City & Hackney Safeguarding Children Partnership

Annual Report 2019/20

Foreword

The 2019/20 period covered significant change and high levels of disruption. This began with our preparations to move to the new safeguarding arrangements and as the reporting year ended, the onset of the COVID-19 pandemic. Whilst this annual report captures our multi-agency performance data, achievements and the lessons we have learnt, it would be remiss of me not to acknowledge our present situation at this challenging moment in time. In this respect, it is important that whilst we do everything we can to support our communities, that we also pause to reflect on the debt of gratitude that we owe to everyone working in and supporting our frontline safeguarding services.

Our commitment to ensure that our children are seen, heard and helped has been tested by the imposition of restrictions that no one could have anticipated a year ago. That said, partners have risen to the challenge. They have developed contingency plans, adapted practice and pivoted to the use of digital technology to maintain vital lines of communication with one another and critically, the vulnerable children and families they support. Our oversight and scrutiny of practice has also continued and the report identifies progress made, the areas we still need to work on and outlines the focus for the year ahead. Whilst I am pleased that the report reflects improvements made by a number of sectors, I am deeply disappointed that we have failed to make progress regarding safeguarding compliance in unregistered educational settings, namely Yeshivas. Our commitment to improve our safeguarding line of sight in this area is undiminished and we are actively considering additional measures to address our ongoing concerns.

Over 2019/20, both The City of London Corporation and Hackney Council were subject to Ofsted inspections of their children's social care services. The City of London Corporation received and overall outstanding rating, with Hackney Council requiring improvement. Whilst both were inspections of local authority services, we must not forget that helping and protecting children and young people is a multi-agency responsibility. It remains our collective responsibility to ensure that safeguarding practice is effective.

Looking back, the data in the report speaks for itself. That said, I do not believe a system whereby we publish this so long after the fact is helpful. Moving forward we must ensure that information is delivered in a more contemporary sense. It is therefore our intention to refresh our approach by publishing a quarterly safeguarding threat assessment. I believe the timely analysis and delivery of safeguarding information that identifies contemporary trends, themes and patterns will enhance collective focus and decision-making.

Furthermore, over the coming year, we will seek to develop our arrangements for hearing the authentic voice of children and young people, enhance independent scrutiny and lead by example by driving a culture of Anti-Racist practice. We must ensure that all of our young people have the ability to live, learn and thrive.

Jim Gamble QPM
Independent Child Safeguarding Commissioner
The City & Hackney Safeguarding Children Partnership

Contents

About the Annual Report
Glossary

The CHSCP
Background
Purpose
Vision
Principles
Key Roles & Relationships
Membership & Attendance
CHSCP Structure
Financial Arrangements

Progress on Implementation
COVID-19
Communication
Technology and Social Media

City Safeguarding Snapshot
Safeguarding in The City of London
City Demographics
Early Help
Children in Need of Help & Protection
Children in Care & Care Leavers
VAWG
Safeguarding Adolescents
Private Fostering
Children with Disabilities
MAPPA
Safer Workforce

Hackney Safeguarding Snapshot
Safeguarding in Hackney
Hackney Demographics
Early Help
Children in Need of Help & Protection
Children in Care & Care Leavers
VAWG
Safeguarding Adolescents
Private Fostering
Young Carers
Disabled Children
Children's Mental Health
MAPPA
Youth Offending
Unregistered Educational Settings
Out-of-School Settings
Safer Workforce

Learning & Improvement
The Voice of the Child, Family & Community
Reviews of Practice
Auditing
Performance Data
Front-Line Intelligence
External Learning

Key Messages for Practice
Child Death Reviews
Training & Development
Priorities & Pledge
What you need to know
The CHSCP

About the Annual Report

The City & Hackney Safeguarding Children Partnership annual report for 2019/20 provides an overview on the effectiveness of safeguarding arrangements in the City of London and the London Borough of Hackney. It sets out the following:

- The governance and accountability arrangements for the CHSCP. This section covers details about the new safeguarding arrangements in the City of London and Hackney, progress made and the immediate actions taken following the Covid-19 lockdown in March 2020.
- The context for safeguarding children and young people in the City of London, highlighting the progress made by the City partnership over the last year.

- The context for safeguarding children and young people in the London Borough of Hackney, highlighting the progress made by the Hackney partnership over the last year.
- The lessons that the CHSCP has identified through its Learning & Improvement Framework and the actions taken to improve child safeguarding and welfare as a result of this activity.
- The range and impact of the multi-agency safeguarding training delivered by the CHSCP.
- The priorities going forward and the key messages for those involved in the safeguarding of children and young people.

Glossary

ABH	Actual Bodily Harm
BME	Black and Minority Ethnic
CAF	Common Assessment Framework
CAFCASS	Children & Family Court Advisory and Support Service
CAIT	Child Abuse Investigation Team
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CDR	Child Death Review
CHSAB	City and Hackney Safeguarding Adults Board
CHSCB	City and Hackney Safeguarding Children Board
CHSCP	City and Hackney Safeguarding Children Partnership
CHYPS	City and Hackney Young People's Service
CPA	Community Partnership Advisor
CPP	Child Protection Plan
CRIS	Crime Reporting Information System
CSC	Children's Social Care
CSE	Child Sexual Exploitation
CYPPP	Children and Young People's Partnership Panel
DBS	Disclosure and Barring Service
DfE	Department for Education
DVIP	Domestic Violence Intervention Project
EIP	Early Intervention and Prevention
ELFT	East London NHS Foundation Trust
ESOL	English for Speakers of Other Languages
FGM	Female Genital Mutilation
FGMPO	Female Genital Mutilation Protection Order
FJR	Family Justice Review
FRT	First Response Team
GLA	Greater London Authority
GP	General Practitioner
HCVS	Hackney Council for Voluntary Service
HLT	Hackney Learning Trust
HUHFT	Homerton University Hospital NHS Foundation Trust
IRI	Independent Return Interview
LA	Local Authority
LAC	Looked After Child / Children
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MAP	Multi Agency Panel
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASE	Multi Agency Sexual Exploitation
MAT	Multi Agency Team
MPM	Management Planning Meeting
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
OFSTED	Office for Standards in Education, Children's Services and Skills
PPU	Public Protection Unit
PSHE	Personal, Social and Health Education
PSP	Pupil Support Plans
SCR	Serious Case Review
SDVC	Specialist Domestic Violence Court
SEND	Special Educational Needs and Disability
SLT	Senior Leadership Team
SRE	Sex and Relationship Education
TRA	Tenant Resident Association
TUSK	Things You Should Know (CHSCB briefing)
UASC	Unaccompanied Asylum-Seeking Children

The City & Hackney Safeguarding Children Partnership

Background

In 2015, the government commissioned Sir Alan Wood to review the role and functions of Local Safeguarding Children Boards (LSCBs). The Wood Report was published in March 2016, with the government formally responding in May 2016. The Wood Report recommendations were subsequently embedded in statute in April 2017 with the granting of Royal Assent to the Children and Social Work Act 2017. As a consequence, four important areas of change have followed.

- Firstly, LSCBs, set up by local authorities, have been replaced. Three safeguarding partners (*local authorities, clinical commissioning groups and chief officers of police in a local area*) must now make **new safeguarding arrangements** to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in the area.
- Secondly, the current system of Serious Case Reviews has been replaced. Safeguarding partners must now make arrangements to identify and review **serious child safeguarding cases** which, in their view, raise issues of importance in relation to their area.
- Thirdly, a **National Child Safeguarding Practice Review Panel** has been created and is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance.
- Fourthly, two partners (*local authorities* and *clinical commissioning groups*) have been specified as 'child death review partners' and must set up new **child death review arrangements**. These new arrangements should facilitate a wider geographic footprint and respond to the statutory guidance defining how deaths will be reviewed and how the bereaved will be supported.

The City & Hackney Safeguarding Children Partnership launched its new arrangements in September 2019. The published arrangements are available **HERE.**

Purpose

The new safeguarding arrangements support and enable local organisations and agencies to work together in a system where:

- Children are safeguarded and their welfare promoted.
- Partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children.
- Organisations and agencies challenge appropriately and hold one another to account effectively.
- There is early identification and analysis of new safeguarding issues and emerging threats.
- Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice.
- Information is shared effectively to facilitate accurate and timely decision making for children and families.

Vision

That all children in the City of London and Hackney are seen, heard and helped; they are effectively safeguarded, properly supported and their lives improved by everyone working together.

Principles

As leaders across a range of organisations, the commitment of the CHSCP is to work together to make the lives of children safer by protecting them from harm; preventing impairment to their health and/or development, ensuring they receive safe and effective care; and ensuring a safe and nurturing environment for them to live in. The CHSCP wants to make sure that everyone who works with children across the City of London and Hackney has the protection of vulnerable children and young people at the heart of what they do. In practice, this means that children are seen, heard and helped:

- **Seen;** *in the context of their lives at home, friendship circles, health, education and public spaces (both off-line and on-line).*

- **Heard*;*** *by professionals taking time to hear what children and young people are saying - putting themselves in their shoes and thinking about what their life might truly be like.*
- **Helped;** *by professionals remaining curious and by implementing timely, effective and imaginative solutions that help make children and young people safer.*

The CHSCP's aim is to ensure that safeguarding practice and outcomes for children are at least good, and that staff and volunteers in every agency, at every level, know what they need to do to keep children protected, and communicate effectively to ensure this happens. All of our activity is underpinned by the following principles:

- **Safeguarding is everyone's responsibility**. As a partnership, we will champion the most vulnerable and maintain a single child-centred culture.
- **Context is key.** Capitalising on the unique opportunities presented by a dual-borough partnership, we will have an unswerving focus on both intra-familial and extra-familial safeguarding contexts across the City of London and the London Borough of Hackney.
- **The voice of children and young people.** We will collaborate with children and young people and use their lived experience to inform the way we work. We will regularly engage with them as part of our core business and ensure their voices help both design and improve our local multi-agency safeguarding arrangements.
- **The voice of communities.** Improving our understanding of the diverse communities across the CHSCP's footprint, we will regularly communicate with, listen to and engage local communities in the work of the CHSCP. We will harness their experience to both inform and improve the way we safeguard and promote the welfare of children and young people.
- **Enabling high quality safeguarding practice.** We will promote awareness, improve knowledge and work in a way that is characterised by an attitude of constructive professional challenge.
- **Fostering a culture of transparency.** We will enable the CHSCP to learn from individual experience and **continuously improve** the quality of multi-agency practice.

Key Roles & Relationships

Safeguarding Partners

The safeguarding partners agree on ways to co-ordinate safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning. All safeguarding partners retain an equal and joint responsibility for local safeguarding arrangements. In situations that require a single point of leadership, safeguarding partners will decide on which partner will take the lead on relevant issues that arise. The safeguarding partners in the City of London and the London Borough of Hackney are **Hackney Council, The City of London Corporation, The City & Hackney Clinical Commissioning Group (CCG), The Metropolitan Police Service (MPS)** and **The City of London Police.** The lead representatives of the safeguarding partners are:

- **Tim Shields, The Chief Executive of Hackney Council**
- **John Barradell, The Town Clerk of the City of London Corporation**
- **Jane Milligan, The Accountable Officer of the City & Hackney CCG**
- **Marcus Barnett, The Commander of the MPS Central East BCU**
- **Ian Dyson, Commissioner, City of London Police**

Relevant Agencies

Safeguarding partners are obliged to set out which agencies are required to work as part of the CHSCP's arrangements to safeguard and promote the welfare of local children. These agencies are referred to as *relevant agencies* and have a statutory duty to cooperate with the CHSCP's published arrangements. A defined number of relevant agencies will meet regularly with safeguarding partners as the CHSCP Executive. Others will be invited when deemed necessary and/or be included in various CHSCP sub-groups / thematic groups. Wider engagement events will also be facilitated through the City & Hackney Safeguarding Partnership which includes a much broader range of agencies, professionals and volunteers involved in safeguarding children and young people. A schedule

of relevant agencies is defined in part 4 of the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018. Safeguarding partners can also include any local or national organisation or agency in their arrangements regardless of whether they are named in the above regulations.

The Independent Child Safeguarding Commissioner

Jim Gamble QPM is The Independent Child Safeguarding Commissioner (ICSC) of The CHSCP. The ICSC is appointed by safeguarding partners and given authority to coordinate the independent scrutiny of the local child safeguarding arrangements. The ICSC is fundamentally independent to local safeguarding partners and relevant agencies. The ICSC has significant experience of operating at a senior level in the strategic coordination of multi-agency services to safeguard and promote the welfare of children.

The ICSC provides independent leadership (through engagement, commentary and lobbying) in respect of local matters relevant to the safeguarding of children and young people. The ICSC holds both safeguarding partners and relevant agencies to account for their effectiveness in safeguarding children and young people. The ICSC chairs The CHSCP Strategic Leadership Team and The CHSCP Executive to ensure fundamental independence is built into the oversight of statutory safeguarding partners and relevant agencies. The ICSC also chairs the Case Review sub-group to ensure independent decision making in respect of the commissioning and progress of reviews. Safeguarding partners delegate this decision-making function to the ICSC and ratify any decisions made. The ICSC continues to be engaged with elected officials to brief on specific issues, raise concerns and to provide an independent overview of practice. This takes place via 1:1 meetings and other forums (such as 'joint chairs' meetings) and those that engage elected members and other local boards (Health & Wellbeing / SAB / CSP). The ICSC is also engaged by the Local Authority scrutiny functions in both the City of London and Hackney.

The Strategic Leadership Team

The Strategic Leadership Team (SLT) are senior officers that can speak with authority for the safeguarding partner they represent. They can hold their organisation to account, take decisions and commit them on policy, resourcing and practice matters. The SLT is chaired by the Independent Child Safeguarding Commissioner and comprises the following:

- **Anne Canning, The Group Director of Children, Adults and Community Health (Hackney Council)**

- **Andrew Carter, The Director of Children and Community Services (The City of London Corporation)**
- **David Maher, The Managing Director (The City & Hackney CCG)**
- **Marcus Barnett, The Commander of the MPS Central East BCU**
- **Dai Evans, T/Commander, City of London Police**
- **Annie Gammon, Director of Hackney Education (Hackney Council)**

We have included the Head of Hackney Education on The CHSCP's SLT. This reflects the importance placed by safeguarding partners on having an 'education lens' within our statutory decision-making processes. Whilst the role does not represent individual schools (in either Hackney or the City of London), it occupies an important position of influence within the local safeguarding architecture. Whilst acknowledging the limitations in respect of 'decision-making' (i.e. this role cannot make decisions on behalf of the sector as a whole), it is a valuable asset for advice, challenge and support at SLT.

The CHSCP Executive

The CHSCP Executive comprises representatives from safeguarding partners and a number of relevant agencies and named / designated professionals. Other relevant agencies will be invited to participate / engage in the CHSCP Executive as and when required. The CHSCP Executive meets bi-monthly and is independently chaired by the Independent Child Safeguarding Commissioner with a nominated safeguarding partner representative being Vice-Chair (Vice-Chairs rotate annually).

Lay Members

The attendance of Lay Members at CHSCB meetings and a variety of other forums has been key to offering a different perspective and helping everyone stay in touch with local realities and the issues of concern in our communities. As part of the transition into the new arrangements, 2019/20 saw both remaining Lay Members, Belinda Blank (City of London) and Shirley Green (Hackney) step down from their positions that they had occupied for a number of years. Both helped critically influence the functioning of the partnership, engaging in a variety of different forums and offering their unique perspective based on their regular engagement in the communities with whom they remain intrinsically connected. The process to replace both Lay Members has been interrupted by Covid-19.

Lay Members continued to demonstrate an unwavering commitment to the work of the safeguarding partnership. The CHSCB is hugely grateful to both Shirley and Belinda (and Sally Glen who stepped down previously) for their dedication, time and effort in promoting improved public engagement in the safeguarding of children and young people.

The CHSCP Team

The CHSCP is supported by a dedicated group of staff. The team includes a Senior Professional Advisor, a Business and Performance Manager, a Training Co-ordinator and a Co-ordinator role.

Relationships with other Boards

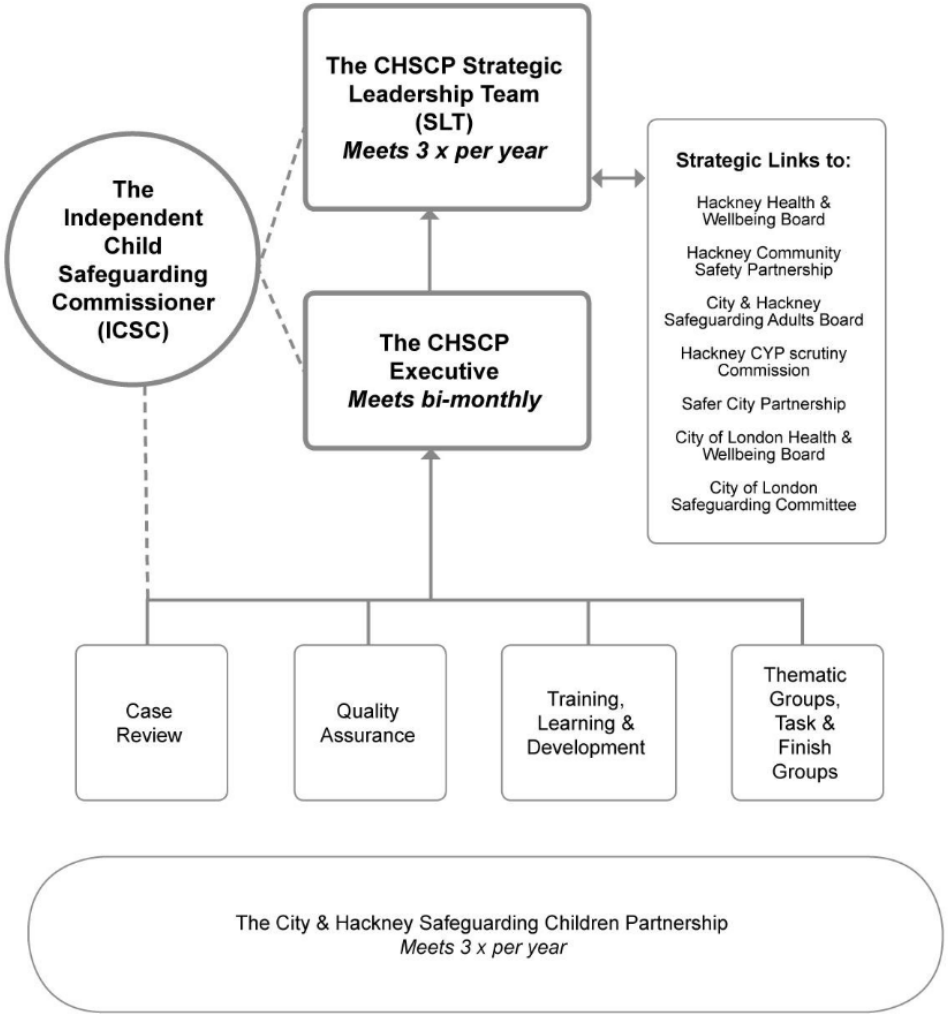
Continued engagement with the City & Hackney Safeguarding Adults Board (CHSAB) and other strategic partnerships in the City of London and Hackney continues through a 'joint chairs' meeting. There have also been additional opportunities for the CHSCP to interface with elected members through the scrutiny functions operating in both the City and Hackney. This has helped ensure that the voice of children and young people and their need for safeguarding has been kept firmly on the agenda in terms of multi-agency work involving vulnerable adults, health and wellbeing and the local response to crime.

