LSCB

Lambeth safeguarding children board

ANNUAL REPORT

2018

2019

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Foreword – Dr Mark Peel

This is my first report as Independent Chair of the Lambeth Safeguarding Children Board and, given the changes to safeguarding policy and law following the Wood Review that will come into effect in September 2019; it will also be the last annual report of this type.

I was delighted to be offered the role of Independent Chair in Lambeth, and took over from my predecessor, Andrew Christie, in July 2018.

First and foremost therefore I would like to thank Andrew for his outstanding work with Lambeth, leading the LSCB. As a result of his efforts (and those of the local safeguarding partnership) my 'inheritance' as the new Independent Chair was to find an effective LSCB and strong local safeguarding partnership, certainly reflective of the improvement journey I knew Lambeth to be making with regard to safeguarding the most vulnerable children and young people, often with very complex needs.

Dr. Mark Peel

Independent Chair

Lambeth Safeguarding Children Board

View from the Chair

The Overall Quality of Safeguarding in Lambeth & the Strength of the Safeguarding Partnership

Over the past year I have been consistently impressed with both the standard and level of commitment to safeguarding evident to me across the safeguarding partnership. As a group of professionals, irrespective of professional background and agency, I have seen a clear commitment to safeguarding our children and young people; working with them and their families directly and working together in partnership to secure the best possible outcomes.

This is often difficult and complex work, and I would like to start here by recognising what I have seen to be the outstanding work of practitioners and managers who I see working together both effectively and professionally.

Lambeth is on a journey of improvement overall, and whilst inevitably there will always be room for improvement in safeguarding, it my view as Independent Chair of the LSCB that the overall standard safeguarding in Lambeth is good and, perhaps more importantly, that it is improving.

One especial strength in Lambeth, from my independent perspective, is the clear link between day-to-day practice and an openness to improvement, including through training, as a result of findings from research, audits, and from the recommendations from Serious Case Reviews (SCR's). There is a strong learning culture in the Borough, very much reflected in internal and external students' uptake of training offered through the LSCB.

It is a familiar criticism of SCR's over the last decade to link failures in safeguarding to poor communication between agencies at the frontline, and similarly to inconsistent management 'vision' between (and sometimes within) agencies. Whilst it is too early for me to make any categorical statement with respect to Lambeth in this regard, the operation and attendance at the Board and the partnership working I have directly observed (for example through the MASH) have not evidenced any particular problem. Moreover, the manner in which agencies have worked together to approve new arrangements and agree the different 'character' of partnership, required under new legislation from September of this year are indicative of strength here.

Undoubtedly, as I get to know Lambeth better, strengths and areas for improvement will present themselves. But at this early stage in my time here, it is already my view that safeguarding in Lambeth has the commitment and strength overall to both rise to new challenges and celebrate improvement.

The wider (non-statutory) partnership

As I have not been in role as Independent Chair for an extended period, it would be arrogant of me to assume that I have already gained a full picture of the very extensive and rich non-statutory services operating in Lambeth. Of course I am familiar with the audit data in this regard, which is positive and encouraging. But I know from prior experience that it takes some time to gain a more nuanced understanding of this sector, and to put 'meat on the bone' of the inevitably two dimensional picture afforded by data alone.

First impressions are however very positive, with a strong non statutory agenda and voice for example being present in formal Board meetings. Certainly I have so far detected no immediately apparent weakness in this area. Indeed very much the reverse.

This is an area I will return to in significantly greater detail next year, as Independent Scrutineer, by which time I will hopefully have a much better personal understanding of the sector.

Matters financial

One of the early challenges the LSCB has had to face, under my stewardship, has been the impact of a Council wide requirement to save money, and the concomitant reduction in direct funding of the LSCB in common with that faced by all other services.

One consequence of this has been a need for me to think very carefully about where and how to best spend reduced LSCB resources. Balancing what 'added value' expenditure has for outcomes for children and young people.

The difficulty here is compounded by the fact that the commissioning safeguarding reviews (Case Studies, Serious Case Reviews and Lessons Learned Reviews) is unpredictable, and whilst all LSCB's would reserve the right to 'go back' to partners with a request for additional funding in unprecedented circumstances, this is clearly, not something to be considered other than in absolute extremis.

Like most organisations the LSCB principal expenditure relates to staffing and, given the comments I will go on here to make here about the comparatively small scale of the LSCB 'business unit' in Lambeth in relation to demand, I cannot contemplate any reduction to staffing.

Investment in training opportunities offered through the LSCB, is a similarly vital (yet often undervalued nationally) element of the Board's ongoing commitment to ensure that an evidence based, learning orientated, approach to safeguarding is consistently 'invested' at practitioner and first line manager level across the partnership as a whole. Once again, there

is no room I feel here for reduction, with the training delivered offering outstanding value for money.

Early on in my time with Lambeth, I chaired the LSCB Conference, and saw for myself how well received and appreciated this high profile event was by all in attendance. We were able to attract really high quality speakers, with the result that we could have filled the limited number of places available almost twice over. Yet overall a 'one day one off' event like the conference will always be expensive and, as a result, is sadly something that I feel we could now only take forward again perhaps through a sponsorship arrangement, or in party with other safeguarding bodies.

The new requirements for safeguarding, set out in "Working Together", touch on a new responsibility with respect to affording 'independent scrutiny', through it is left to those agencies with statutory responsibilities for safeguarding, and all others across the safeguarding partnership, to determine what form and range this should take in reflection of local circumstances and priorities.

