 Serious Case Reviews published by other LSCBs. Issues explored included:
  - How to create safe working cultures within organisations, effective arrangements for responding to allegations/concerns about adults in positions of trust, alongside child focused commissioning practices by national organisations responsible for contracts within the secure estate *(Medway STC SCR, Medway LSCB)*.

  -The importance of young people's individual needs and vulnerabilities being recognised and addressed in thorough assessments and interventions to provide the right support to children at risk of criminal exploitation. The importance of recognising that young people can be both victim and perpetrator. *('Chris' SCR, Newham LSCB)*

  -the complexities of working with non-compliant, chaotic, mobile and duplicitous families, where completing meaningful social work assessments is difficult and the voice of the child is not always captured. The role and influence of a baby's father remained unclear to professionals as information wasn't shared *(Child C SCR, Barking & Dagenham LSCB).*

  - The importance of considering 'safeguarding first' in relation to managing school attendance and of having more than one emergency contact (ideally three adults, which could include friends, family, neighbours) on file for children that is easy to access by relevant staff. The importance of staff actively considering the wider context of a child's life when a child's whereabouts are unknown and understanding how to escalate concerns. *('Chadrack Mbala-Mulo', City and Hackney LSCB)*

-The importance of offering appropriate counselling for parents/carers whenever a child is diagnosed with a disability and that professionals explore their understanding and views towards such disability. That professionals actively consider parents/carers individual cultural background and attitudes towards the provision of services. That there is a consistent process for identifying the key professional in a case and that professionals have the confidence to raise child protection concerns on open cases and escalate concerns. *(Family A, Kingston LSCB).*

- 3 local cases not meeting the threshold for serious case review but where local learning was shared. Issues considered included:
    - responding to a complex case featuring fabricated and induced illness
    - the importance of hospital staff considering the possibility of non-accidental injuries and not delaying safeguarding procedures.
    - the importance of strategy meetings including relevant health staff, especially where a child in an in-patient in hospital and listening to the voice of the child. Importance of discharge planning meetings being well coordinated to ensure patient safety.

- Information regarding the new Child Safeguarding Practice Review Panel and the new requirements for commissioning Child Safeguarding Practice Reviews, to replace Serious Case Reviews, once the LSCB has transitioned to the new safeguarding children partnership arrangements. Once the transition has taken place, the Safeguarding Partners have more flexibility to decide whether or not to commission a Local Child Safeguarding Practice Review.

- The terms of reference for the National Child Safeguarding Practice Review Panel's first national thematic review on adolescents in need of state protection from criminal exploitation.

At the end of the year, the LSCB was sadly notified of one fatal incident involving knife crime. This case will progress to a Serious Case Review.

LSCB partners have also contributed to a Safeguarding Adults Review (SAR), originally commissioned in December 2017 for Kensington and Chelsea, to learn from the case of a vulnerable adult where there was a near miss incident. One of the issues from this case is the importance of practitioners being able to consider a 'Think Family' approach in their work, regardless of whether they work primarily with adults or children. This is an area of work that we hope to embed further across the multi-agency workforce, together with both Safeguarding Adults Boards.

Future plans:

The Case Review Subgroup plans to review how we conduct Rapid Reviews and better disseminate the learning from cases using a new 7 minute briefing template.

LSCB Multi-Agency Training

The LSCB training programme was coordinated by our LSCB Multi-Agency Trainer with support from the Learning and Development Subgroup. Between April 2018 and March 2019, the LSCB delivered **106** face to face training workshops through the LSCB training programme. A total of **1760** 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 a dip in the number of workshops booked. This is likely linked to a change in how bookings were made in the last quarter of the year. The overall attendance at training (across all workshops) was **68%,** though attendance rates for our core safeguarding workshops was higher, at **72.7%.**

The LSCB training programme raised just over £20,000 in revenue this financial year, a mix of fees for attendance from practitioners in the private sector (60%) as well as fees for non-attendance and late notice cancellations (40%).

The LSCB training programme was split into three main sections:

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

Specialist training: this features a variety of more specialist topics including Safeguarding Children and Domestic Abuse, Child Sexual Exploitation, Support and pathways for children who have been raped or sexually assaulted, Safeguarding Children and Gang Awareness, Private Fostering Workshops, Staying Safe Online, and Harmful Practices.