Membership & Attendance

The CHSCB and the meetings convened under the new safeguarding arrangements experience good attendance from organisations during 2019/20. The transition period resulted in the usual cycle of meetings being interrupted, although the CHSCB met twice during the 2019/20, with the SLT and CHSCP Executive meeting in November 2019 and December 2019 respectively. In March 2020, as a result of the first Covid-19 lockdown, the CHSCP pivoted to holding Contingency Oversight Planning Meetings in place of the CHSCP Executive. These were set up to support and challenge partners with the sufficiency of their contingency plans to safeguard children. Attendance rates at the CHSCB and CHSCP Executive are set out below. The x represents the number of seats per organisation.

Independent Chair / ICSC	x	100% Attendance
Lay Members	xx	75% Attendance
The City of London Community & Children's Service	xxx	100% Attendance
The City of London Police	x	100% Attendance
Hackney Children and Families Services	xxxxx	100% Attendance
The Metropolitan Police (Child Abuse Investigation Team)	x	75% Attendance
The Metropolitan Police - Hackney Borough	xx	75% Attendance
Hackney Education	xx	100% Attendance
Hackney Housing	x	25% Attendance
Hackney Council for Voluntary Services	x	75% Attendance
Hackney Primary School representative	x	75% Attendance
The London Community Rehabilitation Company	x	25% Attendance
The National Probation Service	x	75% Attendance
Children & Family Court Advisory & Support Service	x	100% Attendance
Homerton University Hospital NHS Foundation Trust	xxx	100% Attendance
City & Hackney Clinical Commissioning Group	xxxx	100% Attendance
City & Hackney Public Health	x	50% Attendance

CHSCP Structure



Financial Arrangements

Partner agencies continued to contribute to the CHSCP's budget for 2019/20, in addition to providing a variety of resources, such as staff time and free venues for training. Total spending in 2019/20 totalled **£360,147**

- **Hackney Education and The City of London Corporation continued to provide access to free training venues to the CHSCB.**
- **The City of London Corporation covered the major costs for the 2019/20 Annual Conference held in March 2020.**

As part of its Corporate Social Responsibility (CSR) programme, Inege continues to support the local partnership in the production of its annual report.

Serious Case Reviews £36,674
Staffing and Travel £260,635
Training & Annual Conference £34,534
Printing, Supplies and Equipment £12,404
Venues £15,865
Miscellaneous £35

Total expenditure £360,147

Progress on Implementation

Strategic Decision Making

At this early stage in the development of new arrangements, there is evidence that they are having some positive effect impact on multi-agency strategic decision making. We have initially experienced a good level of engagement from statutory safeguarding partners within our new arrangements; a continuation of the culture experienced when the CHSCB was in operation. Safeguarding partners have agreed four key priorities for safeguarding practice and have committed to a pledge as to the implementation of these. We believe the arrangements enable our statutory safeguarding partners to focus on the key issues and risks that require leadership attention. We also remain confident that as the arrangements evolve, this focus and operation of SLT will improve.

Accountability

We are looking to develop a more robust approach to accountability by ensuring that Chief Executives and senior leaders with safeguarding responsibilities are directly engaged with and sighted on their individual organisation's strengths and weaknesses. To do this, we are actively exploring a model used in Ireland under its safeguarding legislation - Children First 2015. This approach requires organisations to complete risk assessments and develop Child Safeguarding Statements that are required by law to be published and displayed. Statements are produced annually and authorised by the CEO declaring that their services are sufficient (and where not, the actions that will be undertaken to improve).

Independent Scrutiny

To strengthen our approach and openness to independent scrutiny, the CHSCP is planning to launch its own Scrutiny Board. It will be led by the Independent Child Safeguarding Commissioner and comprise key roles with responsibility for internal agency scrutiny. The purpose of this group will be, through participation and contributions, to develop a coordinated approach to safeguarding children scrutiny in the City and Hackney, to drive clarity and establish strategic focus relating to scrutiny of safeguarding children and to establish an approach that facilitates constructive engagement with a focus on mentoring and continuous improvement.

Pivot to Digital

We are pivoting to ensure our digital capabilities are mainstreamed into the functions of our arrangements and front-line practice. Whilst a necessity due to the pandemic, we are finding some accrued benefits of working arrangements in this context.

The CHSCP's pivot to digital has extended our reach in terms of on-line training. Since March 2020, we have trained over 700 professionals and volunteers in Level 1 and Level 3 safeguarding training. We have also launched two Apps (Private Fostering and Safer Schools) and an online self-assessment process to replace the Section 11 / Section 157/175 audits. We have created a bespoke version for smaller organisations, including out of school settings.

Safeguarding partners and relevant agencies in both The City of London and Hackney demonstrated flexibility and initiative in developing new arrangements to hold virtual multi-agency meetings and virtual home visits to children and families. Supported by developed practice guidance, in some aspects of work there has been an improvement in multi-agency engagement and the ease in which partners can communicate information rapidly and make decisions to safeguard children and young people.

Relevant Agencies

Whilst we have always experienced good engagement from the vast majority of organisations with safeguarding responsibilities, we believe greater clarity is required in respect of the options available to safeguarding partners should there be active and purposeful non-cooperation. Locally, safeguarding partners have taken an approach of naming all organisations that engage children and young people as relevant agencies (regardless as to whether named in the regulations or not). This has been done with the express intent of leveraging maximum cooperation from (and support to) a range of agencies that have historically operated on the periphery of core safeguarding practice. In 2020, The CHSCP sought the advice of Counsel with regards to the enforcement action available to both safeguarding partners and the secretary of state. From this advice, we understand safeguarding partners retain an option (in particular circumstances) to seek a mandatory injunction to enforce the obligation to comply with the CHSCP's published arrangements or escalate concerns through to regulators. This issue has been escalated to Sir Alan Wood as part of his phase 2 review into the new safeguarding arrangements.

Operational Impact

It is too early to quantify the impact of the new arrangements on operational activity, but in a number of areas, there has been a noted improvement in cooperation and practice. Part of this has been driven by the need for organisations to think and respond differently due to Covid-19. This has forced new ways of working and a pivot to digital solutions that have positively promoted working together as opposed to fracturing it.

The Voice of Children and Young People

New arrangements have yet to be fully developed in this regard, but the voice of children and young people is a priority of safeguarding partners. We are currently reviewing how we capture the authentic voice of children and young people. This work has been delayed as a consequence of the pandemic, but is beginning to gain some traction in specific projects (for example, we are working with the safeguarding adults board to engage young people in respect of transitional safeguarding). Safeguarding partners have committed to supporting and enabling a culture of working that routinely seeks out and reflects the voices of children and young people. This includes the CHSCP engaging directly with children and young people. The lived experience of local children and young people and their voices are evident in the policies we create and the communication channels to our wider partnership. Importantly, it is examined in our activity that reviews multi-agency casework.

Local Learning

We have retained a menu of different ways in which our reviews can be undertaken consistent with statutory requirements and those set out within our learning and improvement framework These methods range from traditional approaches (using an independent reviewer), to ones where local practitioners are facilitated to meet and identify practice improvements. The decision on which model to use rests with the Independent Child Safeguarding Commissioner and is case dependent. Overall, we are committed to speeding up the process of reviews and cascading learning more rapidly. The new Rapid Review process has been helpful to identify early lessons, although we remain cautious not to pre-judge learning in this respect. Some of the most important practice improvements we have identified in our local arrangements were not visible at such an early stage.

Challenges

Challenges, however, remain. Whilst the contexts of safeguarding are different across the City of London and Hackney, the three biggest challenges facing multi-agency safeguarding work are considered to be the following:

- **The impact of COVID-19** creating challenges in respect of the sufficiency of current and future workforce capacity. Contingency arrangements in this regard have been scrutinised by the CHSCP. Whilst there is evidence of resilience, there remains concern as to the potential for future workforce challenges. These centre on the longer-term effects on the mental health of practitioners arising from extended periods of remote working in a highly charged and challenging area of practice.
- **Many support systems for children and young people (via school, services, friends and family) have changed, with some being reduced or removed.** Children and young people are less visible and families are under increased financial and social pressure. There is a general challenge in identifying, preventing and responding to the risks facing children and young people.
- In respect of themes, there are **continuing concerns about meeting the mental health needs of children and young people**, exacerbated as a consequence of COVID-19. Locally, an increase in **head injuries in young children, on-line harm and accidents arising as a result of hazards at home** are other issues on which The CHSCP's is focussing.

COVID-19

Contingency Planning, Oversight & Resilience

Since March 2020, the CHSCP has undertaken ongoing scrutiny of contingency arrangements relating to COVID-19 via analysis of partner contingency plans and partnership meetings. This has served to identify emerging issues throughout the crisis such as attendance at A&E, domestic violence, mental health and more recently, a local increase in head injuries to babies / toddlers and risks arising from hazards in the home. This has led to / is leading to a focused approach by safeguarding partners on targeted awareness raising, specific guidance and training.

During the pandemic, partners have also swiftly pivoted to digital solutions to ensure that partners remain engaged despite not being able to physically meet. Multi-agency processes such as strategy discussions, child protection conferences and visits to children have all been undertaken virtually where required, and supported by the partnership. The CHSCP has also prepared for further challenges by ensuring that safeguarding partners and relevant agencies have clear plans in place and are sufficiently prepared. This has been achieved by conducting a **COVID-19 Operational Resilience Audit**. A major focus of this audit activity has related to workforce sufficiency and the cruciality of safeguarding partners ensuring effective support is in place across the system. Whilst the CHSCP had already identified the health and wellbeing of the workforce as a priority, Covid-19 has accelerated reassurance work by safeguarding partners in this respect. It is positive to note that the anticipated pressures during the first lockdown did not materialise, although we maintain a watching brief on this issue, testing sufficiency and overseeing risk.

88% of organisations have either partially or fully identified best practice and agreed pathways for staff to access occupational health support. These pathways have been shared with managers.

96% have a risk assessment process which assesses the risk to individual employees from the COVID-19 virus. It identifies increased risks due to staff's age, ethnicity, gender and relevant health conditions.

93% of organisations have ensured staff who have suffered bereavement, due to COVID-19 or other reasons, are supported to access specialist support services and that they have policies and practices in place for pastoral support of staff.

Communication

The CHSCP continues to promote its digital platforms and communications reach. The CHSCP website, designed during the 2015/16 period, has allowed for user- friendly content searches and accessible resources.

www.chscp.org.uk

The CHSCP website has continued to allow for user-friendly content searches and accessible resources. Most visited pages were those relating to training and case reviews.

@lscp_chscp

At The CHSCP Annual Conference held on 4 March 2020, our tweets earned over 4.5k impressions

Private Fostering APP

Following the success of the City of London Private Fostering App, the CHSCP developed and launched a bespoke App for the partnership. Alongside providing information about private fostering, the App includes a training module and other important advice for safeguarding professionals.

TUSK Briefings

The CHSCP produces e-briefings called Things You Should Know, more commonly referred to as 'TUSK briefings'. These are circulated to subscribers and also cascaded by Board members to staff within their organisations. The number of subscribers to the TUSK has increased from 570 at the end of March 2019 to 1414.

Safeguarding Children in the Context of their Access to Technology and use of Social Media

With the growing use of technology and social media, all professionals need to adopt a much more sophisticated approach to their safeguarding responsibilities. They need to reflect on the changing nature of communication and how this impact upon practice issues, particularly those focused on the identification and assessment of potential risk. To do this successfully, professionals need to recognize that children and young people do not use technology and social media in isolation. Their offline and online worlds are converged, and both need to be understood when trying to identify the type of support that a child, young person and their family might need.

To help professionals (and parents / carers) better understand this complex environment, new Apps have been launched by Hackney Council and the City of London Corporation. The Safer Schools App provides support on topics including online bullying, mental health, sexting, media literacy, gaming and sexual exploitation online. It costs nothing to download and provides access to advice, guidance and CPD accredited training, with a specific focus on making children and young people safer in the online world.

City of London Safeguarding Snapshot 2019/20

1,453 children and young people under 18
16.9% of total population
11% of children living in poverty
11.2% of children in primary schools in receipt of free school meals (national average 15.7%) (Dec 2019)
21 cases referred / stepped-down to the City's Early Help Team ↓
17 Team around the Child (TAC) meetings held ↓
5 young people going missing from care (12 incidents) ↑
0 incidents of children & young people missing from home ↔

314 contacts to the City Children & Families Team Hub ↔
100 referrals ↑
15% re-referrals ↑
67 statutory social work assessments completed by The City Children & Families Team ↑
78% of assessments completed within 45 days ↑↓
20 child protection investigations ↔
5 children on a Child Protection Plan as of March 2020 ↑
101 Children in Need episodes as of March 2020 (70 in 2018/19) ↑
24 children & young people looked after as of March 2020 ↑
1 MARAC meeting involving children ↔
8 referrals to the LADO ↑
0 Private Fostering arrangements as of March 2020 ↔

Safeguarding in The City of London

City of London Demographics

The City of London has an estimated resident population of about 8500 and a transient daytime working population of around 330,000. Of the resident population, approximately 16.9% are children and young people. The City of London is an economically diverse area, with its population characterised by areas of affluence and poverty. Within the Square Mile, there are large disparities. The Barbican West and East residential areas are among the most affluent areas in England. Portsoken Ward, however, is among the most deprived. An estimated 78% of the City of London population is White British; however, approximately 40% of children are from black or ethnic minority groups compared to 21% nationally. The Bangladeshi community makes up 4% of the total population. Domestic abuse remains a key issue in the City with the majority of child protection investigations in the City involving domestic abuse concerns. There are no children involved in the criminal justice system currently and no teenage pregnancies. Academic attainment for City resident children is higher than the national average. The numbers of children and young people Not in Education, Employment or Training (NEET), obesity rates, infant deaths and underweight babies, hospital admissions for self-harm, deliberate injury, alcohol-related injury and the number of pregnant smokers are all low with numbers ranging from 0 to 5 in each category. Within the City, there is one maintained primary school (with a Children's Centre attached), four independent schools and several higher educational establishments. It has no maintained secondary schools. The majority of children attending these schools come from other boroughs and most of the local authority's secondary school age children go to school outside of the City.

Early Help

'Work is appropriately held within early help, and there is evidence of good direct work with families to effect change. There is effective engagement with partner agencies to support individual families, and, strategically, to develop the early help service further.' OFSTED 2020

Early help services across the City of London are delivered by People's Services and a range of partners, including schools, children centres, one GP surgery and health colleagues as well as other local service providers, including the community and voluntary sector. They are effective, and some are particularly

strong. The range of services available to children, young people and their families in the City continue to adapt and evolve based on the needs of the local population. The early help arrangements in the City have been in place now for a number of years and are embedded with agencies. All children needing an early help service in the City receive a well-resourced, dedicated service, which is provided by trained staff. Over 2019/20, the Early Help Strategy for the City of London continued to drive partnership improvements. With a focus on ensuring the right help is provided at the right time and in the right place, the strategy is focussed on key strategic objectives and is coordinated by the CHSCP City Early Help Sub-Group. Through critical reflection, consultation and co-production with children and families, partners from the Multi-Agency Practitioners Forum and the City's Parent Carer Forum for children with SEND, the following progress has been made:

The City has a clear Thresholds of Need document that has been agreed with partner agencies. This is used to provide services at an appropriate stage and as early as possible to prevent higher levels of need in the future.
There is a single point of contact for referrals to Early Help services and Children's Social Care, enabling timely and appropriate decision making and allocation. The Early Help Assessment is co-created with the family, including discussions with the child/ young person as well as with practitioners from involved agencies. Early help practice in the City of London is ***Empowered****: evidenced through insightful assessments by highly skilled staff, that lead to robust offers of help.* ***Child-centred:*** *evidenced by children and young people routinely being present at meetings or represented through direct work.* ***Integrated****: evidenced through a strong 'Think Family Focus', and a 'top-three' (cases of concern) collaboration across children's, health, adult, housing and homeless service.*

An external audit commissioned by The City of London in 2019 found: The Early Help practice audited was purposeful and well-focused on specific outcomes for children. The quality of intervention is very good and the consistent quality of supervision by the Early Help Coordinator supports strong and reflective practice.

In 2019/20, the total number of cases referred or stepped down to early help services was 21, a small reduction from 27 in 2018/19. There were no re-referrals to early help within 12 months of closure. This has been a consistent pattern and reflects the effectiveness of the multi-agency intervention to improve outcomes for children and young people, preventing problems getting worse.

Children in Need of Help and Protection

'Children in need of help and protection within the City of London receive a good service that is proportionate to their needs and enables them to effect positive change. Risks to children are minimised and, where required, additional support is provided to prevent concerns from escalating.' OFSTED 2020.