One aspect of scrutiny in Lambeth has been independent audit, which I feel has hitherto been distant from practice in terms of data collection and recommendation, as well as extremely expensive. I have taken the view that more practice orientated audit, is likely to be more effective both as a means of bringing independent scrutiny to bear, and also generating evaluation and recommendation more directly and evidently linked to improving practice.

As a result I have taken a view that better audit can be achieved for around half of what historically has been spent.

In the period of this annual report, Dave Basker was commissioned to write an independent "Getting Child Protection Right" audit. The emphasis was on meeting frontline practitioners to understand the effectiveness of case referrals and their outcomes. This has been completed, and delivered strong, valuable recommendations that have already been acted upon. The support professionals gave to this audit further shows the value Lambeth management place on independent scrutiny, and the commitment of staff to supporting vulnerable members of society.

Overall the LSCB areas of responsibility in the new partnership framework will continue to function within our new budget and ongoing difficult financial circumstances, which will nonetheless remain challenging, and require some difficult and unpalatable decisions to be made. I am similarly aware that everyone with responsibility for provision of service can (and often do!) argue that their service or sector is somehow a 'special case' worthy of protection, but as far as safeguarding is concerned, I do genuinely believe this to be the case.

The need in my independent opinion to 'protect' safeguarding services from any further need to save money is something I raised with the Chief Executive in our first meeting. This is certainly something that I will keep a very close eye on over the course of the next year and henceforth.

The voice and influence of the Child

Children and young people are not directly represented in the board membership. However multiagency audits undertaken by the LSCB ascertain the extent to which the voices of children are heard and influence practice and interventions. A young people's panel is used as part of the interview process I went through with regard to appointment as Independent Chair. They certainly asked complex and searching questions, and I am aware that their views, with regard to the performance of all the candidates, were fully taken into account by the formal interview panel.

Across the Country however, the difficulty of bringing the 'voice of the child' to safeguarding is evident, in that no authority has been able to truly do this in anything more than, at best, a piecemeal (and at worst tokenistic) way.

In Leeds a student LSCP is recruited from local college students each year, facilitated and supported by LSCP business unit staff. While in other areas existing local young people's groups are used for consultation, and so on. In most instances however it would appear that whilst the opinions and views of children and young people are often sought in relation to specific issues, it could not be realistically argued that 'the voice of the child' is at the centre of the LSCB.

Whilst more could certainly be done to elicit the voice of the child, and for this to be more fully integrated into safeguarding arrangements, it is my opinion that there are ethical and practical limits as to how far this can be taken, and that this is reflected in the distance between what is espoused across the country in this regard, as opposed to what is actually in place.

Much of the literature here is clear that proactive consultation with children, almost always requires older children and adolescents to represent the views and experiences of much younger children, or for individuals or small groups, to represent the wider experiences of children and young people as a whole. There are clear limitations in both regards.

I have recently completed research in a Northern area of the Country following a high profile Child Sexual Exploitation case, and complex Court case. Many of the astonishingly brave young women who gave evidence, now in their mid to late twenties, and who continue to be supported by a range of services, also now offer an advisory capacity back into services for their younger present day counterparts. Clearly this needs to be handled with enormous sensitivity, and on an individual basis, but this suggests to me at least that the experience of

adults who, as children and young people, were failed by the safeguarding arrangements of the past could be of particular value, taken in tandem with the views of today's young people.

Over the years of course we have heard time and again that children worry enormously that when they have something to important to say that they won't be listened to or believed, that they are somehow to blame or that in speaking out they will 'hurt' their family or people they love and depend upon.

So in Lambeth over the course of the next year I will be taking a closer look at how the voice of the child is 'heard' at the frontline of safeguarding by teachers, social workers, health workers and those in the voluntary sector, to ensure that when children have something to say, that we are ready and able to listen.