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

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

The LSCB conducted a training needs analysis in order to help inform the design and commissioning of the training. This involved the LSCB Trainer consulting with partners about their training needs, in order to help us to understand what the emerging needs may be and if we need to expand on or deliver new training topics. This year, safeguarding adolescents was a topic that was requested. The LSCB Trainer coordinated two development sessions with multi-agency practitioners from all three boroughs from health, children's social care and youth offending teams; to create a workshop outline which will be finalised for the 2019-2020 training programme.

The LSCB has hosted three workshops this year to share the learning from Serious Case Reviews, as this was a priority from the previous year. The attendance for these workshops has been lower than we would like, so we are exploring the possibility of hosting shorter lunchtime learning sessions in different workplaces to

increase the take-up next year.

Wherever possible, the LSCB has asked local partners to deliver or co-deliver the training workshops so that local knowledge and expertise can be shared. For example, the delivery of our core training, the 'Multi-agency Safeguarding and Child Protection' workshop, has been co- delivered by the LSCB trainer and four different social workers, three voluntary sector practitioners from Standing Together Against Domestic Violence, and one police officer. There has been a reduction in support to co-deliver our core workshops from some health partners due to a lack of availability, however, we will continue to explore further co-delivery options in the future.

The LSCB monitors the feedback from LSCB training workshops. At every workshop we deliver, we ask delegates to rate the workshop experience, as well as whether the learning outcomes have been met.

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. Below are some quotes from the question "How will this training impact on your practice?" and the "Additional Comments" text box from two of the core training workshops and one managerial workshop:

Introduction to Safeguarding Children Workshop:

- By being more aware of signs of abuse by making the environment safer for children and to be aware of the local authorities to report to.
- Allow me to notice signs of concern and act accordingly
- The knowledge and updated procedures are very key and will help greatly in my role. I can transfer the skills to other roles/volunteering roles
- Keeping vigilant when it comes to the safety of a child. Will be used every day when I am working with children - in school and on our site (museum/gallery)
- More awareness of what to look out for & how to go about reporting it. I run a volunteer programme (architects going into school) so key points can also be included in their training.
- Very good & dynamic
- Great Training
- Course as a whole was very informative and I would recommend to a colleague.

Multi-agency Safeguarding and Child Protection Workshop:

- Really useful day to meet other non-health agency workers. I will be sharing all this information with my colleagues.
- The training fulfilled my expectations of refreshing my knowledge in all aspects of child protection. It was also good to update my knowledge.
- Great engaging and informative training really glad I came.
- Thank you, very good training with loads of relevant information to take back to setting.
- Is great to have such a diverse group to discuss factors with. Very good with references and support groups & organisations. Need to see how it works in practice.
- A significant impact on my knowledge and understanding of all aspects of safeguarding & referrals. Learning from the presenters but also the participants has increased my wider knowledge & understanding, also my confidence.
- Very informative, I feel equipped to take on the role of deputy safeguarding lead at school.
- I felt that the day should be turned on its head. Almost all the important information was presented after lunch with a lot to get through in a short period of time. A very knowledgeable & charismatic facilitator who held the room very well.
- Some parts of the training were lengthy… would be helpful to be more succinct/ concise to keep people's attention.

Meet the LADO

- Much better awareness of when to refer - if come across where it would be relevant to do so.
- Improve my understanding & confidence in working with the LADO & in-house safeguarding team.
- Awareness of LADO's role and to follow policy/procedure for referral or seeking advice. Will be revisiting all London CP procedures.

The Learning and Development Subgroup has attempted to monitor the impact of the training courses that we deliver via the LSCB training programme, however, this has remained a challenge due to the very low numbers of responses that we have received. 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 (via Survey Monkey) to check the impact three

to six months following their attendance at training. We have noted that still only a small percentage of delegates complete this.

The LSCB Learning and Development Subgroup will challenge this further with line managers in 2019-20.

Future plans:

In 2019-2020, the Learning and Development Subgroup are keen to support the following:

- Workshops regarding the changes that the local authorities are making to the child protection conferences in all three boroughs.
- Workshops on contextual safeguarding and safeguarding adolescents
- Workshops on Modern Slavery and Child Trafficking
- Updating the core 'Multi-agency Safeguarding and Child Protection' workshop with new scenarios and exercises and updated course handbook.