Good practice with children and young people who are in need of help and protection can be seen when help is provided early in the emergence of a problem and there is a well-coordinated multi-agency response. Thresholds between early help and statutory child protection work are appropriate, understood and operate effectively. Risk is effectively mitigated and outcomes improved through good assessment, authoritative practice, planning and review.

The City of London Corporation undertook a virtual visit thematic audit in May 2020. This showed that social workers were aware of the potential deficits in using virtual visits to assess and manage risk. There was evidence when comparing the quality between face to face and virtual visits that social workers had taken this into consideration by following the guidance they had been given. Telephone contact did not give the same depth or quality of information required, as audits completed using this method showed that the interaction was rather one-dimensional. Where possible, video/face to face visits were used. Since August 2020, all visits have been face-to-face, unless there are risk factors which require alternative planning. Data shows a large increase in fact to face visiting for quarter 3.

Contacts, Referrals and Assessments

The Children and Families Team Hub provides responsive screening activities and ensures all contacts are immediately progressed as a referral if the threshold for a statutory social work assessment is met. Signposting activity requires staff to have a continually updated knowledge of local services alongside a comprehensive understanding of the City of London Thresholds of Need. The 314 contacts made to the Children and Families Hub reflects a minor decrease on previous years. However, referrals show an upward trend. The re-referral rate in the City of London was 15%, an increase from 8.7%8**%** in 2018/19. Overall, the performance data in the City continues to be indicative of a good social work response and timely access to appropriate support that helps children and their families.

The Children and Families Team Hub aims to ensure that only those children meeting thresholds for statutory assessments are progressed as referrals. Local Authorities undertake these assessments to determine what services to provide and what action to take. The full set of statutory assessments under the Children Act 1989 can be found **HERE.**

The Children and Families Team completed 67 assessments during 2018/19, almost double the number (35 42) in 2018/19. 78% of assessments undertaken in the City were completed within 45 days or less. The rate of child protection (Section 47) enquiries in 2019/20 evidenced a slight reduction from 137.6 per 10,000 to 123 per 10,000. The threshold for Section 47 enquiries in the City is appropriate. Children are not being unnecessarily subjected to child protection intervention and practice is proportionate to the presenting need. Where a child protection response is required, these are all completed in a timely manner. 100% of Initial Child Protection Conferences take place within 15 days of the strategy meeting where the decision was taken to convene an enquiry. This means that in the City of London, children receive a swift service when safeguarding concerns are apparent. All Section 47 enquiries undertaken in the City are led by a suitably qualified and experienced registered social worker.

Children on Child Protection Plans

'When children are identified as being at risk, strategy meetings are convened in a timely manner and are well attended by professionals, who provide relevant information to inform decision-making. Decisions following these meetings and any subsequent enquiries are clearly recorded by managers to facilitate effective interventions with families.' OFSTED 2020

Following a child protection enquiry, where concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm, social workers and their managers should convene an Initial Child Protection Conference (ICPC). An ICPC brings together family members (and children / young people where appropriate) with supporters, advocates and professionals to analyse information and plan how best to safeguard and promote the welfare of the child / young person. If the ICPC considers that the child / young person is at a continuing risk of significant harm, they will be made the subject of a Child Protection Plan (CPP).

Children who have a CPP are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of one or more of these. The CPP details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how professionals, the family and the child or young person (where appropriate) will know when progress is being made. Five children were subject to a CPP in the City at the end of 2019/20. In 2019/20, 93% of CP visits took place within timescales compared to 83% in 2018/19. No children were on a child protection plan for over 12 months.

Children in Care

A child or young person who is 'looked after' is in the care of the local authority. They can be placed in care voluntarily by parents struggling to cope, they can be unaccompanied asylum-seeking children; or in other circumstances. The City of London Corporation and partners will intervene because the child or young person is at risk of significant harm. As of 31 March 2020, the City was responsible for looking after 24 children and young people, a further increase. The City of London's rate for looked after children (148 per 10,000) is well above statistical neighbours (48) and the England average (67) Proportionately, this reflects a high volume of work for the City of London social workers.

Placement Stability, Type and Location

In 2019/20, 20.8% of children looked after by the City had three or more changes of placement over the year. This is a significant increase from 3.7% 5.0% in 2018/19, although caution should be observed in analysing these figures because variations of one or two children can have a major impact on the rate and this performance can therefore fluctuate. This continues to reflect good performance and means that children looked after by the City tend to enjoy good stability and placements that meet their needs well. The local authority does not have its own fostering service due to the size of the looked after children population, but spot purchases from the Pan London consortium. Ofsted rates all independent fostering agencies used by the City either Good or Outstanding. There are sufficient suitable placements available to meet the needs of the City's looked after children and young people. All placements are outside of the local authority with no 9 young people being placed over 20 miles from the City.

Care Leavers

In some areas, particularly in relation to children in care and care leavers, services have improved, resulting in positive experiences and progress for young people. OFSTED 2020

There is a strong range of support for care leavers in the City of London. Care Leavers are well supported, workers remain in touch with them, there is availability of suitable accommodation and they are provided with health support. 22 out of 28 care leavers were in education, training or employment; one in university, 18 attending college; two in employment/training, and six Not in Education, Employment or Training (NEET) and 1 Unknown (March 2020). For lessons identified by the CHSCP in respect of working with care leavers, with a particular focus on their mental health, see the CHSCP's review **HERE.**

Violence against Women & Girls

Children and young people who are exposed to domestic violence and abuse can grow up in a vacuum of what is expected in terms of a positive and healthy relationship. This can create additional vulnerabilities and/or harmful behaviours. Responding proactively and in collaboration with the Safer City Partnership (SCP), violence against women and girls remains a key priority for the CHSCP, recognising both the short and long-term impact on the safety and welfare of children and young people. During 2019/20, the SCP continued its focus on developing services and a new **Violence Against Women and Girls Strategy**.

Operation Encompass has been rolled out by The City of London Police. Five of the City's schools have completed the training which has been delivered virtually due to COVID-19 restrictions. The remaining school is due to be trained shortly once the Designated Safeguarding Lead (DSL) has settled in post. Training material will be delivered to all schools so they can refresh staff as and when required.

MARAC

Operational arrangements for MARAC (multi-agency risk assessment case conference) processes are clearly defined in the City. The City MARAC operates a lower threshold than in other local authorities and takes cases where a preventative approach would be helpful. This is good practice and enables children with these families to have a better co-ordinated multi agency service. In 2019/20, one MARAC was held where children were involved.

Safeguarding Adolescents

Understanding the context in which children and young people live their lives is an essential feature of effective multi-agency intervention. For the CHSCP, this issue remains central to our overall approach in making children and young people safer. Context is key**.** During 2019/20, the CHSCP refreshed its defined strategy for safeguarding adolescents. This strategy builds on the progress made by the partnership in safeguarding children and young people at risk of child sexual exploitation (CSE) and those missing from home, care and education. It was developed in parallel to our improved understanding of the issues facing young people; established through focused problem profiles, national and local learning and intelligence pictures involving vulnerable adolescents.

The strategy continues draws on evidence about effective practice from contemporary research. It is a focussed document that sets the parameters for developing our understanding of the complexities of young people's vulnerabilities and finding more effective multi-agency responses to these issues. The strategy maintains a focus on making sure that professionals are getting the basics right whilst striving to develop best practice in terms of the following priorities:

- Knowing our Problem, Knowing our Response
- Strong Leadership
- Prevention and Early Intervention
- Protection and Support
- Disruption and Prosecution

Factors in scope within the strategy include, but are not limited to the following:

- Child Sexual Exploitation (including Harmful Sexual Behaviours)
- Children missing from home, care and education
- Children and young people exposed to risk through gang involvement, county lines, trafficking and serious youth violence.
- Domestic Violence and Abuse (DVA)
- Violence Against Women & Girls (VAWG)

- Adolescent Neglect
- Self-harm and Suicide
- Substance Misuse
- Radicalisation
- Special Educational Needs and Disabilities (SEND)

Child Sexual Exploitation

Understanding the nature and prevalence of child sexual exploitation (CSE) and harmful sexual behaviour (HSB) and ensuring that partner agencies provide appropriate safeguarding responses and interventions remains a priority. In February 2017, a revised definition of CSE was issued by the Department for Education (DfE).

'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.' DfE 2017

The City of London continued to experience a low number of cases relating to Child Sexual Exploitation (CSE), with most contacts being about non- residents. Over the last four years, the crimes relating to CSE that have been recorded by the City Police include rape, sexual activity and possession of indecent images. Cases have also included grooming by offenders via the internet / social media.

Partner agencies engaged in the City continue to share intelligence that may influence the knowledge of the profile. Of significance is the City's location as a major transport hub. A quarterly data set of over twenty indicators produced for the MASE Group supplements the information provided by the City Police. This informs understanding, and the identification of risk indicators. In recognition of the overlapping vulnerabilities adolescents face, the City Multi-Agency Sexual Exploitation panel was changed to the Multi-Agency Child Exploitation panel to include all forms of abuse and exploitation that adolescents are at increased risk

of. Although few in number and type and relatively lower level risk in comparison to neighbouring LAs, the City is not complacent and maintains an 'it could happen here' stance.

Operation Make Safe (formerly Alarm Call) has been on hold due to Covid-19. Until restrictions are lifted it is not possible to use cadets to test the response of hotels, coupled with the fact that a large number of City hotels are currently closed due to a lack of trade the MPS have also placed their work on hold. A digital conference is being designed for release in January 2021 to enable engagement and education to take place even if lockdown restrictions are still place.

Children Missing from Home, Care and Education

Responses to children who go missing are robust, and processes and procedures are followed and escalated to senior managers when required. There is a clear understanding of the additional vulnerabilities of unaccompanied asylum-seeking children (UASC) who go missing, and the potential for exploitation and trafficking and significant efforts made to locate them quickly. OFSTED 2020

The City Police lead on all children who go missing from home or care and a coordinated response takes place with the City Children and Families team, working closely with the child's parents or carers. Numbers of children who go missing in the City of London are very low. A specific part of the Safeguarding Adolescent Strategy focuses on the effective management of children who are missing. The City of London has reviewed its Missing from Care Procedures and the arrangements for Return Home Interviews. There remains senior leadership oversight through the missing period with robust partnership arrangements in place. All strategy meetings have health, social care and police engagement as a minimum. This has helped with the timely response to missing episodes and alerting relevant authorities to missing episodes.

NCH Action for Children is commissioned by the City of London Corporation to give missing children a return home interview within 72 hours. These interviews are followed up with therapeutic support depending on the outcome to address risk-taking behaviour. This is in line with statutory guidance published by the Department of Education in 2014. Return home interviews are reviewed and used by the partnership to understand the reasons why children go missing and inform strategy and service delivery.

Since 2015, the City of London Corporation has implemented a rigorous system to identify all children of statutory school age and where they attend school. The City of London maintains this record of where children are placed through the primary and secondary transitions process. A school tracker is updated and reviewed regularly.

Gangs, Criminal Exploitation and Serious Youth Violence

There are a number of ways in which young people can be put at risk by gang activity, both through participation in and as victims of gang violence which can be in relation to their peers or to a gang-involved adult in their household. The City of London Drugs Profile found that the largest area of drug misuse was among affluent City workers with the supply of drugs controlled by organised criminal groups involving male 'runners' in their 20s who often deal pre-ordered drugs out of their cars. While drug related crime involving resident CYPs is low, a case involving a trafficked young person highlights this as an emerging theme that requires close attention and partnership working between Police, Adult and Children's Social Care, and businesses in the City. There is concern in the north that young adults known to be associated with Islington gangs have started to hang around Golden Lane Estate. Community safety partners are monitoring this closely and report 'no hard issues' other than gang related graffiti to date. Work with the estate and Islington is needed to understand this emerging pattern and mitigate associated risks for CYP.

The City of London has completed a Contextual Safeguarding Assessment of the Square Mile bringing together intelligence from the City's vulnerable adolescents profile, City Youth Forum, Community Safety, Neighbourhood teams, and relevant intelligence from LAs on our border. This led to changes in the City's multi-agency arrangements to improve joint intelligence and planning around risks. The Safeguarding Adolescents Forum expanded its remit to consider all child exploitation, including criminal. This work has recently been able to help partners identify children who are being exploited by criminal gangs to steal. The City of London has also commissioned a County Lines peer review. The final report on this has been delayed because of the pandemic

Work in being undertaken to implement Operation Innerste, which is a process that enables police to obtain the fingerprints and photograph of unaccompanied asylum seeking minors when they present at the police station. The aim of the operation is to prevent the minors becoming 'attractive' to traffickers or potential exploiters because they have a footprint in the UK, in effect their identity is locked in before they are placed in local authority care. Pilot schemes have also seen it greatly reduce the number of minors who abscond from their placements and present in a different local authority area.

Adolescent Neglect

Identifying, naming and responding to adolescent neglect can be challenging due to misconceptions that adolescents become more resilient because of their age alone, over-reliance on older CYP to be responsible for themselves, and the assumption that they can and would ask for help if they needed. This is further exacerbated in affluent families where material wealth and access to private services can serve to keep neglect and emotional abuse of adolescents hidden. It is also the case that CYP in affluent families where there is parental substance misuse, mental ill health, or domestic violence can be harder to reach due to the way families use their resources to block access and can hide the extent of their needs through the use of privately funded services.

The City has previously sponsored research on neglect in affluent families. Conducted by Goldsmith University, this research identified teens as a particularly vulnerable cohort with complex safeguarding needs. Research by The Children's Society has also found a potential link between emotional neglect and those children living in more affluent families. Given the City's demographics, this remains a priority, ensuring that practitioners have the necessary skills to recognise and respond to the signs and symptoms of adolescent neglect.

Self-Harm & Suicide

The partnership's focus on self-harm and suicide continued over 2019/20 as a consequence of the deaths of a number of young people from Hackney. Learning from the published reviews into these cases is set out later in this report. The City of London's Suicide Steering Group continued to provide strategic oversight and operational planning covering adults and both children.

Radicalisation

The Counter Terrorism and Security Act received Royal Assent on 12th February 2015. Prevent was placed on a statutory footing in July 2015 to ensure all specified authorities in local areas, as a minimum, understand the local threat and take action to address it, assess if local frontline staff need training to recognise radicalisation, and to ensure that all of those who need to work together to deliver the programme do so in the most effective way. The City of London has not been identified as a Priority Area and as such, receives no additional Home Office funding to deliver its Prevent programme. The Safer City Partnership (SCP)

retains overall governance of this agenda, which includes a focus on ensuring there are sufficient arrangements in place to safeguard children and young people. The City of London Police delivers Prevent training to schools, youth providers and businesses.

Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, person with parental responsibility or a close relative for 28 days or more is privately fostered. The arrangements for managing private fostering in the City accord with statutory requirements. No notifications were received in The City of London during 2019/20. Private Fostering continues to be promoted via the CHSCP Private Fostering App.

Children with Disabilities

Since the introduction of the special educational needs and disability (SEND) reforms in September 2014, the City of London Corporation has made good progress in implementing these. All former Statements of Special Educational Needs were transferred to Education, Health and Care (EHC) plans well in advance of the national deadline of 1 April 2018. All statutory assessments are completed within 20 weeks (the statutory timeframe). There remains a very high level of satisfaction rate amongst families accessing the City of London's services and their view of multi-agency working is good. The SEND Joint Strategy and self-evaluation form (SEF) has been developed with both partners and families to set out the City's priorities and to highlight the areas where the most progress is being made.

The City currently provides short breaks to 12 children and there are 21 children with EHC plans in place. There is a disability lead in the social work team who has specialist knowledge and supports the service when needing to progress assessment work with disabled children. During the Covid-19 pandemic, partners in the City of London have continued to offer close support to children with EHC Plans and their families through a weekly review and have a strong integrated offer between Special Educational Needs and Children's Social Care.

MAPPA

Multi-Agency Public Protection Arrangements (MAPPA) are the statutory measures for managing sexual and violent offenders. The Police, Prison and Probation Services (Responsible Authority) have the duty and responsibility to ensure MAPPA are established in their area and for the assessment and management of risk of all identified MAPPA offenders. The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public from serious harm, by ensuring all agencies work together effectively. Across London on 31 March 2020, there were 6581 6452 Category 1 'Registered Sex Offenders' (RSOs) (an increase from 6452 in 2018/19 and 6317 in 2017/18), 3735 Category 2 'Violent Offenders' (and decrease from 4128 in 2018/19 and 3833 in 2017/18) and 37 Category 3 'Other Dangerous Offenders' (an increase from 27 in 2018/19 and 24 in 2017/18).

Safer Workforce

Despite all efforts to recruit safely there will be occasions when allegations are made against staff or volunteers working with children. Organisations should have clear procedures in place that explain what should happen when such allegations are raised. These should include the requirement to appoint a designated safeguarding lead (DSL) to whom these allegations are reported. It is ordinarily the responsibility of the DSL to report allegations to, and otherwise liaise with, the designated officer in the local authority (referred to as the LADO). The LADO has the responsibility to manage and have oversight of allegations against people who work with children. Reporting to the Assistant Director of People Services, the LADO role in the City is held by the Safeguarding and Quality Assurance Service Manager. The LADO should always be contacted when there is an allegation that any person who works with children has:

- Behaved in a way that has harmed a child, or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Activity

- There were eight referrals made to the LADO during 2019/2020 period, which is an increase of two from 2018/2019. Five met the LADO threshold.
- There were six referrals to the LADO in 2018/19, six in 2017/18, seven in 2016/17 and eleven in 2015/16.

Categories of Concern

- Three cases were related to incidents in the professional's person life and raised concerns in respect of their professional role working with children.
- Two were related to the individual's behaviour
- Three were related to physical abuse.

Themes

Over the last eight years, the highest number of referrals have been made relating to those in the education sector. This overall trend continues. In 2019/20, noted themes included referrals about incidents in the personal life of the professionals concerned and referrals arising from outside of the City of London.