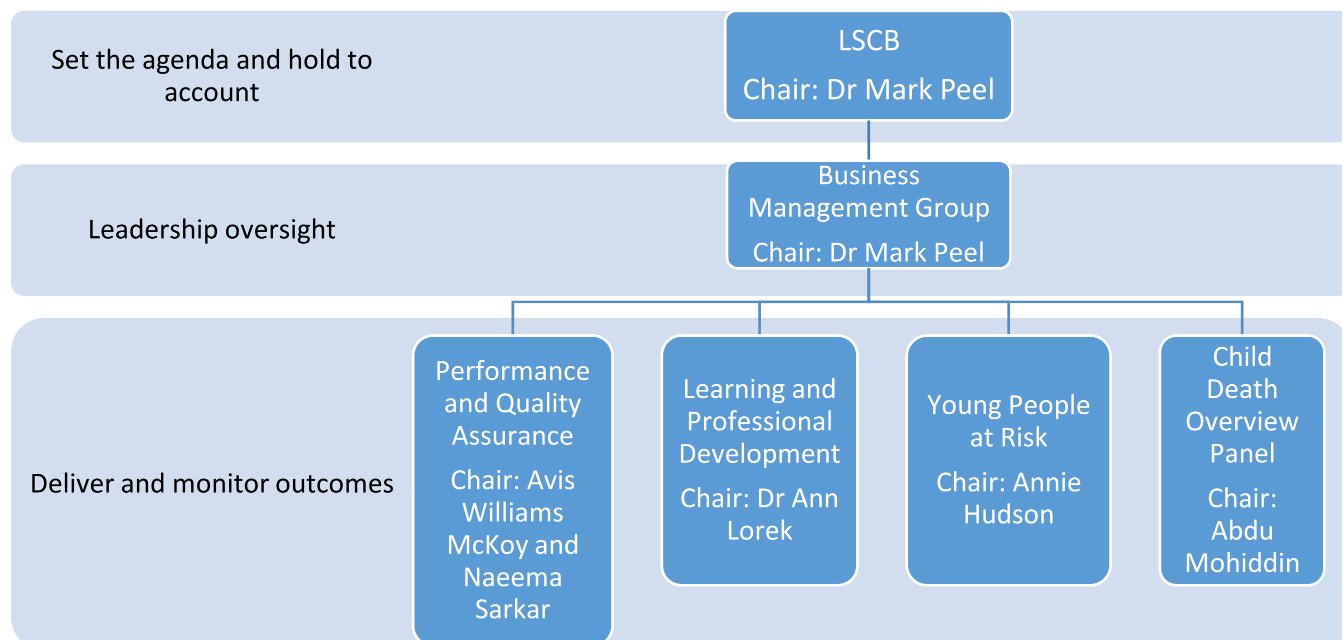
Context

Local leadership

Dr Mark Peel took up the role of the chair of the LSCB in July 2018. The agencies represented on the Lambeth Safeguarding Children Board and its Subgroups include:

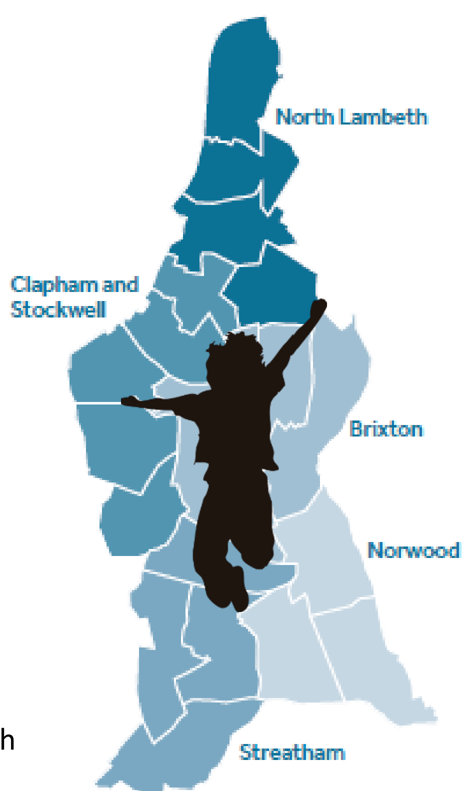
- CAFCASS
- Cause You Can Ltd
- Councillor
- Diocese of Southwark
- Guys & St Thomas' Hospital
- Head Teachers representing schools in Lambeth
- Health Watch Lambeth
- Home Start
- Kings College Hospital
- Lambeth CCG
- Lambeth Children's Social Care
- Lambeth Community Safety
- Lambeth Education
- Lambeth Housing
- Lambeth Public Health
- Lambeth Safer Communities
- Lambeth Youth Offending Service
- London Community Rehabilitation Company
- Metropolitan Police
- National Probation Service
- Red Thread
- SLAM, NHS
- South London and Maudsley
- The Mary Sheridan Centre

The Structure of the LSCB



Children living in Lambeth

Approximately 63,210 children and young people under the age of 18 years live in Lambeth. This is 19% of the total population in the area.



The proportion of children entitled to free school meals:

- In primary schools is 23% (the national average is 14%)
- In secondary schools is 24% (the national average is 13%)

Children and young people from minority ethnic groups account for 64% of all children living in the area, compared with 21% in the country as a whole.

The proportion of children with English as an additional language:

- In primary schools is 51% (the national average is 21%)
- In secondary schools is 45% (the national average is 16%).

The largest minority ethnic groups of children and young people in the area are Black or Black British or of mixed Black/White ethnicity

Approximately 27% of the local authority's children are living in poverty.

Child protection in Lambeth

At 31 March 2019:

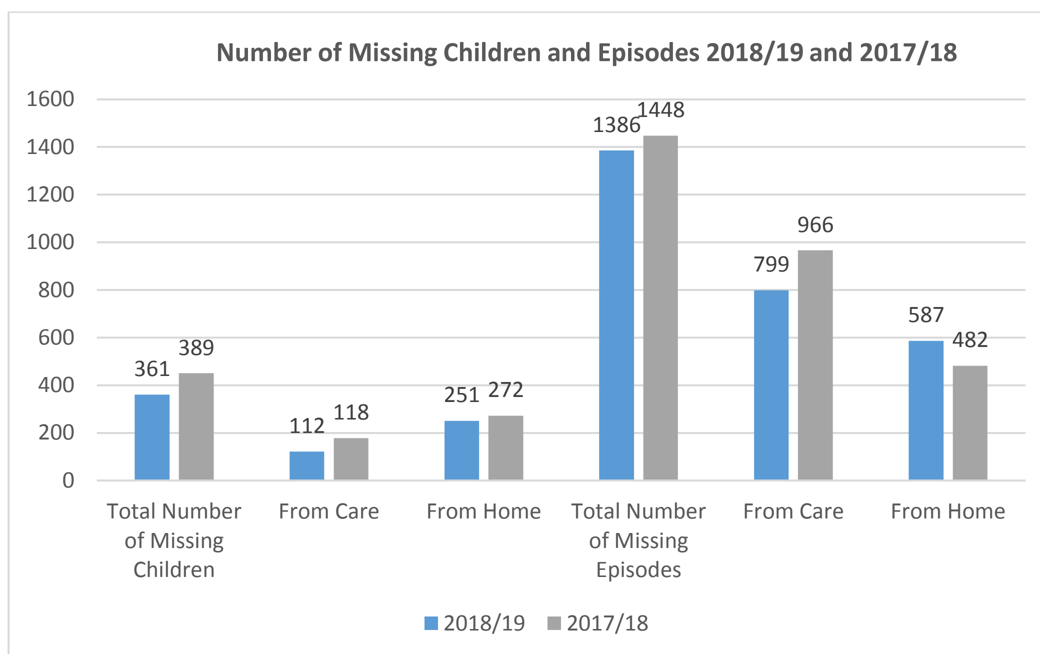
- 254 children and young people were the subject of a child protection plan (a rate of 40 per 10,000 children). This is decrease from 296 children (47 per 10,000 children) at 29 January 2018;
- 1429 children and young people were the subject of a child in need plan (a rate of 2 per 100 children, or 226 per 10,000 children).