In addition, in 2019-2020, the Learning and Development Subgroup will also need to review the effectiveness of the current learning management system (LMS) that we use for workshop bookings. This new LMS was launched in December 2018 as a result of the local authorities purchasing a new cloud-based human resource management system. The LSCB training team currently has to coordinate bookings across one LMS for Hammersmith & Fulham, and another LMS for the Royal Borough of Kensington and Chelsea and Westminster which is time consuming. In addition, feedback from multi-agency partners suggests that it is not user friendly for practitioners to use as they are not directly employed by the local authorities. This has had an impact on the numbers of practitioners being able to book or cancel training workshops in a timely manner. The new LMS also does not provide the LSCB with the data we would like to be able to monitor the take up of safeguarding training across the multi-agency workforce.

Child Death Overview Panel (CDOP)

The LSCB is responsible for:

- Collecting and analysing information about each child 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.

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 which is convened following an unexpected child death in order to make initial enquiries and co-ordinate support to the bereaved family.

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.

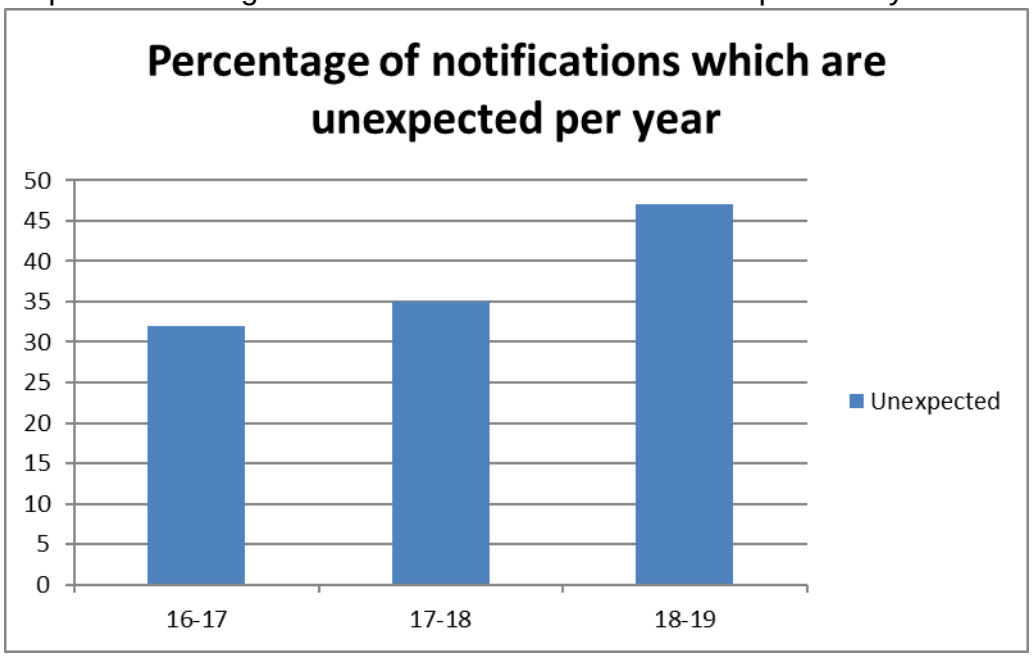
Attendance at the panel from professionals across the range of core membership organisations has generally been very good. There have been difficulties securing regular public health representation due to interim staff being in post following the disaggregation of the three-borough public health team. In their absence, the panel has been chaired by the LSCB Business Manager.

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 case reviews, police investigations or an inquest occurring.