LADO Training & Awareness Raising

Awareness raising activities by both the CHSCP and the City of London continued during 2019/20. Designated Safeguarding Leads continue to access training through the CHSCP. Part of this training focuses on the role of the LADO and the City of London LADO has been involved in delivering this training in the City. This has enabled professionals who would not necessarily meet with the LADO to gain a better understanding around the role and when they need to refer. Sessions with partners through the staff induction and Multi-Agency Forums, such as the City of London's Children's Partnership Board and Education Safeguarding Forum have also promoted awareness. The Safeguarding Lead in the Education and Early Years' Service has been integral in supporting the message around role of the LADO by briefing early years settings on the procedures in reporting professional allegations. The LADO also maintains close links with the Designated Safeguarding Leads in Schools. The City of London also hosted the National LADO conference in May 2019, this has significantly raised the profile of the City not only within Greater London but also nationally.

Hackney Safeguarding Snapshot 2019/20

Approximately 63,655 children and young people under 18
23% of total population
28% of children living in poverty
27.9% of children in primary schools in receipt of free school meals (national average 15.7%) (Dec 2019)
33% of children in secondary schools in receipt of free school meals (national average 14.1%) (Dec 2019)
459 children were subject to a CAF and MAT intervention in 2019/20 ↑
291 new early help cases identified and supported through the MAT process ↑
Young Hackney are working with 600 young people though Early Help Teams, providing tailored support.
Approximately 170,780 attendances at activities delivered by Young Hackney from young people throughout the year. ↓
108 children missing from home or care ↓ / 821 episodes of children going missing from home or care ↑
16044 contacts to Hackney CFS ↑
5031 referrals ↑
15.8% re-referrals ↓
4923 assessments completed by Hackney CFS ↑
63% of assessments were completed within 45 days ↑
924 child protection investigations ↓
251 Children on a Child Protection Plan as of March 2020 ↑
3094 Children in Need episodes as of March 2020 (2904 in 2018/19) ↑
402 children with a disability (open to Disabled Children Service as of March 2020) ↑
432 children & young people looked after as of March 2018 ↑
253 MARAC meetings involving children and young people living in families with domestic violence↓
309 referrals to the LADO ↑

Safeguarding in Hackney

Hackney Demographics

The London Borough of Hackney is an inner-city London borough. There are over 60,000 children and young people under the age of 18 years, representing 4% of the total population. Of these, around 19,000 are aged less than five years. Over 58% of children and young people living in Hackney belong to black or other minority ethnic backgrounds, compared with 21.5% in the country as a whole. It is a richly diverse community with significant numbers of Asian, Black African, Black Caribbean, Black British, Turkish, Kurdish and Charedi Jewish children. Hackney's Orthodox Jewish Community population of around 30,000 represents more than 10% of Hackney's total population and around 50% of the community is under the age of 19 years. There are over 180 languages spoken in the borough. Hackney is ranked the second most deprived borough in England and it is estimated that 35.6% of children and young people in Hackney are living in poverty, with around 28-32% eligible for and in receipt of free school meals.

Early Help

'Children and families are helped and supported by a range of effective early help services.' OFSTED 2019

Children and young people in Hackney continue to have access to and benefit from an extremely wide range of early help services that are sharply focused on meeting the diverse needs of local communities. These services are delivered by the Hackney Children and Families Service, Hackney Education and a range of partners, including 74 schools, a network of 21 children centres delivering a range of services and working closely with schools, GPs and health colleagues as well as other local service providers, including the community and voluntary sector.

Children's Centre Family Support and Multi-Agency Team (MAT) Meetings

Family support in children's centres seeks to improve parenting capacity, protect children from harm and neglect and improve outcomes for young children. Family support is part of the early help Universal Partnership Plus offer to families with children predominantly but not exclusively, under 6 years and is

coordinated by the MAT (Multi-Agency Team meetings), underpinned by the Common Assessment Framework (CAF) early help assessment. MAT meetings have continued to occur fortnightly in each of the six strategic Children's Centres in Hackney. Chaired by a qualified social worker employed by Hackney Learning Trust, MAT meetings are attended by a range of professionals including midwives, health visitors, Children's Centre family support teams, speech and language therapists and First Steps. Early help interventions delivered include: parenting programmes; individual and small group work to address family relationships and dynamics; support with: housing; finance; child behaviour; sleeping; toilet training; routines; and the transition to nursery and school.

MAT received 291 new referrals (277 in 2018/19) and worked with a total of 459 families subject to an early help assessment and referral (447 in 2018/19). In addition to the 459 early help assessments, MAT received 66 'handoffs' from the First Access & Screening Team (FAST) in order to coordinate a response following contact.

Young Hackney

Young Hackney provides early help, prevention and diversion service for children and young people aged 6-19 years old and up to 25 years if the young person has a special education need or disability. The service works with young people to support their development and transition to adulthood by intervening early to address adolescent risk, develop pro-social behaviours and build resilience. The service offers outcome-focused, time-limited interventions through universal plus and targeted services designed to reduce or prevent problems from escalating or becoming entrenched and then requiring intervention by Children's Social Care.

The number of named individuals accessing Young Hackney universal provision decreased by 5% in 2019/20 compared to the previous year. 22,787 named individuals accessed Young Hackney provision in 2019/20, compared to 24,024 named individuals in 2018/19. There were 170,780 attendances by named children and young people aged 6-19 years during 2019/20 at the wider youth provision delivered through Young Hackney and commissioned services for young people. This is a 3.6% decrease compared to 2018/19 when there were 177,299 attendances by named children and young people. Part of this decrease may be explained by the increasing concerns from parents about the risk of COVID-19 which began in March 2020, before the Government official lockdown date of 23 March 2020. Many people began to work from home, and vulnerable children or children in families with those at risk began to be educated virtually/at home. Hackney CFS Annual Report 2019/20

Children in Need of Help and Protection

Good practice with children and young people who are in need of help and protection can be seen when help is provided early in the emergence of a problem and there is a well-coordinated multi-agency response. Thresholds between early help and statutory child protection work are appropriate, understood and operate effectively. Risk is effectively mitigated and outcomes improved through good assessment, authoritative practice, planning and review.

Contacts, Referrals and Assessments

'Thresholds are applied consistently and effectively at the front door when concerns first arise, and children and families receive the right level of initial help when they need it.' OFSTED 2019

The First Access & Screening Team (FAST) acts as a single point of contact for referrals to Children's Social Care in Hackney and provides responsive screening activities. All contacts with FAST are immediately progressed as a referral to Children's Social Care if the threshold for a statutory assessment is met. Related signposting activity requires staff in FAST to have a continually updated knowledge of local services at their fingertips coupled with a sound understanding of the Hackney Child Wellbeing Framework. The FAST ensures children are quickly allocated resources to meet their needs or safeguard their welfare, working to a principle of right service, first time. Like other Multi-Agency Safeguarding Hubs (MASH) across London, FAST works alongside co- located partners from Hackney CFS, police, probation and health services to share information, jointly risk assess and promote access to services. This joined up approach enables proportionate and timely decisions about the type and level of services children need and facilitates timely access to resources. The FAST development continues to be co-ordinated by a multi-agency steering group of key partners. Hackney's FAST also supports children and young people to access universal and targeted early help provision. In 2019/20, FAST received 16044 contacts from a range of sources of which 5031 were accepted as a referral to CFS. This is a marked increase in the number of referrals compared to 2018/19 (4190). The percentage of re-referrals decreased from 16.5% to 15.8%. Against this indicator, Hackney continues to track well below the national average and either below or in line with statistical neighbours.

Following contact, the FAST aims to ensure that only those children meeting thresholds for statutory assessments are progressed as referrals to CFS. Local Authorities undertake these assessments to determine what services to provide and what action to take. The full set of statutory assessments under the Children Act 1989 can be found **HERE**.

4,923 assessments were completed in 2019/20, an increase on 4290 in 2018/19 and 4,438 in 2017/18. 64% of assessments were completed within 45 days. This is lower than the most recently published statistical neighbour data – 88% of their assessments were completed within 45 days over a 12 month period as of 31 March 2019. Our assessment timescales have improved since March 2020, with 80% of assessments between April-August 2020 completed within 45 days, and 94% of assessments in September completed within 45 days. There was a significant increase in the number of assessments completed in the second half of 2019-20, from November 2019 onwards that impacted on our ability to improve assessment timescales following a continued focus on this area in 2019-20. Once this high volume of cases moved through the system, the decrease in the number of assessments in 2020-21 has meant that assessment timescales have improved significantly. ***Hackney CFS Annual Report 2019/20***

Strategy Discussions

'Strategy discussions do not involve all relevant partners sharing agency information until the initial child protection conference stage. This means that subsequent enquiries and assessments for many children don't include key information, for example that held by the police about adults. Better practice in information-sharing is evident in strategy discussions concerning harm to children on open cases.' OFSTED 2019

Ofsted's inspection of Hackney's children's social care services in 2019 identified that in some strategy discussions, they do not involve all relevant partners sharing agency information until the initial child protection conference stage. In response, The CHSCP has developed **this protocol** as a practical guide for Hackney professionals involved in a child protection enquiry. It covers details about when strategy discussions should be convened, who needs to be involved and what factors need to be considered. The protocol includes an **agenda template** that will help you follow the process and understand the decisions that need to be made.

Children on Child Protection Plans

Following a child protection enquiry, where concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm, social workers and their managers should convene an Initial Child Protection Conference (ICPC). An ICPC brings together family members (and children / young people where appropriate) with supporters, advocates and professionals to analyse information and plan how best to safeguard and promote the welfare of the child / young person. If the ICPC considers that the child / young person is at a continuing risk of significant harm, they will be made the subject of a Child

Protection Plan (CPP). From 2011 to 2017, there has been an increasing trend in the number of children and young people subject to a CPP in Hackney. However, following a 30% increase seen between 2016 and 2017, there was a significant swing, with CP Plans decreasing by 39% as at the end of March 2018 (from 330 to 200). This reduced rate remained broadly the same as at the end of 2019 (194). Over 2019/20, there has been a growth in activity in this regard. At the end of March 2020, 251 children had a CP Plan in place.

Related to this indicator is the number of children subject to a CPP for a second or subsequent time. This measure is used as a potential indicator as to whether a CPP has been successful in effectively reducing risk. During 2019/20, the percentage of children being subject to a CPP for a second or subsequent time decreased from to 23% compared to 18.6 % in 2018/19.

Children in Care

***'Children in care and leaving care in Hackney benefit from a strong service.'* OFSTED 2019**

A child or young person who is in care or 'looked after' is in the care of the local authority. They can be placed in care voluntarily by parents struggling to cope, they can be unaccompanied asylum seeking children; or in other circumstances, Hackney CFS and partners will intervene because the child or young person is at risk of significant harm. As of 31st March 2019, Hackney was responsible for looking after 432 children and young people compared to 405 at the end of March 2019. This is a 7% increase. Overall numbers have increased since 2011 (270), and whilst Hackney has historically had lower numbers of children in care per 10,000 population, 2018/19 saw Hackney's rate (64) exceed Statistical Neighbour rates (60.4) for the first time. In 2019/20, the rate is 64 per 10,000.

Placement Stability, Type & Location

On the whole, stability is associated with better outcomes for children. Proper assessment of a child's needs and a sufficient choice of placements to meet the varied and specific needs of different children are essential if appropriate stable placements are to be achieved. Inappropriate placements tend to break down and lead to frequent moves. The percentage of looked after children with three or more placements in one year decreased from 13% in 2018/19 to 12% in 2019/20. The children who experienced multiple placement moves were generally aged over 13 years; their placement changes were associated with issues

linked to higher levels of need and complexity related to adolescence. The percentage of looked after children aged under 16 looked after continuously for at least 2½ years who have been living in the same placement for at least 2 years (or placed for adoption and their adoptive placement together with previous placement lasting for at least 2 years) as of 31st March 2020 was 66%, a further improvement on previous reporting, although Hackney has historically tracked below statistical neighbour and national averages in this regard. Similar to earlier years, the vast majority of looked after children are in foster placements (75%). Of the 432 children looked after by Hackney at March 2020, 23% were placed in Hackney (26% in 2018/19). There has been an increase in the percentage and number of children placed within 20 miles of Hackney, with 329 (76%) of children placed within 20 miles during 2019/20, compared to 300 (74%) in 2018/19. This is in part due to the increased use of in-house fostering placements.

Care Proceedings

The rate of care proceeding applications in Hackney increased 10.3 per 10,000 in 2018/19 to 16.4 per 10,000 in 2019/20 (107 applications). This rate is higher than the national average (10.8 per 10,000).

A new Strategic Plan was launched by Cafcass in autumn 2019. It has been developed with significant input and engagement from staff across all parts of the organisation, including the FJYPB, our family justice system partners and wider stakeholders. Ongoing engagement with each of these groups is a key feature of our new strategy which recognises the importance of working together to improve outcomes for all the children we work with as part of a wider family justice system.

Care Leavers

The Leaving Care Service ensures that young people are supported to develop independent living skills, offered career advice and training and educational opportunities, and supported to reach their full potential in all aspects of their life. 313 care leavers aged 17-21 were being supported by the Leaving Care Service, as of March 2020, a 2% increase compared to the 308 being supported at the same point in March 2019. This number has continued to rise and the service was supporting 326 care leavers aged 17-21 at the end of August 2020. 79 care leavers aged 22-24 were being supported in March 2020. This is a

20% increase compared to the 66 care leavers aged over 21 who were being supported by Leaving Care, as of March 2019. This number has continued to increase and the service was supporting 82 care leavers aged 22-24 at the end of August 2020.

*Each year over 10,000 young people leave the care system and become care leavers . Their immediate transition to independence and the years that follow can be difficult for many. With little to no family support, the lived experience of some can be extremely challenging and isolating. In 2020, **the CHSCP published a briefing paper** building on our collective understanding of the challenges faced by care leavers. It provides a number of headline messages for improving multi-agency safeguarding practice. It summarises the lessons from the reviews of two cases involving care leavers who tragically died by suicide. Wherever you work, use this briefing paper to generate discussion about the vulnerability of care leavers, particularly in the context of their mental health. Talk about what you can do differently, reflect on the key messages and above all, ensure your individual practice is sufficiently attuned to them.*

Violence against Women & Girls

It is estimated that 3 in 10 women (aged 16+) will have experienced domestic abuse at some point in their lives and that 1 in 5 children have been exposed to domestic abuse in the home. Applying these figures to local populations would suggest that 34,142 women have experienced intimate violence, with 5804 children and young people being either directly or indirectly affected by it. Responding proactively and in collaboration with the Community Safety Partnership remains a key priority for the CHSCP, recognising both the short and long-term impact on the safety and welfare of children and young people. The CHSCP is represented on Violence Against Women and Girls operational and strategic panels, which is comprised of statutory and voluntary sector organisations. The partnership in Hackney progressed its ambition to move from a strategy based on tackling DV to one that aims at a wider approach responding to all forms of VAWG. This development follows national and regional policy and aims to embrace all forms of violence that are committed against women and girls as they have a number of commonalities and therefore suggest a linked approach. Operationally, the Domestic Abuse Intervention Service (DAIS) in Hackney encompasses the following areas:

- **Intervention Officers**. The Intervention Officer posts allow for the recruitment of social workers, former police officers, probation officers as well as qualified domestic abuse advocates. This will build a service with a mix of skills and backgrounds who are experienced in assessing and managing risk.

- **Perpetrator interventions**. This model integrates allows for the flexibility for staff to engage with perpetrators directly as needed to deliver a responsive, holistic and victim-focused risk management service.
- **Operational and strategic management.** Managers are responsible for operational case work and for strategic / partnership working. This differs from the usual model whereby a 'VAWG co-ordinator' role sits separately from the delivery of risk management services working with clients.

From April 2017, the Domestic Abuse Intervention Service (DAIS) joined the Children and Families Service as part of the Early Help and Prevention Service. DAIS works with anyone experiencing domestic abuse who is living in Hackney, aged 16 or over, of any sex and gender, and of any sexual orientation. The service assesses need; provides information and support on legal and housing rights; supports service users with court attendance; supports service users to obtain legal protection; and works with service users and other professionals to address their needs. The service also works with perpetrators of domestic abuse to try to reduce risk.

DAIS received an average of 25 referrals per week in 2019/20, similar to the rate received in 2018/19. This followed a 61% rise in referrals between 2015/16 and 2018/19. The impact of the lockdown in response to coronavirus led to a 50% increase in referrals between 23 March 2020 and 4 July 2020 as compared to the same period in 2019. DAIS adapted its core service delivery to ensure continuity of service while at the same time leading within the Council and across the Hackney partnership on the promotion of a joined up, adaptive and resilient response. DAIS remained fully operational and the Council has allocated additional resources to expand the staff team to meet this demand. Referral numbers have now stabilised to an average of 26 between August and September 2020. ***Hackney CFS Annual Report 2019/20***

MARAC

The number of cases considered at MARAC (multi-agency risk assessment case conference) continues to reflect a robust response to providing multi-agency support to victims and children at risk of domestic violence and abuse. 492 cases were heard at MARAC in 2019/20, a 9% increase from 2018/19 when 450 cases were heard. 110 of the total number of cases heard at MARAC in 2019/20 were 'repeat' referrals, a 3% decrease from 2018/19 when 113 of the total were repeat referrals. In 2019/20 of the 492 cases, 253 (49%) there were children in the household.

The Primary Care MARAC Liaison service at Homerton University Hospital received a Highly Commended Safeguarding Initiative award from the Health Service Journal. The judges felt that this team provided a comprehensive overview of the development, and demonstrated excellent outcomes in relation to improved engagement in primary care. It was great to see the multi-agency team working together to optimise the opportunity to safeguard patients. Webinars on domestic abuse have also been delivered by the Homerton Safeguarding Children Team with subject specific experts, Hackney DAIS, Safe and Together Team and the Specialist Health Visitors for Domestic Abuse.