Children looked after in Lambeth

At 31 March 2019, 352 children are being looked after by the local authority (a rate of 56 per 10,000 children). This is a reduction from 407 (65 per 10,000 children) at 29 January 2018. Of this number:

- 253 have been placed with foster families, with 185 being placed outside of the local authority
- 5 children have been placed for adoption
- 69 children and young people live in homes, hostels and other supportive residential placements, and a further 11 living in other residential settings
- 13 have been placed with their own parents
- 1 young person is living in lodgings, residential employment or independently

Children Missing from Home or Care



N.B The number of missing children does not add up as 2 children were missing from care and home during the course of the year.

There has been a reduction in the number of children going missing from care as well as children missing from home. This is largely because social workers and placements have a better understanding about the difference between unauthorised absences and missing.

There has been an improvement in the number of Return Home Interviews (RHIs) offered and completed for missing children this year compared to the previous year. In 2017 38% were offered a RHI, this increased to 76% in 2018. The increase in the number of RHIs after each missing episode has improved especially in relation to children missing from home. In 2017 a return home interview was offered after each missing episode in 27% of missing episodes, compared to 2018 where the figure is 54%. This is because the Integrated Referral Hub offer missing children a RHI as a part of their screening process for those children missing from home and not open to Children's Services.

Although there has been some improvement, it is recognised that more needs to be done. Following a restructure in Lambeth's Children's Social Care, plans are in place to recruit two RHI youth workers to improve engagement.

Children Experiencing or at Risk of Sexual Exploitation

Child Sexual Exploitation (CSE) remains a priority practice area for Lambeth Children's Services. CSE has been identified by the government as a "national threat" (Tackling Child Sexual Exploitation, HM, March 2015) and continues to have a high political and media profile.

At present there are no official statistics on how many children and young people have been sexually exploited in the UK (Beckett et al, 2018) and as CSE is not an explicit criminal offence Police data is not readily available for statistical comparison.

Lambeth CSE profile

Year	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Lambeth CSE referrals	21	97	123	119	105	83

A total of **83** children considered to be at risk of child sexual exploitation concerns were referred to Lambeth Children's Social Care in 2018-2019. This includes internal referrals for children who were already open to children's services for other reasons.

The decline in CSE referrals is primarily believed to be professional networks developing a greater understanding of what constitutes CSE as opposed to other forms of sexual abuse and violence against women.

From the total of **83** referrals, **76** children were assessed to have met threshold for intervention from Children's Services. The remaining **7** children were given advice and signposted to services.

At the end of 2018-2019 there were **42** cases open to Lambeth CSC where children and young people were in receipt of services and support to reduce risk to CSE. This list of the CSE cohort is reviewed on a monthly basis by the CSE Coordinator and the number of children has fluctuated from **34** to **48** open cases per month.

Progress against our three key priorities:

The LSCB agreed a set of priorities as part of a three-year strategy from 2017-2020. These priorities were selected using quality assurance and performance data about the strength of safeguarding activity in Lambeth.

The first two overarching ambitions are about strengthening the effectiveness of the early help and child protection system in relation to different types of abuse and neglect.

The third ambition reflects key areas of need in the borough: protecting children from exploitation and serious youth violence. Alongside these strategic priorities, the LSCB will continue to improve its delivery of multi-agency audits, learning and development, communication and scrutiny of the work of individual member agencies.

1. Getting the Basics of Child Protection Right

A multiagency audit was undertaken to enable the LSCB to have a line of sight of the quality of frontline practice. The purpose of the audit was to:

- Assess the effectiveness of Early Help to make sure children are provided with help when problems emerge and that practitioners recognise needs and respond appropriately. Assessments of need for early help are undertaken by a lead practitioner, and information is shared with consent, and local organisations and agencies work well together. The right help is given to the child at the right time. Families are informed; involved and effective partnership working is evident.
- Ascertain if thresholds are understood by the partners and applied appropriately and that there is evidence of professional challenge and escalation, if and when, necessary.

The key findings of the audit included:

- Assessments, judgements and decisions about children who are referred are child centred, take account of relevant significant history and children are seen and spoken with at the earliest opportunity. No children are left at risk, initial threshold decisions are proportionate and take account of multi -agency information.
- Managers in all agencies provide clear direction and oversight in a timely way, with a focus on the needs of the child. The work of the MASH and IRH is effective and facilitates good information sharing and discussion. All decisions and recommendations are matched well to need and risk. Children at immediate risk of significant harm are quickly

recognised, strategy discussions /meetings are timely, involve the right people rationale for S47 enquiries are clear and actions in the best interests of children's safety.