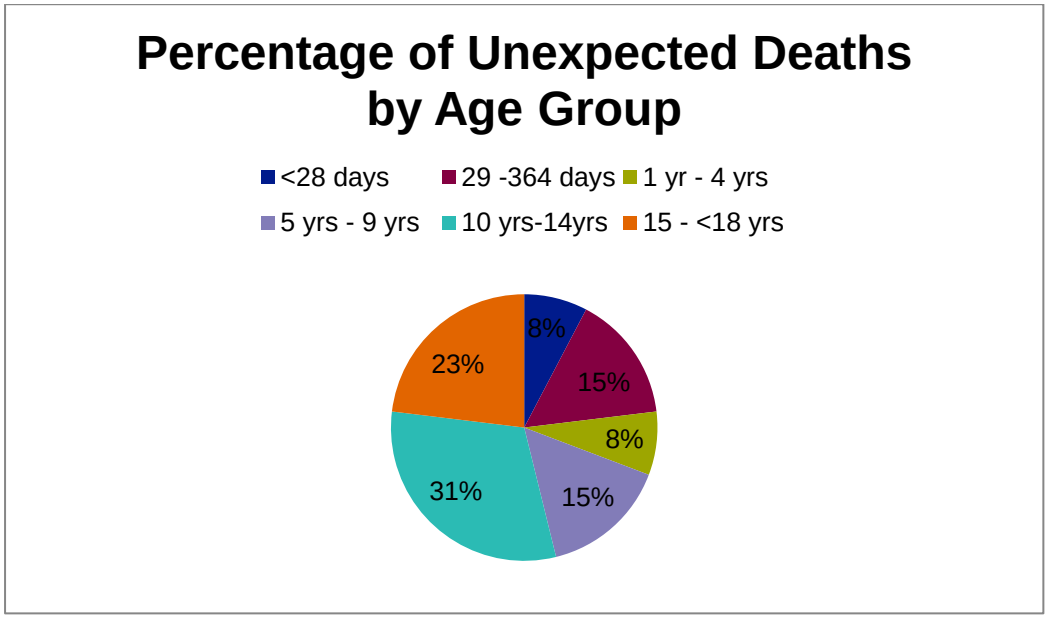
Child Death Notifications:
In 2018-19, the CDOP Panel received 40 child death notifications in total, one of which was a late notification, identified from Inquest schedules, which was not sent to the CDOP by the Coroner at the time of the child's death in 2016.
30 of the notifications were for children ordinarily resident across the three local authorities, and 10 notifications were about children who normally reside overseas.

Unexpected Child Deaths:
In 2018-19, a total of 14 deaths (47%) were unexpected and required a rapid

response meeting to be held which is an increase on previous years.



Over half the unexpected deaths in 2018-19 occurred in children over the age of 10 years, with just under a quarter occurring in infants under 1 year. This is in contrast to 2017-18 where 58% of unexpected deaths were in children under 1 year of age.



Learning from child death reviews:

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

Following the publication of the new 'Working Together to Safeguard Children 2018' in July 2018, and alongside this, new guidance 'Child death review: statutory and

operational guidance (England)' in October 2018, work has been undertaken to help shape a new CDOP service covering the eight north west London boroughs, including: Brent, Ealing, Harrow, Hillingdon, Hounslow, Hammersmith & Fulham, Kensington and Chelsea, and Westminster.

This is because the new statutory guidance requires CDOPs to cover a geographical footprint that would enable a minimum of 60 cases to be reviewed per year. Funding was secured from the Early Adopters funding stream from the DfE for a project manager to help the eight north west London CDOPs to collaborate and develop this new service.

The above 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 will include 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.

Going forward, CDOP will no longer report directly to the Safeguarding Children Partnership, and instead will report to the Local Authorities and Clinical Commissioning Groups.

LSCB Website and Social Media

The LSCB website statistics show that the most viewed webpages are still the LSCB Training Pages and Safeguarding Contacts Pages. Work to update the LSCB microsite has been held back due to larger web projects being undertaken in the local authority which hosts the pages. However, in 2019-2020, further work is planned to reflect the upcoming changes from the LSCB to the new Local Safeguarding Children Partnership (with logos being updated) and a scrolling carousel of new items on the front page which will signpost visitors to the website to updated content.

Further projects to develop in the upcoming year will be a range of Seven Minute Briefings for practitioners, to help share key safeguarding messages to safeguarding partners.

The LSCB maintains a social media presence on Twitter (@LSCBx3). We have grown our following to 574 followers and continue to use this platform to amplify messages about national safeguarding campaigns such as Safer Internet Day and local initiatives such as our One Life, No Knife events for children and young people, as well as promoting multi-agency training opportunities.


EE WiFiCall 11:55 78%
LSCP x3
581 Tweets
Tweets
Tweets & replies
Media
Likes
LSCP x3 @LSCPx3 · 05/02/2019
This is an easy resource for parents/carers to use with children for #SaferInternetDay2019
Ofcom · 05/02/2019
Today is #SaferInternetDay2019 and we've created a fun, informative worksheet to help parents and teachers have open conversations with children about staying safe online. Check it out: ofcom.in/SID2019
Nearly all of our 8-11 year olds said they would tell a family member if they saw something worrying, nasty, or offensive online.
23% Teacher
19% Friend
88% Parent
3% No-one
2% Police
2% The website themselves
1% Don't know if they would tell anyone


EE WiFiCall 12:08 75%
You Retweeted
IKWRO
@IKWRO
Are you a professional working in Hammersmith & Fulham, Kensington & Chelsea or Westminster? We're running a FREE training on 26th March on the issues of #HonourBasedViolence and #ForcedMarriage. Register here:
Local Safeguarding Children Board
eventbrite.com
Tweet your reply