Safeguarding Adolescents

Understanding the context in which children and young people live their lives is an essential feature of effective multi-agency intervention. For the CHSCP, this issue remains central to our overall approach in making children and young people safer. Context is key**.** During 2019/20, the CHSCP refreshed its defined strategy for safeguarding adolescents. This strategy builds on the progress made by the partnership in safeguarding children and young people at risk of child sexual exploitation (CSE) and those missing from home, care and education. It was developed in parallel to our improved understanding of the issues facing young people; established through focused problem profiles, national and local learning and intelligence pictures involving vulnerable adolescents.

The strategy continues draws on evidence about effective practice from contemporary research. It is a focussed document that sets the parameters for developing our understanding of the complexities of young people's vulnerabilities and finding more effective multi-agency responses to these issues. The strategy maintains an unswerving focus on making sure that professionals are getting the basics right whilst striving to develop best practice in terms of the following priorities:

- Knowing our Problem, Knowing our Response
- Strong Leadership
- Prevention and Early Intervention
- Protection and Support
- Disruption and Prosecution

Factors in scope within the strategy include, but are not limited to the following:

- Child Sexual Exploitation (including Harmful Sexual Behaviours)
- Children missing from home, care and education
- Children and young people exposed to risk through gang involvement, county lines, trafficking and serious youth violence.
- Domestic Violence and Abuse (DVA)
- Violence Against Women & Girls (VAWG)
- Adolescent Neglect
- Self-harm and Suicide
- Substance Misuse
- Radicalisation
- Special Educational Needs and Disabilities (SEND)

The partnership has continued to develop its understanding of exploitation and extra-familial harm including criminal exploitation, county lines and trafficking. This has been supported by the ongoing work of the Contextual Safeguarding Project. The Extra-Familial Risk Panel, a key operational component, continued to be held fortnightly to ensure consistent oversight and planning for cases where young people are at risk of experiencing, or are involved in, harmful behaviours outside the home. There is strong multi agency attendance from Police, Education, Health, Youth Offending Team, Young Hackney and the Integrated Gangs Unit. The Panel develops operational actions which looks to reduce harm and disrupt exploitation of children. Themes and strategic issues from the Extra-Familial Risk Panel are shared with the Multi-Agency Child Exploitation (MACE) group for wider consideration and agency action. Both forums also report back any significant issues via the CHSCP Safeguarding Adolescents Group.

The contextual safeguarding project in Hackney has been evaluated and this was published in November 2020: https://www.researchinpractice.org.uk/all/news-views/2020/november/evaluating-a-contextual-safeguarding-system-to-address-extra-familial-risk-and-harm/ This is an independent evaluation of the implementation of the contextual safeguarding system in Hackney published by the Department for Education (DfE). The evaluation, led by the University of Sussex in partnership with Research in Practice, was part of the second wave of DfE Innovation Programme funding. The evaluation findings indicate that:

The implementation of Hackney's new Contextual Safeguarding system is progressing well. Systems and approaches to support Level 1 work are now almost fully embedded in Hackney and further advanced than comparators' systems in most respects (based on interviews with professional leads and social workers, staff surveys, and documentary analysis in Hackney and with the comparator local authorities). While not all Level 2 interventions, or the procedures that support them or assess their impact, are in widespread and consistent use across Hackney, the Contextual Safeguarding approach means that Hackney is now much better equipped to address extra-familial risk and harm at Level 2 than comparable local authorities.

Child Sexual Exploitation

Understanding the nature and prevalence of child sexual exploitation (CSE) and harmful sexual behaviour (HSB) and ensuring that partner agencies provide appropriate safeguarding responses and interventions remains a priority. In February 2017, a revised definition of CSE was issued by the Department for Education (DfE).

'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.' DfE 2017

Analytical research has been undertaken to interrogate data relating to CSE and HSB and to identify emerging themes and trends which inform service development. The research has highlighted three broad CSE profiles in Hackney:

- **CSE risk resulting from peer-on-peer abuse (sexual offences/exploitation against one or more victims and usually perpetrated in a group setting)**
- **CSE risk from an adult perpetrator (typically a young person believing themselves to be in a 'relationship' with an adult after being introduced to them by a normally vulnerable friend, or through online contact)**
- **Exploitation via social media (inciting or encouraging a victim to take and send explicit images of his/herself)**

Children Missing from Home, Care and Education

The Police lead on all children who go missing from home or care and a coordinated response takes place with Hackney CFS working closely with the child's parents or carers. For those young people who repeatedly go missing this co-ordinated response often involves a lead professional from education, Young Hackney, Youth Justice Service and the Integrated Gangs Unit.

Hackney CFS has led on strengthening the partnership's understanding of and response to children and young people who go missing from home and care. Missing episodes are considered as part of a broader spectrum of vulnerabilities effecting adolescents which include CSE, harmful sexual behaviour (HSB), radicalisation and gang and youth violence.

When a young person returns from an episode of going missing, they are offered an independent return home (IRH) interview by the Children's Rights Service. The use of Independent Return Home Interviews continues to be effective in supporting young people to share information about push and pull factors, what happens when they go missing and what support they need to reduce further episodes. The implementation of a daily meeting with Missing Police has supported better working relationships, information sharing and development of robust risk assessments and timely plans to locate children and offer the appropriate support. The most prominent themes in reasons children and young people have been going missing is 'difficulties at home or school', with overcrowding being highlighted in a number of cases. Mental health and emotional wellbeing was also a key precipitating factor for missing episodes and additional learning needs whereby young people became confused with how to get home or made poor decisions due to peer influences.

In 2019/20, 108 young people went missing from home or care on 821 occasions (compared to 144 young people on 568 occasions in 2018/19). In 66% of the occasions where a young person went missing it is recorded that they were offered an interview and in 42% of cases, the interview was accepted. A daily discussion is held with Hackney Missing and Exploitation Police to review cases of missing children and consider their vulnerabilities and support required. A fortnightly 'High Risk Case Alert' is sent to the Director and Heads of Service in Hackney CFS to ensure senior managers are sighted on young people who are presenting with the highest risk and ensure plans are in place to reduce this risk and minimise harm.

In respect of children missing education, The Children Missing Education (CME) Team continues to identify, monitor and track children missing or not receiving a suitable education. This includes liaison with FAST when there are safeguarding concerns. The work of the CME team fits closely with other strands of work to support vulnerable pupils including supporting schools and families to prevent poor school attendance, truancy, exclusions and supporting schools and families to get children back to school once absence has occurred. The team liaises closely with the Education Attendance and Admissions services.

When looking at the rolling number of cases, the overall CME figure had been relatively low before the identification of pupils previously attending independent settings. Between October 18 and January 19, the service received a high number of referrals following the closure of a school in the Charedi community. Between October and November 2019, the service also experienced a sharp rise in CME numbers, with an increase of 226 children. In addition, the service recorded a slight increase in August 19 following an intensive review of those children registered as Electively Home Educated (EHE). A significant number of children 385 children (all the Charedi community) remain open to the CME Team due to a lack of clarity on the child's circumstances, a lack of engagement or refusal to comply with Hackney's EHE services.

Gangs, Exploitation and Serious Youth Violence

There are a number of ways in which young people can be put at risk by gang activity, both through participation in and as victims of gang violence which can be in relation to their peers or to a gang-involved adult in their household. Over 2018/19, the CHSCB's focus on this aspect in the context of vulnerable adolescents was further developed. The CHSCB's annual conference in 2018/19 specifically focused on the criminal exploitation of young people, with further training rolled out over 2019/20. In late 2020, the CHSCP published a Serious Case Review Concerning Child C.

On 1 May 2019, Child C, a 15 year old male, died as a result of being stabbed whilst in the street. Child C had been permanently excluded from school and three months before his death, he had been seriously injured in another stabbing incident. There had been a noticeable increase in police contacts and concerns about deteriorating behaviour and escalating risk. Child C was going missing and local intelligence suggested he was being criminally exploited and possibly involved in county lines. On 19 December 2019, a 15-year-old boy was found guilty of his murder at the Old Bailey. A 16-year-old boy and an 18-year-old male were both convicted of manslaughter. A fourth suspect, a boy aged 16, died in custody prior to trial after becoming unwell. The **Serious Case Review (SCR)**

of Child C makes nine findings and fifteen recommendations for practice improvement. Read the statement of Jim Gamble QPM, the Independent Child Safeguarding Commissioner of The CHSCP **HERE.** The findings of this SCR include:

Exclusion from mainstream school can heighten risk. As identified in the Child Safeguarding Practice Review Panel's report on criminal exploitation, '*exclusion from mainstream school is seen as a trigger point for risk of serious harm*' and permanent exclusion can be '*a trigger for a significant escalation of risk*'. Both statements resonate with the lived experience of Child C.

Education settings need access to local intelligence. Pupil Referral Units (PRU) and Alternative Education Provision (AP) have minimal influence over which children are placed in their facilities. This can result in young people who live in rival gang areas being in the same classroom. Whilst staff had a good understanding of the needs of individual pupils, the risk dynamic created by the cohort of pupils was less understood.

A focus on the individual child is important. When working with children who are victims of serious youth violence, emphasis needs to be placed on their individual needs. For young people from black and minority ethnic backgrounds, practitioners should explore what their racial and cultural identity means for them in the context of where they are growing up and how they live their lives on a daily basis. It is essential that practitioners are confident to explore these issues, have a good understanding of the implications and can tailor plans appropriately.

Clarity is needed about interventions to mitigate extra-familial risk. Whilst local procedures were followed, the difference this made to Child C's outcomes is less tangible. The review recognises that at the time of Child C's death, multi-agency contextual safeguarding practice in response to extra-familial risk was new and developing. It is also important to recognise that the circumstances involving Child C were complex and extremely challenging. There were no easy solutions.

Developing positive relationships with young people is important. As with many children in need or at risk, Child C is likely to have benefitted from a strong relationship with a trusted adult with whom he could build a relationship. There is a firm evidence base showing how this can make a significant difference in the lives of children, but it is acknowledged that Child C became progressively harder and harder to engage.

Involving and supporting parents is essential to effective safety planning. As noted by the Child Safeguarding Practice Review Panel's report on criminal exploitation: *'When parents are active in safety planning and implementation there appears to be a greater chance of success.'* Whilst it was good practice to engage Child C's family, the

review found that there was an over-reliance placed upon them. A curfew, increased adult supervision and adult escorts were agreed, but were all contingent on the family to action.

Inconsistent judgements about risk creates uncertainty. There was a lack of consistency in how different agencies defined risk, its implications and the responses to it. In the opinion of the lead reviewer, there was adequate information to conclude that the risk to Child C was imminent after the stabbing incident in February 2019. The collective judgement arrived at by agencies, did not equate to the actual risks facing Child C.

The use of child protection procedures. There was ambiguity about the 'status' of intervention with Child C. This led to a lack of structure and confusion about multi-agency action. The overall consequence of this lack of clarity was that planning and management oversight was weak and opportunities to intervene were missed. No agency had a sufficient grip or a true appreciation of the risks facing Child C, his interactions with other young people in his community, or where and how he socialised.

Poor case recording can directly impact on practice. Poor recording features as an issue in many reviews, although it can sometimes be difficult to see how this directly impacts on children. In Child C's case, inaccurate recording by the hospital (that Child C was going to live with his father) resulted in no onward referrals being made for community-based services. Opportunities to meaningfully engage with Child C at a critical moment after being injured were lost.

Adolescent Neglect

Like younger children, adolescents are more likely to experience neglect at home than any other form of child harm. A report by the Children's Society into adolescents and neglect found that there was evidence that professionals struggle to identify adolescent neglect and are unsure what to do when they come across it. This has partly been based on misconceptions, including that adolescents become resilient to neglect and that neglect is less harmful than other forms of maltreatment. Neglect has been linked to a variety of problems for adolescents, including to 'challenging' behaviours e.g. poor engagement with education, violence and aggression, increased risk-taking (offending or anti-social behaviour, substance misuse, early sexual intercourse). It can lead to poor physical health, difficulties with relationships (with peers and adults) and be behind 'internalised' problems – e.g. low levels of well-being or mental ill health.

Self-Harm & Suicide

The partnership's focus on self-harm and suicide continued over 2019/20 as a consequence of the deaths of a number of young people from Hackney. Learning from the published reviews into these cases is set out later in this report.

Radicalisation

Statutory guidance expects Local Authorities to assess the threat of radicalisation in their areas and to take appropriate action. The Community Safety Partnership (CSP) retains overall governance of this agenda, which includes a focus on ensuring there are sufficient arrangements in place to safeguard children and young people. The Prevent Strategy is a key part of the Government's counter-terrorism Contest strategy. It aims to stop people becoming terrorists or supporting terrorism and has three objectives - challenging ideology, supporting vulnerable individuals and working with sectors and institutions. A strategic priority for Hackney's Prevent work is to ensure the safeguarding of children and young people to prevent them becoming drawn into supporting terrorism. In Hackney a multi-agency Channel Panel, chaired by the Head of Safer Communities, works at the pre-criminal stage to support vulnerable individuals where a risk of radicalisation is assessed and a plan of action devised.

During 2019/20, there were 26 referrals to the Hackney Channel Panel (an increase from 17 in 2018/19). All referrals concerned male subjects, with the highest number being generated from the education sector. As with the previous year, eight of these referrals involved young people under 18.

Substance Misuse

Young Hackney provides specialist treatment for young people affected by substance misuse – either directly or because a family member is using drugs. The service also has a dedicated officer who provides support and interventions for young people in contact with youth justice. Over 2019/20, the team worked with 210 young people on a targeted basis – as compared to 202 in 2018/19. The service also delivered outreach sessions to young people in schools and youth hubs.

Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, person with parental responsibility or a close relative for 28 days or more is privately fostered. Comparison with national and statistical neighbours has not been undertaken following the DfE ceasing to publish statistics on notifications and closing the private fostering data collection for local authorities. A review of all private fostering arrangements (15 in total at the time) was conducted in January 2020 and a new Private Fostering Policy was rolled out the following month. Numbers remained broadly in line with last year. As of 30 September 2020, only nine private fostering arrangements were open to Hackney. The team had been in the process of assessing a number of new arrangements but these children returned to their families due to COVID-19.

Young Carers

Young carers are children and young people under 18 who provide regular or on-going care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances. A young carer becomes vulnerable when the level of care giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical well-being or educational achievement and life chances'.

40 new referrals were received for Young Carers in the first three months of the service coming in-house, a large number being made following a Young Carers Awareness Day in January 2020. At the end of March 2020, there were 290 identified young carers in Hackney. Hackney Young Carers Project provides a variety of support services which includes group work, and one to one work with children in more complex situations. ***Hackney CFS Annual report 2019/20***

Disabled Children

Following this deterioration in services, senior leaders took remedial action earlier in the year and implemented a plan for improvement. This is beginning to have some positive impact in improved safeguarding practice and more robust management oversight of the progress of children's cases. OFSTED 2019

At the end of March 2020, the service was working with 402 children and young people. Of these, 267 were male and 132 were female (3 children were not yet born). This is an increase of 20% compared to 2018/19, when the service was working with 336 children and young people, In 2017/18, the service was working with 241 children and young people.

Children's Mental Health

The Child and Adolescent Mental Health Services (CAMHS) in City and Hackney are provide by Homerton University NHS Foundation Trust (First Steps and the CAMHS disability team, a joint service with the ELFT CAMHS); Clinicians employed by London Borough of Hackney's children's social care and the Specialist Service is provided by the East London NHS Foundation Trust (ELFT). ELFT CAMHS provides the specialist (tier 3) community based service, the CAMHS provision within the Young Hackney Service and a service for adolescents with more complex mental health needs, for example, first onset psychosis and complex eating disorders. East London NHS Foundation Trust also provides the inpatient service (tier 4) and the out-of-hours service for City and Hackney.

CAMHS did (and still does) a clinical rag rating of children who should be seen face to face for clinical reasons, but also prioritises children in terms of digital inclusion/digital poverty (i.e. those who can't connect or don't have access to privacy etc). Before schools re-opened, CAMHS were very aware that not all vulnerable children weren't being 'seen' in school or by other agencies as regularly and safeguarding was considered by CAMHS practitioners when contacting those families. The CAMHS risk assessment covers safeguarding, DV, exploitation and other safeguarding issues

Since the first Covid-19 lockdown in March 2020, there been a significant increase in the number of children and young people admitted to Homerton hospital in emotional distress. In the first 3 months of 2020/2021, there have been 11 admissions of which eight young people were transferred to the Coborn adolescent psychiatric unit. This is a 73% increase compared to the same period last year.

Kooth – A new online counselling and emotional wellbeing service for children and young people (11-19yrs) was launched from 1 April 2020. The service provides a safe and secure means for young people to access online support from a team of qualified counsellors who provide guided, outcome-focused help. The service provides additional support through moderated, scheduled forums to facilitate peer led support and self-help articles (many written by service users) to provide self-help support. Kooth has no referrals or waiting lists, and young people can access this service anonymously by signing onto the Kooth site.

MAPPA

Multi-Agency Public Protection Arrangements (MAPPA) are the statutory measures for managing sexual and violent offenders. The Police, Prison and Probation Services (Responsible Authority) have the duty and responsibility to ensure MAPPA are established in their area and for the assessment and management of risk of all identified MAPPA offenders. The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public from serious harm, by ensuring all agencies work together effectively. Across London on 31 March 2020, there were 6581 6452 Category 1 'Registered Sex Offenders' (RSOs) (an increase from 6452 in 2018/19 and 6317 in 2017/18), 3735 Category 2 'Violent Offenders' (and decrease from 4128 in 2018/19 and 3833 in 2017/18) and 37 Category 3 'Other Dangerous Offenders' (an increase from 27 in 2018/19 and 24 in 2017/18).

Youth Offending

Overall, Hackney has a relatively low proportion of 10-18 year olds involved in the youth justice system. The number of young people re-offending in Hackney within a 12 month period has significantly decreased over the last year, from 71 at the end of March 2019 to 47 at the end of March 2020, a 33% decrease year on year. The number of young people entering the Youth Justice System for the first time in Hackney increased from 82 in 2018/19 to 88 in 2019/20. Hackney's first time entrant rate per 100,000 has increased from 326 in 2018/19 to 349 in 2019/20, this is higher than the most recent 2018/19 statistical neighbour average (312).