- Meaningful assessments of help, support and protection –Early help and child and family assessments are timely, Child focussed and contextual, make good use of research, history and multi–agency information to inform analysis, recommendations and decisions. Direct work with children is consistently good quality and gives a sense of the child's lived experiences. Chronologies and evidence based tools are effective in getting the best outcomes for child and family.
- Purposeful outcome focused planning, EH CIN, CP. Early Help and CIN, CP plans are reflective of assessed need/risk, involve the child/family, relevant practitioners and show management oversight and direction. Practice outcomes and evidence based theory, research and practice wisdom impact positively on children's lives - need and risk is balanced and changes required are clear and understood by all parties.
- S47 enquiries, child's experience, multi-agency information sharing – agencies, with appropriate consent, have shared information with other, relevant agencies and have asked for information when necessary. Information sharing is appropriate, timely and relevant, particularly across Children's and Adult Social Care.
- Children assessed at risk of significant harm are progressed to Initial Child Protection conference appropriately.
- Child protection conferences involve the relevant professionals plan to reduce risk through multi-agency working to an outcome focussed plan. Professional discussion and challenge is evident and partnership work with child and family produces good outcomes.
- Supervision – practitioners are well supported by managers who know what good practice looks like, help to reflect on their work and revise plans when necessary. Reflective supervision has impact on the quality of practice.
- Impact for child and family – practice has clear, measurable outcomes for children and their families. At all points in the child's journey from early help to child protection planning there is evidence of relational collaborative working and effective improvements through meaningful assessment and purposeful planning for children in Lambeth.

This audit found that in most cases the children's partnership is getting child protection right in Lambeth. All practitioners and managers spoken with across the partnership talk highly of working in Lambeth and have a real sense of wanting to get the very best for children and families. Despite some extremely challenging child and family problems practitioners face on a daily basis there are many examples of child focussed, strengths based practice with good support from managers who are available. Risks to children are well considered and balanced alongside needs and help and support. There is evidence that fathers are well engaged and supported when the need arises.

All staff reported they have access to good professional development and training and that supervision was highly valued both formal and ad-hoc. The health practitioners in the MASH

reported effective working relationships and that on occasions challenging conversations were had to ensure the very best for children and families.

The police were positive about the colocation of agencies promoting effective, timely and responsive services to vulnerable children and building good working relationships, whilst acknowledging there is more to be done around attendance at ICPCs and information sharing in young people's safety plans.

However, the audit found that when the police are not present at ICPCs any relevant new and emerging information or intelligence may not be available to ensure a comprehensive analysis of known and potential risks to the child and that this needed to be addressed. Improvements could also be made by harnessing the participation of the schools safeguarding representatives in the MASH.

Most social workers liked the Signs of Safety Framework as it helps them to be clear with families about strengths worries and potential dangers to a child. Most reported that families respond well to how information is reported. The Heart of Practice training is highly valued as is the Advanced Practitioner (AP) role in supporting practitioners and in providing group supervision on cases or practice issues.

Most felt that interagency working and information sharing was good in Lambeth across the children's partnership. This was evident from the audit with some very good examples of information sharing and multi-agency working involving Schools and colleges, adult services, health including CAMHS, police, YOS, children's centres and housing.

Most mentioned the good work and positive working relationships with staff at the Mary Sheridan Centre and the role of the Designated Safeguarding Lead in some schools who often undertake a good deal of support to children in school before making referrals.

For some time there has been a concern regarding GP input for child protection conferences. Joint audits undertaken by the Named GO Safeguarding Children Lambeth CCG and Children's Social Care identified problematic systems and information sharing issues to ensure that the right GPs were invited to child protection conferences and that GPs responded by sending reports or attending in person. Corrective action was taken and there has been a notable improvement in GP contributions to multiagency information sharing for children subject to a child protection plan.

2. Strengthening Early Help: Neglect and Domestic Violence

An audit was completed in May 2017 on Neglect and findings for improvement were taken forward. In 2018 and 2019 the LSCB agreed to focus on domestic violence. Violence against women is a significant issue in Lambeth. The national domestic violence helpline reports that the number of calls received from women in Lambeth is the highest of all London local authorities (Source VAWG).

The audit was commissioned by the LSCB as part of a rolling programme offering insight and scrutiny of practice across agencies within the borough. The purpose of the audit was to assess the effectiveness of early intervention to support the victim, the child(ren) and the perpetrator.

To test if information was shared safely with the appropriate consent and ascertain if victims were provided with the support that they needed and if risks were managed well. The audit sought to establish whether practitioners in the network had used an appropriate risk assessment tool (ideally the DASH risk assessment) to identify the risk to the victim, and if the risk rating were shared with professionals including MARAC. The audit also sought to establish if practitioners had assessed the risk to the child(ren) (ideally using the Barnardo's Risk Identification Matrix) and if risk assessments were updated as required and put on the system and if action was to reduce risk.

The audit found that practice was variable with effective interventions making a real difference in stopping further incidents of domestic violence in 60% of the sampled cases. Appropriate actions were taken by agencies for those children where the current risks continued. In some cases parents(s) had taken appropriate action. One case, where the perpetrator was a young person remained concerning for agencies.

The audit found evidence of good communication and interagency working in the majority of these cases. There are, however, on-going issues about sharing of information on CIN cases and the right information being put onto GP case files.