Appendix 1 – LSCB Membership and Attendance

LSCB Main Board Attendance
2018-19

Role	17th April 2018	17th July 2018	16-Oct-18	22-Jan-19
LSCB Chair	y	y	y	y
Executive Director of Children's Services (Tri and later Bi-borough)	y	y	y	y
Director of Family Services (H&F)	y	y	y	y
Director of Family Services (RBKC)	y	y	y	y
Director of Family Services (WCC)	y	y	y	y
Director of Schools (Asst Director)	y	y	y	y (delegate)
Head of Safeguarding & Quality Assurance, RBKC & WCC	y	y	y	y
Head of Safeguarding & Quality Assurance LBHF	y	y	n	y
LSCB Business Manager	y	y	y	y
Director of Adults Safeguarding (or rep)	y	y	y	y
Housing	y	y	n	y
Police Basic Command Unit (BCU)	y	y	y	y
Probation	y	y	y	n
Community Rehabilitation Company	n	y	y	y

CAFCASS	n	n	n	n
Prisons	n	n	n	n
Ambulance Service	n	n	n	n
Voluntary Sector	n	y	y	y
Lay member	y	y	y	y
NHS England	n	n	n	n
Health CCGs	y	y	y	y
Designated Doctor	n	n	y	y
Designated Nurse	y	n	y	y
Head of Safeguarding, CLCH	n	y	y	y
CLCH Director of Nursing	n	n	n	n
Imperial Director of Nursing	y	y	y	n
Chelwest Director of Nursing	y	y	n	n
WLMHT/West London NHS Trust	y	n	y	y

Appendix 2 – LSCB Budget 2018/2019 Outturn

	LBHF	RBKC	WCC	Total
CONTRIBUTIONS				
Sovereign Borough General Fund	-79,169	-60,740	-77,710	**-217,619**
Metropolitan Police	-5,000	-10,000	-5,000	**-20,000**
Probation	-2,000	-2,000	-2,000	**-6,000**
CAFCASS	-550	-550	-550	**-1,650**
London Fire Brigade	-500	-1,000	-1,500	**-3,000**
CCGs (Health)	-20,000	-20,000	-20,000	**-60,000**
Total Partner Income	**-28,050**	**-33,550**	**-29,050**	**-90,650**
Training income	-6,956	-6,956	-6,956	**-20,867**
Total Funding	**-114,175**	**-101,246**	**-113,716**	**-329,136**
EXPENDITURE				
Salary expenditure	66,003	66,003	66,003	**198,009**
Independent Chair	5,745	5,745	5,745	**17,235**
Training	1,240	1,240	1,240	**3,720**
Other LSCB costs	877	877	877	**2,632**
Total expenditure	**73,865**	**73,865**	**73,865**	**221,596**
Final outturn variance	-40,309	-27,380	-39,850	**-107,540**
BALANCE SHEET				
Reserves Brought Forward	-45,216	-129,650	-81,499	**-256,365**
Adjustment in year				
Contribution to LSCB balance sheet accounts	-40,309	-27,380	-39,850	**-107,540**
Reserves to take forward	**-85,525**	**-157,030**	**-121,350**	**-363,905**

Excluding corporate overhead recharges

Notes: All costs to be shared equally between the three boroughs, with the exception of serous case review expenditure, if any, which is funded from the LSCB reserves in the relevant local authority.

Glossary:

Glossary of terms

Barnardo's Taith model	A service to raise awareness of harmful sexual behaviours and help young people through a structured intervention to build a positive future. It aims to reduce offending behaviours and provides opportunities for therapeutic support.
CAFCASS	Children and Family Court Advisory and Support Service
CAMHs	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel: a statutory panel for reviewing information on all child deaths, looking for possible patterns and potential improvements in services, with the aim of preventing future deaths.
Children	Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change their status or entitlements to services or protection.
Child protection	Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.
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.
Clinical Commissioning Group (CCG)	A clinically-led statutory NHS body responsible for the planning and commissioning of health care services for their local area.
Community Rehabilitation Company (CRC)	A private law enforcement agency that works alongside the National Probation Service to support offenders to complete their probation orders.
Community Safety Partnership	Community Safety Partnerships were set up under the Crime and Disorder Act 1998. They are made up of representatives from the police, local authorities, fire and rescue authorities, health and probation services, who work together to protect their local communities from crime and to help people feel safer. They address issues including anti-social behaviour, drug and alcohol misuse and re-offending.
Contextual Safeguarding Network	Network from the University of Bedfordshire that brings together practitioners, researchers and policy makers who are committed to protecting young people from harm outside the home. www.contextualsafefuarding.org.uk