Unregistered Educational Settings

Unregistered Educational Settings (UES) provide 'full-time' education to children of compulsory school age, but teach a curriculum that is too narrow for the setting to constitute a 'school'. The consequence is that they cannot be registered (or regulated) and this is a significant concern for The CHSCP. Large numbers of children in Hackney attend UES and are outside the line of sight of safeguarding professionals. There is no direct mechanism to ensure that the premises within which children congregate in these settings are safe and that practice meets established minimum standards for safeguarding. Whilst the Independent Child Safeguarding Commissioner, Hackney Council and the wider safeguarding partnership have endeavoured to find a resolution to this problem (and despite continuing efforts to engage community leaders), no real progress has been made. In 2020, the CHSCP developed a protocol to help manage the response to

the identification of UES and any concerns arising in respect of them. It is disappointing that this has been necessary, but in the absence of any appetite from either community leaders or Yeshivas themselves to cooperate, this is the best we are able to do as a partnership. The Department for Education's consultation concerning the regulation of UES and other settings closed at the end of November 2020. Government need to use this opportunity to strengthen both registration requirements and regulation. Without such change, children and young people will continue to be exposed to a two-tier safeguarding system that is simply unacceptable.

To help the multi-agency safeguarding partnership respond to this issue, The CHSCP has launched The Unregistered Educational Settings Hackney Operational Protocol to provide a framework to coordinate action and make children and young people safer. It is available on the CHSCP website **HERE.** *The protocol covers two stages. Stage 1 is focused on the actions to be taken when potential UES are identified in Hackney. Stage 2 deals with the multi-agency response when safeguarding concerns are raised about UES.*

Out-of-School Settings

Many children and young people participate in some form of organised activity outside of school at some point during their primary and secondary school years. There is plenty of excellent local practice which provides a wide range of activities and opportunities to young people and the community, for example improving cultural awareness, building self-esteem and encouraging our children to be active citizens within their community. In Hackney, the Out Of School Settings (OOSS) project has been launched to help parents and carers make sure that their children are happy, safe and protected in after school and extra-curricular activities. Led by Hackney Education, this DfE funded project intends to strengthen the safeguarding arrangements within Out of School Settings and work includes the following:

- The development of an OOSS portal (completion spring 2021)
- The development and launch of an OOSS app (completion spring 2021)
- The development and launch of the CHSCP Self-Assessment Audit Tool for OOSS (underway)
- Parent/carer comms (launch summer 2021)
- A piece of work to support unregistered settings within the Orthodox Jewish community (preliminary work underway)

Safer Workforce

Despite all efforts to recruit safely there will be occasions when allegations are made against staff or volunteers working with children. Organisations should have clear procedures in place that explain what should happen when such allegations are raised. These should include the requirement to appoint a designated safeguarding lead (DSL) to whom these allegations are reported. It is ordinarily the responsibility of the DSL to report allegations to, and otherwise liaise with, the designated officer in the local authority (referred to as the LADO). The LADO has the responsibility to manage and have oversight of allegations against people who work with children. The LADO should always be contacted when there is an allegation that any person who works with children has:

- Behaved in a way that has harmed a child, or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

There were 309 referrals to the LADO in 2019/20, a 16% increase from 266 referrals in 2018/19. The annual increase is in line with the trajectory since the inception of the LADO database and record keeping, although there was a reduction in referrals during lockdown and the impact on referral rates after April 2020 is still to be analysed.

There is a strong and effective working relationship between Hackney Education and the LADO service. This is particularly important as the majority of LADO referrals are from education settings. The LADO has worked extensively with the Head of Wellbeing and Education Safeguarding over the last year to address the ongoing difficulties posed by unregistered educational settings and the challenges around safeguarding in these settings.

Activity

There were 309 referrals to the LADO in 2019/20, a 16% increase from 266 referrals in 2018/19. The annual increase is in line with the trajectory since the inception of the LADO database and record keeping, although there was a reduction in referrals during lockdown and the impact on referral rates after April 2020 is still to be analysed.

There is a strong and effective working relationship between Hackney Education and the LADO service. This is particularly important as the majority of LADO referrals are from education settings. The LADO has worked extensively with the Head of Wellbeing and Education Safeguarding over the last year to address the ongoing difficulties posed by unregistered educational settings and the challenges around safeguarding in these settings.

Categories of Concern

Physical abuse remains the highest category of concern.

The other three categories (neglect, sexual and emotional) are less prevalent during LADO contacts.

The second highest category is concerns in private life. Settings and employers are increasingly more aware of the potential risks the experiences or behaviour in the private lives of employees may have upon their performance and approach to working with children in their employment. The employing organisation also needs to consider potential reputational damage if the concerns are serious and warrant a criminal investigation.

The 'other' category continues to record a relatively high number of contacts (9.3%). These relate to information sharing with the police or other organisations (non-recent matters mostly), parental complaints rather than allegations of harm or concern, and notification of unregistered settings without specific harm by an individual being identified.

Themes

The increase in contacts with the LADO during 2019/20 is likely to be attributable to continued awareness raising, the LADO service being well embedded and improved professional familiarity. The role of Hackney Education encouraging referrals is also identified as a likely reason for additional activity. This is good practice.

One new theme identified relates to parents directly contacting the LADO service to make a referral. Four calls were recorded on the LADO database. In addition, we have noticed that parents have contacted the police before notifying the school of their concern or allegation or if they are dissatisfied with the outcome of a school's investigation. This has been echoed by colleagues at a number of London LADO Network meetings. Another theme relates to the involvement of the LADO service in relation to the conduct of police officers. The position as applied by the LADO service in Hackney (and for other local authorities as agreed at the London LADO Network) is that harm caused to children and young people as a result of the conduct of police officers needs to be

dealt with through police internal procedures i.e. the local professional standards unit. Police officers have a niche occupation whereby they are not in regulated activity with children, they are policing the public. Their work inevitably brings them into contact with children and young people who are arrested or in custody, which will on occasions include elements of physicality, such as restraints or managing resists to arrests.

Where complaints arise in respect of the conduct of the police, although a LADO investigation will not necessarily follow, it has been agreed that the LADO will follow up to ensure that the complaint is being dealt with and that the police will share the outcome of their investigation. This provides reassurance that a) the matter had been investigated and b) an official outcome had been reached. The MPS Child Safeguarding Development Group has attended two London LADO Network meetings to work in collaboration with the LADOs as they are in the process of refining a draft MPS LADO Engagement Protocol. This has unfortunately been placed on hold due to the current impact on services as a result of the COVID-19 pandemic.

LADO Training & Awareness Raising

The Safeguarding in Education Team (Hackney Education) run an extensive training programme throughout the year covering safe practice and the procedures for dealing with allegations against adults who work with children and young people. They continue to run specific training dealing with managing allegations for managers in the early years and school sector, once every academic year for schools and twice for early years managers. The training that the LADO facilitates, is set up following an identified need either by the organisation that expressed an interest/need or through referrals (either quality or number) that indicate a training session would prove helpful.

NHS Staff Training: *The training was co-presented by the LADO and the Head of Safeguarding at Homerton University Hospital NHS Foundation Trust. One session included staff working in Mental Health and the second session was attended by mostly health visitors. The training was well received and positive feedback was given regarding the training's applicability and the helpfulness of the case examples. The immediate feedback following the first session was applied to the delivery of the second session. One particular discussion about indecent images of children stimulated thinking about practices regarding the sharing of images of children in health settings. This generated amendments in protocol to set clear guidance on what is permissible and what the responsibilities of health staff are.*

Learning & Improvement

Since implementing a revised Learning & Improvement Framework in 2013/14, there has been significant activity undertaken across both the City of London and Hackney. A range of lessons have been identified leading to tangible impact and improvement across the safeguarding system. To identify lessons, the CHSCP applies a focus on the following areas:

The Voices of the Child, Family & Community

As part of the CHSCP pledge, safeguarding partners have committed to supporting and enabling a culture of working that routinely seeks out and reflects the voices of children and young people. They have further committed to engaging directly with children and young people and that the lived experience of local children and young people will be evident in the policies we create, the practice we review and the communication channels that our wider partnership creates. Importantly, it will be evident in our multi-agency casework and our intervention to improve the outcomes of children and young people. In summary, the lived experience and voice of children and their families are central to the CHSCP's shared vision, ambition and approach to multi-agency safeguarding.

However, it important that we respond to this issue beyond the rhetoric. Safeguarding partners have agreed the need to avoid tokenistic initiatives that do little to strengthen practice, improve outcomes and potentially replicate ongoing work. The CHSCP is currently considering a range of actions to strengthen its approach in this context and will report on progress next year.

Reviews of Practice

Child Safeguarding Practice Reviews (CSPR) are undertaken on 'serious child safeguarding cases' to learn lessons and improve the way in which local professionals and organisations work together to safeguard and promote the welfare of children. These reviews were previously known as Serious Case Reviews (SCRs) but were transitioned to a new CSPR structure from July 2019. The detailed arrangements for CSPRs are set out in the CHSCP's local protocol **HERE.** In determining whether or not a CSPR is required, the following criteria must be considered:

- The case highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- The case highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.
- The case highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.
- The case is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.

The following circumstances should also be considered:

- Where the safeguarding partners have cause for concern about the actions of a single agency.
- Where there has been no agency involvement, and this gives the safeguarding partners cause for concern.
- Where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around.
- Where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

Some cases may not meet the definition of a 'serious child safeguarding case', but nevertheless raise issues of importance to the City of London and /or Hackney. This might include cases where there has been good practice, poor practice or where there have been 'near-miss' events. The CHSCP may choose to initiate a local child safeguarding practice review in these or other circumstances.

Activity

- During 2019/20, the Case Review Sub-Group met on four occasions.
- Five serious incident notifications were submitted to the Child Safeguarding Practice Review Panel. All children were Hackney residents.
- Three notifications resulted in Serious Case Reviews being commissioned (pre-July 2019).
- One SCR and a review involving two care leavers who died by suicide remained ongoing.

- The review of the care leavers was published in November 2020. Child C was published in December 2020
- Full details of all the reviews published by the CHSCP are available **HERE.**

One case raised at the Case Review Sub-Group related to a young mother who died by suicide (Ms A). She had two children of her own and was also caring for her two siblings as her own mother had drug and alcohol problems in another LA area. The case did not meet the criteria for a Safeguarding Adults Review or Serious Case Review however questions were raised around the rationale to place the siblings with Ms A. The CHSCP subsequently wrote to the local safeguarding partnership to bring the case to its attention. The response received noted that thoroughness in Section 20 Children Act placements (with particular regard to agency checks undertaken as part of the risk assessment/guardian suitability process) had recently been explored in a similar case (Child LH). Practice issues and learning had been embedded and multi-agency audits undertaken to review whether practice has changed. The case of Miss A preceded the Child LH review and subsequent procedural changes.

Previous Reviews

MULTI-AGENCY CASE REVIEW – CHILD E 2014

This review was initiated following a professional's visit to Child E's home that identified significant concerns regarding neglect. Questions were raised about the opportunities for earlier identification of the environment in which Child E was living; with an independent review subsequently being agreed by the Independent Chair. The following summary sets out the key areas of learning identified, some of the specific actions undertaken by the CHSCB and a range of examples of the impact that this review has had on the safeguarding system.

Key Learning

- **Children need to be seen, heard and helped, the importance of home visits and escalating concerns**
- **The importance of identifying and dealing with neglect**
- **The need for all staff to "Think Family"**
- **The importance and clarity of information sharing**

SERIOUS CASE REVIEW – FC 2015

In 2015, the CHSCB published a Serious Case Review (SCR) in respect of Case FC. The review involved a Hackney foster carer who, prior to his recruitment, was anonymously reported to the police about his use of indecent images of children. The police failed to investigate this complaint properly at the time and although information was retained about the anonymous report, it was never disclosed to Hackney Council. Over thirty children were subsequently placed by Hackney Council with this foster carer. In 2014, he received a custodial sentence after being found guilty of rape and a range of other sexual offences. Some of the victims were children in care. He is known to have sexually abused five children of primary school age, one victim in the community and one other unidentified victim abused some 30 years earlier. The SCR found that despite the police knowing about the initial allegation, on each of the occasions when the foster carer was subject to the regular criminal record checks that carers are required to undergo, a decision was made not to share that information with Hackney Council. At no time was Hackney Council given the opportunity to make an informed decision about the foster carer's employment. He escaped this scrutiny due to repeated professional judgements being made by the police on the basis of a particular understanding of legislation and case law regarding the sharing of 'soft intelligence'.

Key Learning

- **The weaknesses in the guidance relating to the disclosure of 'soft intelligence' under the Police Act 1997**
- **The need for GP contracting of counselling services to be clear about how to handle a disclosure**
- **An explicit recognition that children who are in public care need to be kept safe**
- **Educational work with children and young people to reduce the likelihood of further sexual abuse**

MULTI-AGENCY CASE REVIEW – CASE K 2015

In September 2013 (when they were aged 8 and 2) the police removed both children from their family home because of the extremely poor home conditions. It is now known, prior to this intervention, the family home had not been visited by any professional since late 2008. Both children were well known to a number of agencies and there were concerns about their health and development, which in the case of Child 1 were long-standing. He had a statement of special educational needs (SEN), a severe communication disability and developmental delay. Child 2 had more recently been diagnosed as having a significant developmental delay. Historically there had been concerns about possible neglect. Mother was convicted of cruelty and received a community sentence. They

have remained in the care of the local authority and there is currently no plan to return them to her care. After the children were removed the mother was diagnosed with severe depression.

Key Learning

- **The importance of home visits and not only seeing families in 'settings'**
- **The importance of identifying and naming neglect as a potential concern – to ensure swift action is taken to protect children.**
- **The importance of robust and thorough assessments of potential neglect**
- **The importance of joint working across children's and adult services and 'thinking family'**
- **The need for robust arrangements for safeguarding children in education settings.**
- **The recognition of neglect and children with disabilities – additional vulnerabilities for this cohort.**

SERIOUS CASE REVIEW – CHILD H 2016

Child H was a baby girl who lived with her mother and father at the home of the maternal grandparents. Child H died at the age of six weeks. Medical advice indicated that the death had been caused by inflicted injuries. Child H's parents, Ms M and Mr F, were arrested but subsequently no charges brought. No one has been held to account for Child H's death. The circumstances of the death met the statutory requirement that a SCR be conducted.

Key Learning

- **The importance of distinguishing between parental learning difficulties v disabilities – the thresholds for engagement by other services and the assessment of any needs in the context of parenting capacity.**
- **The importance of thinking family and engaging relevant specialisms (whether adult or children) as part of the assessment process.**
- **The importance of management oversight and supervision of case work to ensure its quality.**
- **Ensuring a clearer understanding of Psychosocial Meetings held at Homerton Hospital.**

JOINT SERIOUS CASE REVIEW / DOMESTIC HOMICIDE REVIEW – CHILD D 2016

Child D and her mother were murdered by mother's ex-partner (father of Child D). There was no significant multi-agency involvement prior to the deaths, although mother reported concerns regarding domestic violence to police and their response has been subject to separate investigation by the Independent Police Complaints Commission (IPCC).

Key Learning

- **Professional curiosity in the context of people experiencing domestic violence and abuse.**
- **Accurate risk assessments of the risk of domestic abuse.**
- **The need for agencies to work together effectively.**
- **The need for robust supervision to ensure high quality work.**
- **The importance of sufficient resources being made available for front-line staff to do their jobs effectively**

MULTI-AGENCY CASE REVIEW – CHILD L 2016

Child L was a 17 year old male who was fatally stabbed. The assailants (who were found guilty of murder) were of a similar age and were known to Child L. Child L came to the attention of statutory services in the months before he died. On two occasions he was reported missing to the police and had been arrested or had contact with the police on at least seven separate times for drug offences in a number of cities across the UK - including in the period when he had been reported missing.

Key Learning

- **Seeing beyond criminal behaviours to consider if a young person, in particular young men, are potential vulnerable or at risk of harm/exploitation.**
- **Recognition of the increase vulnerability of young people who move across geographical areas as there is greater risk of them falling through statutory service gaps.**

SERIOUS CASE REVIEW – CHILD M 2018

Child M and his sibling were subject to Child Protection Plans following injuries that Child M's sibling sustained whilst in the care of Child M's father. In 2016, Child M was taken to hospital by his mother and on examination was found to have bruising to his face and transverse fractures to both femurs. In criminal proceedings father was found not guilty in relation to the GBH against Child M. Both mother and father were found guilty of child cruelty.

Key Learning

- **The recognition of avoidant behaviour & disguised compliance**
- **The need for professional curiosity and challenge in the context of ensuring children are safe.**
- **The need to guard against professional optimism**

MULTI-AGENCY CASE REVIEW – CHADRACK 2018

Chadrack was 5 years old when both he and his mother were found dead at their home in 2016. Chadrack had Special Educational Needs and Disabilities and was non-verbal. From the inquest into their deaths, it was concluded that Chadrack lived alone in the family home for over a fortnight after his mother's death. He was unable to feed himself or seek help. He died of starvation and dehydration.

Key Learning

- **The importance of thinking safeguarding first when dealing with absence, attendance and missing from education.**
- **Ensuring professionals attempt to understanding the context of the child's life and that of the parents / carers.**
- **The practical application of professional curiosity; beyond rhetoric.**
- **The need to rule safeguarding 'in or out' as an issue before anything else.**
- **Keeping children safe in education; proactively asking for information on vulnerabilities which may impact on the child or family network.**

SERIOUS CASE REVIEW - CHILD N & CHILD O 2018

In March 2017, Child N was assaulted by his father and pronounced dead in hospital. His female twin (Child O) sustained serious injuries in the same incident. Father subsequently pleaded not guilty to murder but admitted manslaughter on the grounds of diminished responsibility and in October 2017 was sentenced to indefinite detention.