The CAADA-DASH risk indicator checklist was used in some but not in all cases. Given the expectations that this tool will be used to both assess risk from DV, whenever possible, and also review the risk, this was of concern to the audit group.

The MARAC process appears to work well, and is seen as a good multi agency forum for discussion and progression of cases. It was not always clear from the agencies' case file audits whether these actions had been followed up post MARAC and reviewed accordingly.

DV services had been offered to all victims. However, take up of services was often limited. Full engagement in DV work for both the victim and perpetrator remains an issue.

As a result of the findings of this audit a multiagency action plan was developed to improve practice. The action plan has been tracked by the Performance and Quality Assurance Subgroup.

3. Young People at Risk

In 2017, we launched the two-year Young People at Risk Strategy. The strategy identified priorities in four clear strands:

1. Prevention
2. Identification
3. Help and Protection
4. Disruption

Key multiagency progress against these strands include:

Following the successful early help Streatham Pilot which ran from June to November 2018, we are providing a new community early help offer which includes:

- named early help contacts for professionals across the borough
- a multi-agency locality action panel (LAP) which meets every 2 to 4 weeks (depending on caseloads) where professionals can discuss complex cases and harness local help and resources for the children and families they support
- training on a range of issues relevant to families in Lambeth such as gangs and group violence, trauma and emotional wellbeing
- a practical toolkit for practitioners supporting families based on a framework of assess, plan, do, review.

The appointment of a Young People at Risk Data analyst will increase our capacity and capability to share intelligence and identify children and young people at risk, using mapping and tracking to develop and inform appropriate strategies.

Since 2017 Lambeth has incorporated Young People's Safety Plans for children experiencing contextual harm across all of Children's Services. These are multi agency meetings following the Signs of Safety format with an independent chair. The plan focuses on reducing risk outside the home, whilst trying to minimise the negative stigma which comes with child protection procedures.

In December 2018, the Multi Agency Contextual Harm Panel was launched to ensure all children at risk of contextual harm receive the best response from professionals. The MACH panel also identifies themes, patterns and concerns, and to escalate these for strategic discussion at Multi-agency Child Sexual/Criminal Exploitation Panel meeting (MASE).

A MASE meeting is held every month. This is a tactical multiagency meeting to allow partners to share information and feed into action plans to support young people at risk of sexual and/or criminal exploitation.

In 2018, Rescue and Response were commissioned to work in Lambeth. This is a 3 year MOPAC funded project to work with children affected by county lines. It is a consortium of charities who are working together with local authorities to support vulnerable young people and develop services aimed at addressing the issue. The charities involved are St Giles Trust, Abianda, and Safer London. There is currently a waiting list for young people needing the support in Lambeth.

Lambeth have a contextual harm champion – an Advanced Practitioner who is responsible for developing further guidance and training on how to respond to risks around missing children and contextual harm.

The Child Exploitation Risk Matrix is being adapted to include all areas of contextual harm and will be inbuilt into Mosaic making it easier to monitor, report and respond to the issues.

The Lambeth AIM (Assessment, Intervention and Moving On) service offers social workers, YOS officers, CAMHS practitioners and education staff who work with young people in Lambeth a monthly multi-agency forum in which they can discuss any young person who is presenting with inappropriate or harmful sexual behaviours to inform their assessment, formulation, safety planning and interventions with young people and their families. This discussion is also used as a platform to discuss whether a specialist AIM assessment and intervention is needed by the AIM service.

The LSCB Young People at Risk Strategy will now be reviewed and its impact evaluated, with a view to refreshing the strategy for 2020 – 2021. This will need to take account of the very considerable work being undertaken to shape and deliver a robust strategy for tackling serious youth violence. This strategy is organised around a number of workstreams (including community engagement, education, response and support, early help, disruption and deterrence, neighbourhoods).

The Learning and Improvement Cycle

A key strength of Lambeth's safeguarding arrangements is the degree to which all of the partner agencies are open to improving the quality of the services they offer through training and development.

It has been positive, for example, that recommendations from Serious Case and Local Reviews have been applied as the learning has been identified and often far in advance of completion and publication of reviews. This learning has been applied through learning events, trainings and to practice.

Given that Serious Case Reviews can take considerable time to complete, and are often further delayed by the need to complete matters judicial, it is a particular strength in the Borough, that lessons learnt are not similarly delayed.

Serious Case Reviews

Child K: Findings and Action

In November 2016, Child K was assaulted by his mother's partner, Mr C, and later died as a result of the injuries he sustained. Mr C was convicted of the murder of K in July 2017, and is presently serving a life sentence in prison.

This Serious Case Review was commissioned jointly by the Lambeth and Bromley Children's Safeguarding Boards, with a view to:

(i) gaining a better understanding of the events that led up to the death of K, and of any involvement of professionals and agencies with responsibilities for safeguarding, and

(ii) identifying any opportunities for learning coming from the tragic death of K, which might serve to improve services, and better protect children in future.

The full report can be accessed on the new LSCP website: www.lambethsaferchildren.org.uk.

The report recommendations include:

- Recommendation 1: The National Probation Service, London should audit a sample of licence cases to ascertain whether the guidance is followed or whether non-compliance with guidance is a wider systemic issue or was unique to this case. The audit should include compliance with the need to undertake full assessments of the suitability of the accommodation and any risk to adults or children living in the household when the

offenders' circumstances change. This audit should involve liaison with appropriate local agencies. It is understood that the Community Rehabilitation Company also supervises offenders on licence. Outcome: This will give assurance to the National Probation Service and its Partners that Offenders who may pose a risk of violence and who do not adhere to their licence conditions are properly assessed and managed and will provide assurance to the Probation Service and its Partners that Offenders who pose a risk of violence and who do not adhere to their licence conditions are properly imposed and managed.