Co-ordinated Community Response	An inter-agency approach for responding to domestic abuse, to help local police, law enforcement agencies, the courts and wider community to support victims and survivors of domestic abuse.
DfE	Department for Education – central Government department.
Designated Safeguarding Lead	A practitioner, usually part of the management team, who takes the lead on safeguarding children matters in their team/agency.
Domestic Homicide Review (DHR)	A multi-agency review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by a person to whom they were related, or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves
Early Help	Also known as early intervention, is the support given to a family when a problem first emerges. It can be provided at any stage in a person's life. Early help services can be delivered to parents, children or whole families, but their main focus is to improve outcomes for children.
FGM	Female Genital Mutilation – a harmful practice where the female genitalia are deliberately cut, injured or changed, but there is no medical reason for this to be done.
GBH	Grievous bodily harm
IDVA	Independent Domestic Violence Advisor
IRIS	IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme, including training and education and enhanced referral pathway to specialist domestic abuse services.
IGU	Integrated Gangs Unit: a multi-agency unit, aiming to reduce serious youth violence. It consists workers from the local authorities, Met Police, Probation and St Giles Trust, a mental health nurse and employment coach, working together to support young people aged 10-24 who are involved in group violence, or on the periphery of gangs. The team also works with neighbouring boroughs to tackle cross border gang violence.
LADO	Local Area Designated Officer: Local authorities should have designated a particular officer, or team of officers to be involved in the management and oversight of allegations against people who work with children. Any such officer, or team of officers, should be sufficiently qualified and experienced to be able to fulfil this role effectively, for example qualified social workers. Arrangements should be put in place to ensure that any allegations about those who work with children are passed to the designated officer, or team of officers, without delay
LSCB	Local Safeguarding Children Board – a statutory partnership to coordinate the work
LSCP	Local Safeguarding Children Partnership (replaces the LSCB from October 2019)
MARAC	Multi-Agency Risk Assessment Conference: a victim focused information sharing, and risk management meeting attended by all key agencies, where high risk cases domestic abuse cases are discussed.

MASE Panel	Multi-Agency Sexual Exploitation Panel: a multi-agency panel to develop a strategic overview of child sexual exploitation and reduce the risk of harm to children and young people at risk.
MOPAC	Mayor's Office for Policing and Crime
Multi Agency Safeguarding Hub (MASH)	The MASH is a team made up of co-located staff from Children's Social Care, Police and Health from across the three boroughs with links to Probation, Housing and Youth Offending Teams. The MASH provides the capacity, skills and the practical arrangements to collect, analyse and securely store the information held by all partners about children and families that is relevant to an assessment of safeguarding risk. It does this in defined timescales that reflect the level of risk identified.
Private Fostering Arrangements	Private fostering is an arrangement made where someone other than the child's immediate family is looking after a child for longer than 28 days. Examples of private fostering situations include: children with parents working or studying elsewhere; children whose parents are overseas; children on holiday exchanges. Private fostering arrangements should be notified to the relevant local authority children's social care team.
Section 11 Audit	A Self-Assessment audit to allow partner agencies to demonstrate how they meet key safeguarding standards.
Serious Case Reviews (SCR)	A statutory review, required under Working Together to Safeguard Children 2015 when abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
Safe and Together Model	This child-centred model provides a framework for multi-agency practitioners to work alongside survivors of domestic abuse, and better intervene with perpetrators, in order to keep the child/ren safe and together with the non-abusing parent.
Safeguarding Partner	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.
Standing Together Against Domestic Violence (STADV)	Standing Together support organisations, including the Police, criminal justice partners, social services, healthcare workers and charities, to identify and respond effectively together to domestic abuse.
Think Family	A Think Family approach is the steps taken by practitioners to identify wider family needs which extend beyond the individual they are supporting.
Transitions	This Term relates to the transition between children's and

	adults' services. Young people may still need support when they turn 18. 'Transition' is the period of time when young people are moving from childhood into adulthood. Services for adults are different from those for children, so it's important that young adults get the services they need to live a full life.
Violence Against Women and Girls Partnership (VAWG)	A local strategic partnership that oversees the response to domestic abuse and harmful practices such as FGM.