Key Learning

- **The need to consider identified or unidentified fathers in terms of potential value or risk in the context of parenting capacity.**
- **The need for routine enquiries to be made with respect to the possibility of domestic abuse.**
- **The relevance of cultural / linguistic barriers to understanding and the need to understand the context of the family.**

MULTI-AGENCY CASE REVIEW – RACHEL 2019

Rachel was 16 years and 3 months when she took her own life. Her family, school and local Child and Adolescent Mental Health Services (CAMHS) had been concerned about her well-being for some time, including a risk of self-harm, suicidal ideation and acts. She had also become known to her GP, the local Emergency Department, the London Ambulance Service, the Police and Children's Social Care.

Key Learning

- **The need for professionals to have an holistic family view of support and/care.**
- **The importance of supporting parents/carers in safety planning and providing opportunities for engagement with professionals.**
- **The need to consider parents' worries and observations in the assessment process.**
- **The impulsivity of young people and the fact sometimes they will tell adults what they think they want to hear.**
- **Professionals needing to remain curious and maintain healthy scepticism in all contexts.**
- **The influence of social media, internet use and media.**
- **The importance of robust safety planning and ensuring all key agencies are alert to potential risks.**

MULTI-AGENCY CASE REVIEW - X 2019

X took his own life in October 2016. He had just had his sixteenth birthday and was in Year 11 at school, preparing for GCSEs. X lived with his mother and father. His older sister had just moved away from home to university, outside London.

Key Learning

- **Drug use and alcohol use amongst young people – particularly the use of Xanax.**
- **The use of the internet and social media in self-harm and suicide.**
- **The need for professionals to support awareness of mental health in young people - Peers as Supporters.**
- **The need to create environments where boys / young men can seek help.**

Auditing

The CHSCP's Self-Assessment Framework

During 2019/20, the CHSCP designed a new Safeguarding Self-Assessment Framework to help organisations make children safer. It replaced the Section 11 audits and Section 157 / 175 audits and is intended to make the process easier to access and update. Whether an organisation is a safeguarding partner, a relevant agency or is one named within our local arrangements, there is an expectation that the self-assessment is completed.

The Safeguarding Self-Assessment process involves the completion of an on-line tool. There are three different formats depending on the size and type of the organisation. Once completed and submitted, organisations will automatically be sent a pdf report of results and identified actions. The system can be updated by an organisation at any point a change is identified or an action complete. At the time of writing, the self-assessment process is ongoing. Results will be formally reported in the next annual report. There remains work to be done, particularly with the cohort of individual out of school settings in the City and Hackney to help them understand their responsibilities to complete this assessment.

To date, a number of organisations have queried whether returns can be submitted by 'umbrella organisations' that oversee particular settings in our area (they can't). Some have also responded stating that as they don't believe they are a relevant agency under the Relevant Agency Regulations, then there is no requirement for them to engage. We believe this is an incorrect interpretation as will be taking further legal advice. Our current position is that Section 16H Children Act 2004 resolves any debate about relevant agency status. This section contains a wide power exercisable by the safeguarding partners to request a ***person or body*** *to provide information to them (or various other persons or bodies identified in the section). There is no limitation or definition of 'person or body' therefore the request can be made to anyone. The information in the self-assessment is being requested pursuant to enabling or assisting the performance of functions conferred to safeguarding partners by Section 16E. This information is essentially needed for making the local arrangements to safeguarding children and the need to work together to identify and respond to the needs of children in our area. In this context, organisations have an obligation to comply (s16H(2)) and safeguarding partners retain a power to enforce compliance by injunction (s16H(3)).*

Multi-Agency Case Audits

The CHSCP multi-agency case auditing identified a range of examples of good safeguarding practice being undertaken by the partnership. Lessons have also been identified that have led to tangible improvements. Multi-agency case auditing allows the CHSCP to deliver one of the best learning opportunities for front-line workers; directly engaging them in a process that reflects upon, assesses and measures the quality of professional practice. One round of multi-agency case auditing was held in 2019/20 focusing on the mental health of children and young people. All audits result in an outcome focussed action plan that the QA Sub-Group use to track and evidence improvements in front-line practice. Learning is also disseminated to agencies/front line staff via the *Things You Should Know* (TUSK) monthly briefings. Full details are available on the CHSCP auditing webpage however strengths and key messages are detailed below.

THE CITY OF LONDON (MENTAL HEALTH OF CHILDREN & YOUNG PEOPLE)

GOOD PRACTICE

Education Services were involved in the case even though there was no statutory requirement

There was a good level of professional attendance at Child in Need and Care Programme Approach (CPA) meetings.

The Children and Families Team reflected on the young person's social media usage (a component of the local assessment framework), suicide contagion and learning from recently published CHSCP Local Reviews to help assess risk and inform their approach to working with this family.

The voice of the child was confidently relayed by the CAMHS Care Coordinator and seen to help assess risk and support safety planning.

Evidence of timely interventions (strategy discussion with key partners, CAMHS intervention and a face-to-face discussion following disclosure of abuse).

Ongoing thought was given to the most appropriate professional to engage the young person.

Sensitive decision making by the social worker on whether it would be helpful to speak to the young person at the point of their being critically unwell.

Overall, the positive work undertaken by CAMHS in a challenging and uncertain set of circumstances was acknowledged.

KEY MESSAGES FOR PRACTICE

Understanding of Autism Spectrum Disorder (ASD)

The cases audited (in both City of London and Hackney) presented a common factor in the late identification of ASD. As a partnership, there are opportunities to explore how professionals can be supported in early identification, communicating with ASD young people, working with parents (who may themselves have witnessed traumatic events) and understanding the impact ASD may have on a young person in the context of self-harming behaviour.

Information Sharing

This case highlighted areas for continued improvement in information sharing:

Sharing of safety plans with appropriate professionals (on agreement and as changes are made).

Ensuring that a core list of key professionals are invited to planned and emergency meetings.

Outcomes of meeting being consistently communicated to key professionals.

The need for increased awareness of the School Nursing Teams to ensure that the right professionals are informed of CIN meetings, sent relevant correspondence, and involved in discharge planning for school aged children.

Absent Fathers

One audited case highlighted the need for professionals to seek clarity on the identity of absent fathers or other male figures who play/have played a role in the family. This is especially important for young people who struggle with, or display self-harming behaviours linked to their identity. Continued professional curiosity around absent fathers / paternal extended families can help professionals identify the wider support network, fully assess risks and increase the young person's understanding of themselves and their emotional wellbeing.

HACKNEY (MENTAL HEALTH OF CHILDREN & YOUNG PEOPLE)

GOOD PRACTICE

Evidence of professionals working with parents to engage in services resultant in good attendance at appointments.

The use of family therapist from the same cultural background to engage family and online interpreting service to ensure mother understood conversations.

When a young person attended a sexual health clinic, their named person was informed to ensure consistency of care. This avoided the young person having to retell their story (an issue fed back by the young person).

Professionals ensured a young person had access to home education and they subsequently exceeded prior expectations by completing a number of GCSEs. The young person now has plans to attend college.

Good information sharing, with CAMHS letters copied to the Adult Mental Health Consultant and evidence of good information sharing between social workers and CAMHS practitioners.

A young person was able to express insight into their condition, including warning signs and when to call the emergency services.

Evidence of effective multi-agency working. The Home Tuition Service and School worked flexibly to transition learning and support for a young person. Allegations of assaults were responded to line with standard procedures. It was agreed a young person to be seen with a paediatrician (not normal practice for over 13s). Good multi-agency working between CSC and Police to locate young person when missing.

The Child in Need plan had a clear set of contingency arrangements for escalating concerns.

Evidence of challenge and escalation, professionals meetings being convened and CAMHS use of the complex care forum to ensure the service was delivered at the right level of need.

Effective escalation with professionals recognising the parent's strengths but also identifying the extent to which they could consistently engage with the plan.

KEY MESSAGES FOR PRACTICE

Understanding of Autism Spectrum Disorder (ASD)

The cases audited (in both City of London and Hackney) presented a common factor in the late identification of ASD. As a partnership, there are opportunities to explore how professionals can be supported in early identification, communicating with ASD young people, working with parents (who may themselves have witnessed traumatic events) and understanding the impact ASD may have on a young person's in the context of self-harming behaviour.

Information Sharing

Health professionals should be aware that they are able to access records outside of their caseload if there is a child protection/safeguarding concern.

If professionals experience a lack of response from adult mental health professionals (e.g. information requests) this should be escalated to the ELFT Named Professional for Safeguarding Children.

Safety plans should be shared with appropriate professionals (on agreement and as changes are made).

There is a need for increased awareness of the School Nursing Teams to ensure that the right professionals are informed of Child in Need meetings, sent relevant correspondence, and involved in discharge planning for school aged children.

Communication from Hackney's First Access & Screening Team about 'no further action' / closure letters should contain enough detail for agencies to understand the rational for closure and clear direction for future re-referrals.

Calling Professionals Meetings

Any professional in the network who has concerns about a case can call a professionals meeting. A professionals meeting may be important: where there is uncertainty amongst professionals about the necessary steps to safeguard the welfare of a child; where there is concern that the family is undermining attempts to understand potential risks to children; where professional disagreements arise that are impacting on effective work with the family, or where professionals need an opportunity to reflect on the plans for working with a family when progress is not being made.

Social Media Footprint

One case highlighted a general reminder, where possible, for professionals to assess young people's social media footprint. This is especially important for young people with increased vulnerabilities.

Consideration of Young Carers

All young carers are entitled to a local authority carer's assessment. This is especially important for care givers who are reaching adulthood and who may not be meet the threshold for support by the community mental health team.

Wider Family

A reminder for professionals to formally include the wider family network in discussions around safety planning and to gain their views on what is happening within the family. This learning was also identified in the CHSCB Local Review on Rachel. This case highlighted the need for professionals to consider the lived experience of siblings and support from early help services in relation to traumatic experiences they have witnessed.

Performance Data

The scrutiny of key performance data continued to be a key function of the Quality Assurance Sub-Group in 2019/20, with reports on performance being regularly provided to key safeguarding leaders during 2019/20. The CHSCP has agreed to review its dataset going forward to ensure this remains proportionate and avoids duplication of metrics already captured. The CHSCP will report on progress next year, although it should be noted that the pandemic has delayed this work.

Front-Line Intelligence

The CHSCB undertook a staff survey in 2018/19. This aligned with the partnership's focus on 'A Healthy Workforce' and was designed to measure how organisations support their staff and the subsequent impact on safeguarding practice. The CHSCP will undertake its next full survey in 2021-22.

External Learning

The CHSCP is a learning organisation and is constantly looking outwards to identify relevant learning opportunities that may help assist in its role of co-ordinating and ensuring the effectiveness of the safeguarding systems across the City of London and Hackney. Where relevant, national reviews and inspection reports are considered by the CHSCP. Links to NSPCC thematic briefings and wider learning from other local areas continued to be disseminated to front-line staff via CHSCP training and **TUSK briefings.**

Key Messages for Practice

Safeguarding First

For many organisations, safeguarding is one priority amongst many. Because of this, risk to children and young people can escalate when safeguarding is absent from an organisation's culture and how its professionals and volunteers discharge their duties. It essential that leaders promote such a culture. If anyone has any doubts as to the importance of this message, read The CHSCP's review on **Chardrack Mbala-Mulo.** To help promote such a philosophy of 'Safeguarding First', always think about safeguarding whatever you are doing, whatever policy you are following and whatever action you might be taking. Professionals should also listen to what children and young people have said they need from those who work with them (Working Together 2018).

Children have said they need

Vigilance: to have adults notice when things are troubling them

Understanding and action: to understand what is happening; to be heard and understood; and to have that understanding acted upon

Stability: to be able to develop an ongoing stable relationship of trust with those helping them

Respect: to be treated with the expectation that they are competent rather than not

Information and engagement: to be informed about and involved in procedures, decisions, concerns and plans

Explanation: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response •

Support: to be provided with support in their own right as well as a member of their family

Advocacy: to be provided with advocacy to assist them in putting forward their views

Protection: to be protected against all forms of abuse and discrimination and the right to special protection and help if a refugee.

Context

Context is key and understanding the context of a child's life is essential for effective safeguarding. In terms of practice, this is about how the partnership works together to better understand the lived experience of children at home, in education and in health, alongside those aspects that are typically outside of the family environment; such as peer groups, places and spaces, and the virtual world that children occupy through their use of technology and social media. Knowing about these contexts will help us determine whether they reflect pathways to harm or pathways to protection. However, it is usual that no one individual has oversight on the detail of everything. In this respect, a first and important step is to make sure that professionals are confident in sharing information and talking with each other. If you are worried about a child or young person, you are allowed to talk with other professionals without fearing you are doing something wrong. You aren't. Talking to each other and sharing information when trying to protect people from actual or likely harm or to prevent a crime is lawful and in the substantial public interest.

Curiosity

Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This has been described at the need for practitioners to practice 'respectful uncertainty' – applying critical evaluation to any information they receive and maintaining an open mind. In safeguarding the term 'safe uncertainty' is used to describe an approach which is focused on safety but that takes into account changing information, different perspectives and acknowledges that certainty may not be achievable. Professional curiosity can require practitioners to think 'outside the box', beyond their usual professional role, and consider families' circumstances holistically. Professional curiosity and a real willingness to engage with children, adults and their families or carers are vital to promoting safety and stability for everyone.

Much has been written about the importance of curiosity during home visits and the need for authentic, close relationships of the kind where we see, hear and touch the truth of their experience of 'daily life' and are able to act on it and to achieve similar closeness with parents or carers. Practitioners will often come into contact with a child, young person, adult or their family when they are in crisis or vulnerable to harm. These interactions present crucial opportunities for protection. Responding to these opportunities requires the ability to recognise (or see the signs of) vulnerabilities and potential or actual risks of harm, maintaining an open stance of professional curiosity (or enquiring deeper), and understanding one's own responsibility and

knowing how to take action. Children in particular, but also some adults, rarely disclose abuse and neglect directly to practitioners and, if they do, it will often be through unusual behaviour or comments. This makes identifying abuse and neglect difficult for professionals across agencies. We know that it is better to help as early as possible, before issues get worse. That means that all agencies and practitioners need to work together – the first step is to be professionally curious.

Curious professionals will spend time engaging with families on visits. They will know that talk, play and touch can all be important to observe and consider. Do not presume you know what is happening in the family home – ask questions and seek clarity if you are not certain. Do not be afraid to ask questions (and difficult questions) of families, and do so in an open way so they know that you are asking to keep the child or young person safe, not to judge or criticise. Be open to the unexpected, and incorporate information that does not support your initial assumptions into your assessment of what life is like for the child or young person in the family.

Challenge

Differences in professional opinion, concerns and issues can arise for practitioners at work and it is important they are resolved as effectively and swiftly as possible. Having different professional perspectives within safeguarding practice is a sign of a healthy and well-functioning partnership. These differences of opinion are usually resolved by discussion and negotiation between the practitioners concerned. It is essential that where differences of opinion arise they do not adversely affect the outcomes for children, young people or adults and are resolved in a constructive and timely manner. Differences could arise in a number of areas of multi-agency working as well as within single agency working. Differences are most likely to arise in relation to the criteria for referrals, outcomes of assessments, roles and responsibilities of workers, service provision, timeliness of interventions, information sharing and communication. Safeguarding is everyone's responsibility and front-line staff need confidence in talking with each other about decisions that have been made, discussing any concerns regarding those decisions and where there isn't agreement; escalating those concerns as appropriate. Remember, equally important is the culture of how we work; and it is vital that front-line staff are encouraged to remain professionally curious and to raise issues where they feel that their concerns for children and young people aren't being addressed. To help staff resolve professional differences, the CHSCP has issued a simple **Escalation Policy.**

Child Death Reviews

New CDR Arrangements

Local authorities and clinical commissioning groups (CCGs) are now the named Child Death Review (CDR) partners. CDR partners must make arrangements for the review of every death of a child normally resident in the local authority area. The purpose of child death reviews is to identify and act on learning at local and national level that could prevent future deaths. Formal collaboration between regional CDR partners is in place to ensure that child death reviews are undertaken at greater scale. This covers the City of London, Hackney, Newham, Tower Hamlets and Waltham Forest.

Facts & Figures 2019/20

- At the time of writing, the CDOP annual figures remain inaccessible due to the cyberattack on Hackney Council.
- National data reflects that the rate of infant mortality (deaths of children under the age of 1) in Hackney is 4.0 per 1000 live births (2016-18). This rate is similar to the England average of 3.9 per 1,000 children but worse than the London average of 3.3 per 1,000 children.
- In 2018/19, the CHSCB reported that child mortality rates (deaths in children and young people aged 1-17) in Hackney and the City of London were 11.7 per 100,000 children for 2015-17 which is similar to both the England and London average of 11.2 and 11.0 per 100,000 children respectively. It represents the boroughs lowest rate since 2010 when rates stood at 16.3 per 100,000 children and is in line with the trend in most London boroughs, of declining rates in child mortality.

As part of its functions, CDOP is required to categorise the preventability of a death by considering whether any factors may have contributed to the death of the child and if so, whether these could be “modified” to reduce the risk of future child deaths. During 2018/19, the CDOP identified modifiable factors in a third (33% or 5) of the deaths reviewed. A national comparison is not possible as NHS Digital is yet to publish year end data 2019/20. The CDOP is confident that all cases are reviewed comprehensively, and that professional challenge remains a central part of the review process.

Training & Development

Training Summary 2019/20

The training opportunities offered by the CHSCP are designed to meet the diverse needs of staff at different levels within the wide range of organisations that work with children, young people or adult family members. Sessions range from those that raise awareness, about safeguarding and child protection to specialist topics aimed at more experienced staff. **The training programme focuses on areas of practice prioritised by the CHSCP, with learning from local and national case reviews integrated into the training material.** Based on the evidence gathered during 2019/20, The CHSCP remains confident that single and multi-agency training is of high quality. The training programme continues to improve the knowledge and skills of the safeguarding workforce and is helping contribute towards positive outcomes for children and young people.