- Recommendation 2: Her Majesty's Prison & Probation Service should be asked review the Prison Rules relating to visits with and letters to and from domestic violence offenders and offenders convicted of offences against children to consider how potential victims of grooming or coercive control can be protected, including potential new victims; and to assess whether the guidance on exchange of information about such contacts with relevant safeguarding agencies is sufficient. There should be liaison with the local (Brixton) prison with regard to these findings. Outcome: This action will enable consideration to be given to any risk, including risk of grooming or coercive control conducted through contacts with known domestically violent prisoners.

- Recommendation 3: The Lambeth Safeguarding Children Board should seek reassurance from its partners that relevant frontline staff and their managers involved in the assessment and management of cases where there is domestic abuse are aware of the arrangements for sharing information about offenders through the Domestic Violence Disclosure Scheme and the MAPPA arrangements (as set out in the London Child Protection procedures Section B3/28). Outcome: Information about a history of violence will be properly considered and shared by the partner agencies, to improve the quality of assessments and interventions.

- Recommendation 4: The Lambeth Safeguarding Children Board should review how families which are supported by the No Recourse to Public Funds Team (NRTPF) that are experiencing domestic abuse are helped and supported. Lambeth Children's Services should assure the Lambeth Safeguarding Children Board that relevant staff are aware that when families that are victims of domestic abuse have no recourse to public funds and need the support of a Refuge that consideration will be given to accessing funds to secure such a placement. Outcome: These actions will provide assurance that a mother and child/ren can be considered for a place in a Refuge where they have no access to benefits, and where that is considered the appropriate means of support.

- Recommendation 5: The Lambeth Safeguarding Children Board should seek assurance from its partner agencies that when assessing incidents of alleged domestic abuse, the risks to children, including emotional abuse, are fully assessed as set out in section B3/28 of the London Child Protection Procedures. 'Safeguarding children affected by domestic abuse and violence'. Advice should be provided to staff about the importance of thinking about the welfare of children when considering the application of bail conditions relating

to adults in cases of domestic abuse. Advice should also be provided to staff about considering the emotional impact of witnessing domestic abuse and good practice intervention. The Lambeth LSCB should undertake a multi-agency audit of domestic abuse cases, including of families supported by the NRTPF team. Outcome: This action will provide assurance that children in domestically abusive situations are fully assessed and their needs are taken into account, as well as the safety of adults who are the victims of domestic abuse.

The recommendations from the review have been followed up by agencies in Lambeth and tracked by the Performance and Quality Assurance Subgroup of the LSCB.

Ongoing reviews

Two additional Serious Case Reviews were started in 2018/2019. These reviews will be concluded in 2019/20.

A learning review is also underway following a new born baby failing to thrive. This review report is due to be completed in 2019/20.

Training

Building on the robust multi-agency professional programme developed in 2017, the LSCB has maintained an effective training programme in 2018-19. The foundations laid by previous LSCB Training and Development Managers has ensured that our basic training programmes are embedded in national and local guidance, LSCB priority areas, and linked to findings of national and local SCR and audits.

These core programmes have been maintained since the Training and Manager post has been vacant (March 2019) and whilst a permanent post holder is being recruited to an appropriate banding level.

Additional effort has been made to ensure that single agencies are providing updates on key issues and themes related to SCRs and to the key board priorities.

Additional learning events have been developed in the multiagency forums as shared learning, including for professionals working with children with disability, and a successful seminar for Fabricated and Induced illness.

Following a highly successful and impactful conference on Adverse Childhood Experiences there has been further training for a wide range of professionals and voluntary agencies in Lambeth, including development of an organisation having a trauma informed approach.

Education training has been taken on by the single agency where appropriate for teachers, as was the case already for other agencies. This allowed focus on more complex multiagency issues as part of training.

An overview of the trainings run by the LSCB over 2018-19:

Forty Eight courses were scheduled to take place, covering twenty different topics; two had a duration of two-days and nine were cancelled.

During 2018 – 19:

- **12** Multi-Agency Safeguarding Training courses took place, **263** delegates attended
- **6** Education and Early Years - Designated Lead Professionals courses took place, **129** delegates attended
- **13** specialist courses ran covering a range of topics
- **363** delegates attended specialist courses
- **1** bespoke multiagency training was developed on Fabricated Induced Illness led by our Health partners and involving colleagues from Lambeth Local Authority and hospital and community-based Health from both Lambeth and Southwark.