- **70 training sessions in total (increase from 58 in 2018/19)**.
    - 50 training courses (full and ½ day sessions)
    - 11 Reducing Parent Conflict (RPC) training sessions (funded through Department for Work & Pension),
    - Two Serious Case Review Learning Seminars and Seven Masterclasses/ Seminars.
- 1459 available training places, of which 1391 (95%) were booked in advance of the course date.
- Of the 1391 booked places, 209 delegates (15%) did not attend the training or cancel their booking in advance of the course.
- 60% of attending delegates worked in Hackney, 9% in the City of London, and 31% worked across both Boroughs.
- The CHSCP also updated its core Safeguarding training presentations, which have been positively received by delegates.
- Increased the number of Safeguarding Children with Disabilities/SEND courses delivered.
- Increased the training offer in relation to FGM, Breast Flattening and Cultural Awareness training.
- Maintained an enhanced offer in relation to Exploitation, including Young People and Substance Misuse, County Lines, and Safeguarding in a Digital World.
- Delivered a bespoke Safer Recruitment course in the City of London.

Attendance

Agency	2017/18		2018/19		2019/20		% Trend*
	Number	%	Number	%	Number	%	
Cafcass	0	0%	0	0%	1	0.1%	
City & Hackney CCG	5	0.6%	10	0.9 %	13	1.1%	
CoL Children's Centres/ Nursery	9	1.2%	4	0.4 %	8	0.7%	
CoL Corporation	14	1.8%	23	2%	22	1.9%	
CoL Housing	4	0.5%	5	0.4 %	6	0.5%	
CoL Police	4	0.5%	15	1.3 %	0	0%	
CoL Schools & Further Education	21	2.7%	22	2%	43	3.6%	
CoL Other	3	0.4%	3	0.3 %	3	0.3%	
ELFT – Adult Mental Health	14	1.8%	55	4.9 %	52	4.4%	
ELFT – CAMHS	11	1.4%	36	3.2 %	32	2.7%	
ELFT – Forensics	7	0.9%	3	0.3 %	19	1.6%	
Health Other	32	4.2%	5	0.4 %	20	1.7%	
Homerton University Hospital	27	3.5%	123	10. 9%	100	8.5%	
LBH Children's Centre/ Nursery	42	5.4%	40	3.6 %	70	5.9%	
LBH: Children & Family Services	146	18.9 %	241	21. 4%	320	27.1%	
LBH: Hackney Learning Trust	30	3.9%	32	2.8 %	17	1.4%	
LBH: Health & Community Services	8	1%	21	1.9 %	10	0.8%	
LBH Neighbourhoods & Housing	33	4.3%	25	2.2 %	14	1.2%	

LBH Schools & Further Education	92	11.9 %	74	6.6 %	78	6.6%	
LBH Other	21	2.7%	14	1.2 %	10	0.8%	
London CRC	0	0%	0	0%	3	0.3%	
Metropolitan Police	7	0.9%	4	0.4 %	3	0.3%	
National Probation Service	10	1.3%	11	1.0 %	34	2.9%	
Public Health	7	0.9%	20	1.8 %	3	0.3%	
Voluntary & Community Services	137	17.8 %	125	11. 1%	92	7.8%	
Whittington Health	9	1.2%	6	0.5 %	8	0.7%	
Other	78	10.1 %	207	18. 4%	201	17%	
TOTAL	**771**	**100%**	**1124**	**100 %**	**1182**	**100%**	

Annual Conference: Safeguarding & The Digital Thread

The CHSCP Annual Safeguarding Conference was held on Wednesday 4th March 2020 at the Guildhall in The City of London. The theme of this year's conference was Safeguarding & the Digital Thread with a specific focus on youth produced imagery, social media apps and offenders and technology.

- The conference was attended by a total of 167 delegates.
- 229 delegates originally booked to attend the conference
- 24 cancelled before the date of the conference.
- Of the remaining 205 potential delegates 153 (75%) attended the conference and 52 (25%) did not attend the conference or did not cancel their booking.
- A further 14 delegates attended without having previously booked a place.
- Of the 167 delegates who attended the conference 25% work in the City of London, 25% work in the London Borough of Hackney and 50% work in both boroughs.
- **92% felt the conference met their expectations of the day**
- **93% felt that learning from the conference would impact upon their safeguarding practice.**
- **96% of the delegates rated the conference sessions as either EXCELLENT (56%), VERY GOOD (29%) or GOOD (11%).**

I will be more curious about how the young people I work with use online platforms, and to have more open conversations with young people regarding their online behaviours.
I have gained awareness of the many social media platforms and will consider the language we use when investigating/ supporting a Safeguarding incident.
I am now more aware of social media platforms & dangers and have increased awareness of potential avenues for exploitation.

Evaluation & Impact

Supported by its Training Evaluation and Analysis Framework, the CHSCP continues its practice in monitoring and evaluating the effectiveness of training, including multi-agency training, for professionals in the area. Work undertaken to review the quality of training in 2019/20 has enabled the CHSCP to gain important insight into the difference it is making towards improved outcomes for children and young people.

- **BEFORE** training **62%** of delegates believed their knowledge was **GOOD, VERY GOOD or EXCELLENT**.
- **AFTER** training **98%** stated their knowledge was **GOOD** (19%) or **VERY GOOD** (57%) **EXCELLENT** (22%).
- **96%** of those who answered the question stated that the training would enable them to practice more effectively and **97%** stated that the trainers facilitation skills, teaching style and knowledge were **GOOD** (9%) **VERY GOOD** (31%) or **EXCELLENT** (57%). This is really excellent feedback and a testament to the skill and expertise of our internal & commissioned trainers.
- **90%** of delegates rated the content of SCR Learning Seminars as **GOOD** (6%) **VERY GOOD** (30%) or **EXCELLENT** (54%).
- **98%** stated what they had learned would be useful to them in their roles and **94%** stated what they had leamed would help them safeguarding children & young people more effectively.

How will you use the experience gained in training within your work?

I feel more confident in identifying families that need to be referred & most important knowing how to complete the forms correctly. (Early Help)

I am now able to identify specific factors of the implications of neglect and abuse and how this may affect their relationships! (Neglect)

I will feel more confident to recognise & support victims. Will be able to support other staff more effectively. (DVA Seminar)

Assessment of intoxication using the signs I learnt today. (Young People & Substance Misuse)

Remembering professional curiosity/ challenge. Standing still is falling behind. Reading lessons learned from Serious Case Reviews (DSL)

I now have a better knowledge of apps & platforms that can be used when discussing issues with young people & families. (Safeguarding in a Digital world)

Feeling more confident to challenge & address things immediately and in a way that leaves everyone feeling heard. (Difficult conversations)

I now have better insight into the reality of county lines working for young people & how to break the myth. (County Lines)

Any other comments?

The delivery was exceptional. The lecturer really captured the audience. Very well delivered. (Neglect)

This was by far and away the best safeguarding course I have attended. The facilitator was EXCELLENT Thank you. (DSL Refresher)

This was as close to life changing training as it can practically get - it was uncomfortable and at times it hurt - exactly as it should be in order to learn. (BRAVE)

This is by far the most informative course I've been on for a long time. Plenty to think about and apply. (Safeguarding in a Digital world)

I have a better understanding of what young people I work with are facing every day. Also helps me think about interactions with young people affected by gangs/ county lines that I work with currently (BRAVE)

Excellent facilitators - knowledgeable, contextualised everything, kind, caring and humorous (County lines)

Priorities & Pledge

CHSCP PRIORITIES 2020/21

Priority 1: Health & Stability of the Safeguarding Workforce Outcome: Safeguarding partners and relevant agencies attract, retain, develop and support their workforce. A healthy and stable workforce contributes to high quality safeguarding practice.

Priority 2: The Voice of Children and Young People Outcome: Multi-agency safeguarding practice reflects the lived experience of children and young people. The voices of children and young people are central to all aspects of intervention. These influence action and improve outcomes.

Priority 3: Getting the Basics Right Outcome: Safeguarding practice in the City of London and Hackney is at least good. Children and young people are effectively protected from harm by early, robust, timely and coordinated multi-agency intervention and support.

Priority 4: The Appetite to Learn Outcome: Safeguarding partners and relevant agencies are actively engaged in the CHSCP's learning & improvement framework. Leaders encourage the independent scrutiny of their safeguarding arrangements by the CHSCP, challenge performance and disseminate and embed lessons across their agencies.

A key commitment for the CHSCP remains in 'making the invisible visible' and our focus on better understanding vulnerability. This reflects the importance that safeguarding partners and relevant agencies apply to ALL children and young people living in hard-to-reach groups and communities that are less engaged with public safeguarding services. It also includes a focus on improving outcomes for ALL people through close cooperation with other key strategic forums.

CHSCP PLEDGE 2020/21

Health & Stability of the Safeguarding Workforce - *Without a healthy and engaged workforce, no agency can fully participate in and support the work of the partnership. The CHSCP will therefore seek to develop a better understanding of the pressures that staff and volunteers face and the steps that can be taken to mitigate them. This work will be undertaken in the context of what we know about the current conditions - organisational change and restructure, reduced resourcing levels and increased demand. It will include regular evaluation of workforce stability, its capacity and the support available to help deliver consistently high quality practice.*

The Voice of Children and Young People - *We will support and enable a culture of working that routinely seeks out and reflects the voices of children and young people. This will include the CHSCP engaging directly with children and young people. The lived experience of local children and young people and their voices will be evident in the policies we create, the practice we review and the communication channels that our wider partnership creates. Importantly, it will be evident in our multi-agency casework and our intervention to improve the outcomes of children and young people.*

Getting the Basics Right - *Whilst committed to driving change and innovation, the CHSCP is aware that good practice begins with getting the basics right. We will maintain a focus on ensuring that such basic principles are embedded in our work. This will include an emphasis on issues such as the effectiveness of multi-agency meetings, ensuring that not only that the right agencies attend, but that they send the right people and share relevant information. We will concentrate on issues such as identifying and responding to neglect, the timeliness of engagement, maintaining good records and the application of strong visible leadership.*

The Appetite to Learn - *We are committed to maintaining our improvement journey and to that end, we will actively seek out and embrace opportunities to learn. We will refocus our quality assurance activity and ensure our commitment to undertaking local reviews is maintained, whilst capturing opportunities to learn from others. We will routinely revisit the action plans of previous reviews to ensure that identified improvements are reflected in contemporary partnership practice. Critically we will respect the independent scrutiny role of the Independent Child Safeguarding Commissioner, the right to 'roam', the right to ask difficult questions and the right respectfully challenge. Whenever required, safeguarding partners and relevant agencies will provide whatever information they can to address a relevant enquiry or concern.*

Vulnerability & Making the Invisible Visible - *The CHSCP will seek to better understand the vulnerabilities that can negatively impact on the outcomes for children and young people, particularly with those for whom oversight and engagement is limited. We will seek to develop a more complete understanding of what vulnerability looks like in the City of London and Hackney and work to mitigate and prevent harm. We will map vulnerability as we know it based on age, location, need and the context of young people's lives, at home, in care and in the public spaces and places (including the internet) they frequent. We will identify existing and emerging harms, including neglect, physical, emotional and sexual abuse, abusive relationships, CSE, CSA, peer on peer abuse, the impact of negative digital collateral and criminal exploitation, including county lines.*

What you need to know

CHILDREN AND YOUNG PEOPLE
Nothing is more important than making sure you are safe and well cared for.
As adults, sometimes we think we always know best...we don't..... and that's why your voice is so important.
This is about you and we want to know more about how you think children and young people can be better protected.
We want to talk to you more often and we want to know the best way to do this.....please help.
If you are worried about your own safety or that of a friend, speak to a professional you trust or speak to ChildLine on 0800 1111

PARENTS AND CARERS
Public agencies are there to support you and prevent any problems you are having getting worse...Don't be afraid to ask for help.

Tell us what works and what doesn't when professionals are trying to help you and your children.
Make sure you know about the best way to protect your child and take time to understand some of the risks they can face.
You'll never get ahead of your child when it comes to understanding social media and IT – but make yourself aware of the risks that children and young people can face.

THE COMMUNITY
You are in the best place to look out for children and young people and to raise the alarm if something is going wrong for them.
We all share responsibility for protecting children. Don't turn a blind eye. If you see something, say something.
If you live in Hackney, call the **First Access Screening Team (FAST) on 0208 356 5500**
If you live in the City, **call the Children & Families Team on 0207332 3621**
You can also call the NSPCC Child Protection helpline on 0808 800 5000

FRONT-LINE STAFF AND VOLUNTEERS WORKING WITH CHILDREN OR ADULTS
Make children and young people are seen, heard and helped. SAFEGUARDING FIRST, CONTEXT< CURIOSITY & CHALLENGE
Your professional judgement is what ultimately makes a difference and you must invest in developing the knowledge, skills and experiences needed to effectively safeguard children and young people. Attend all training required for your role.
Be familiar with, and use when necessary, the Hackney Child Wellbeing Framework and/or The City of London Thresholds of Need tool to ensure an appropriate response to safeguarding children and young people.
Understand the importance of talking with colleagues and don't be afraid to share information. If in doubt, speak to your manager.
Escalate your concerns if you do not believe a child or young person is being safeguarded. This is non- negotiable.
Use your representative on the CHSCB to make sure that your voice and that of the children and young people you work with are heard.
If your work is mainly with adults, make sure you consider the needs of any children if those adults are parents.

LOCAL POLITICIANS

You are leaders in your local area. Do not underestimate the importance of your role in advocating for the most vulnerable children and making sure everyone takes their safeguarding responsibilities seriously.

Councillors Anntoinette Bramble (Hackney) and Randall Anderson (The City of London) are the lead members for Children's Services and have a key role in children's safeguarding – so does every other councillor.

You can be the eyes and ears of vulnerable children and families... Keep the protection of children at the front of your mind.

CHIEF EXECUTIVES AND DIRECTORS

You set the tone for the culture of your organization. When you talk, people listen. Talk about children and young people. Talk about SAFEGUARDING FIRST.

Your leadership is vital if children and young people are to be safeguarded.

Understand the capability and capacity of your front-line services to protect children and young people - make sure both are robust

Ensure your workforce attend relevant CHSCB training courses and learning events.

Ensure your agency contributes to the work of CHSCB and give this the highest priority. Be compliant with minimum standards for safeguarding.

Advise the CHSCB of any organisational restructures and how these might affect your capacity to safeguard children and young people

THE POLICE

Robustly pursue offenders and disrupt their attempts to abuse children.

Ensure officers and police staff have the opportunity to train with their colleagues in partner agencies.

Ensure that the voices of all child victims are heard, particularly in relation to listening to evidence where children disclose abuse.

Ensure a strong focus on MAPPA and MARAC arrangements.

HEAD TEACHERS AND GOVERNORS OF SCHOOLS

Ensure that your school / academy/ educational establishment is compliant with statutory guidance KCSIE.

You see children more than any other profession and develop some of the most meaningful relationships with them.

Keep engaged with the safeguarding process and continue to identify children who need early help and protection.

CLINICAL COMMISSIONING GROUPS

CCGs in the health service have a key role in scrutinising the governance and planning across a range of organisations.

Discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children.

THE LOCAL MEDIA

Safeguarding children and young people is a tough job.

Communicating the message that safeguarding is everyone's responsibility is crucial - you can help do this positively.

Hundreds of children and young people are effectively safeguarded every year across the City and Hackney.

This is news.

The CHSCP

Independent Child Safeguarding Commissioner

Jim Gamble QPM

Safeguarding Partners

Tim Shields, The Chief Executive of Hackney Council

John Barradell, The Town Clerk of the City of London Corporation

Jane Milligan, The Accountable Officer of the City & Hackney CCG

Marcus Barnett, The Commander of the MPS Central East BCU

Ian Dyson, Commissioner, City of London Police

The Strategic Leadership Team

Anne Canning, The Group Director of Children, Adults and Community Health (Hackney Council)

Andrew Carter, The Director of Children and Community Services (The City of London Corporation)

David Maher, The Managing Director (The City & Hackney CCG)

Marcus Barnett, The Commander of the MPS Central East BCU

Dai Evans, T/Commander, City of London Police

Annie Gammon, Director, Hackney Education

The CHSCP Executive

Chris Pelham, Assistant Director People, City of London

Matt Mountford, Detective Chief Inspector, City of London Police

Valeria Cadena, Community Safety, City of London

Annie Coyle, Interim Director, Hackney CFS

Lisa Aldridge, Head of Service (Safeguarding & Learning), Hackney CFS

Pauline Adams, Head of Service (Young Hackney), Hackney CFS

Dr Sandra Husbands, Director of Public Health

Ajman Ali, Director of Housing Services, Hackney Housing, London Borough of Hackney

Maurice Mason, Community Safety Partnership Manager, Hackney

Paul Senior, Assistant Director, Hackney Education

Azad Odabashian, Assistant Detective Chief Inspector, Metropolitan Police Service

Dr Nick Lessof, Designated Doctor Safeguarding Children, City & Hackney CCG

Dr Emma Tukmachi, Named GP Safeguarding Children, City & Hackney CCG

Reagender Kang, Interim Designated Nurse, City & Hackney CCG

Amy Wilkinson, Integrated Commissioning Workstream Director, City & Hackney CCG

Dr Briony Arrowsmith, Named Doctor (Community), Homerton University Hospital

Marcia Smikle, Head of Safeguarding Children, Homerton University Hospital

Catherine Pelley, Chief Nurse/ Director of Governance, Homerton University Hospital

Andrew Horobin, Deputy Borough Director, East London NHS Foundation Trust

Timothy Bull, Associate Director for Safeguarding Children, East London NHS Foundation Trust

Henry Iwunze, Associate Director for CAMHS, East London NHS Foundation Trust

Kristine Wellington, Head of Safeguarding, Hackney Council for Voluntary Services

Clare Ansdell, Head of Service, National Probation Service

Kauser Mukhtar, Area Manager - North London, London Community Rehabilitation Company

Lee Sandy, Borough Commander, London Fire Brigade

Participant Observers

Anntoinette Bramble, Deputy Mayor, Lead Member for Children's Services, London Borough of Hackney

Randall Anderson, Common Councilman, Lead Member for Children's Services, City of London

CHSCP Team

Rory McCallum, Senior Professional Advisor to the CHSCP

Sandra Reid, Business & Performance Manager

Sarah Seymour, Training & Development Co-ordinator

Silvia Kirk, CHSCP Coordinator