The most popular courses were:

- Safeguarding Essentials: Multi-Agency Safeguarding Training (Working Together)
- Safeguarding Essentials: Education and Early Years - Designated Lead Professionals

Attendance:

- 755 people (places) attended training during this period (fully attended)
- 13% of all places booked were cancelled
- 11% of delegates did not attend the training they had booked (no show)
- 83% of delegates who had a place confirmed to attend training, fully attended

Attendance by Sector:

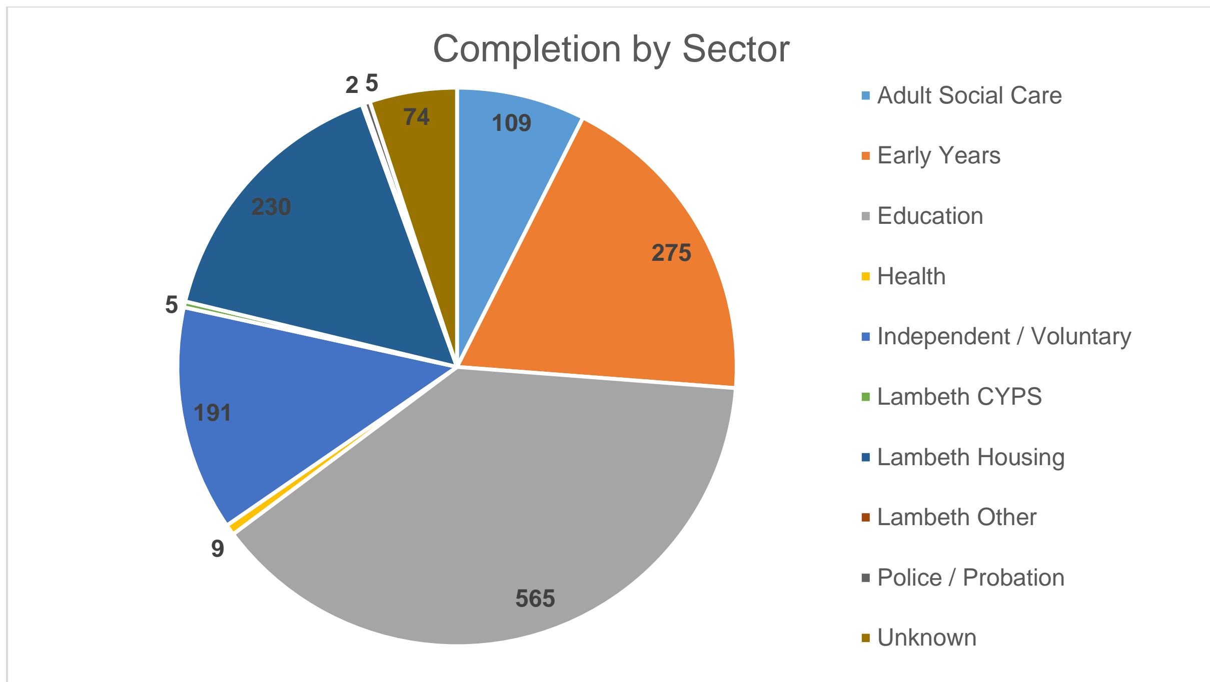
Independent, voluntary and charitable organisations took up 25% of all places available, closely followed by health (20%) and Early Years (17%)

Sector	Fully Attended	No Show	User Cancelled	% Booking Requests	Grand Total
Independent / Voluntary / Charitable	194	33	50	25%	330
Health	181	32	18	20%	259
Early Years	111	26	39	17%	219
Education / School	100	23	21	14%	187
Lambeth CYPS	75	20	29	12%	153
Lambeth Council	50	7	14	6%	82
Probation Services	18	2	3	2%	29
Unknown	15	4		2%	20
Police	5		2	1%	18
Other LA	3			1%	10
Faith Group	3	1		0%	4
Grand Total	**755**	**148**	**176**	**100%**	**1311**

E-Learning Completion Rates

During the period April 2017 to March 2018, 1465 individuals registered to complete the Introduction to Safeguarding e-learning. Education and Early Years have the highest take up rates.

- 79% of those who registered completed the course
- Education (39%) and Early Years (19%) represents over half of all participants



E-Learning Scores

At the end of the course participants are asked to answer a series of questions to see how much information they have remembered. The maximum score is 20, the table below details the results.

- 49% of participants scored 75% or higher
- 2% pf participants scored under 50%

Evaluation Data Commentary

- There is a positive difference between the before and after scores for all of the courses detailed in the table above; the score difference ranges from 0.1 to 1.1
- The “after” self-rating levels for all courses are 3.0 or higher (in all bar two cases) indicating that the level of knowledge and understanding at the end of the sessions is between good and excellent

Probability of Implementing Learning into Practice

The table below indicates how likely it is that delegates will implement what they have taken from the training into practice.

- Between 70% - 100% of delegates said there was a high probability of implementing what they had learnt into practice
- The Designated Safeguarding Lead (93%) and Safer Recruitment (100%) courses scored very highly on this statement

What is the probability of you implementing what you have learnt into your practice				
	Course Title	**High**	**Medium**	**Low**
Essential Safeguarding Courses	Multi-Agency Safeguarding Training	78%	18%	4%
	Designated Safeguarding Leads	92%	8%	0%
	Situational Learning	70%	26%	4%
Specialist Safeguarding Courses	Safeguarding Across Faiths and Culture	88%	12%	0%
	Safer Recruitment	100%	0%	0%
	Working with Resistance	71%	29%	0%

Implementation of Learning Timescales

The table below details how quickly delegates think they will implement their learning.

- The Situational Learning and Safeguarding across Faiths and Culture sessions had the highest number of delegates who said the training would impact on their practice within one week.

- 20% of delegates said it may take up to six months before they were able to implement their learning from Working with Resistance training, this is attributed to the type of work they undertake and the number of “resistant” service users that they engage with.

By when Will Do This?					
	Course Title	**Within 1 week**	**Within 1 month**	**Within 3 months**	**Within 6 months**
Essential Safeguarding Courses	Multi-Agency Safeguarding Training	54%	31%	10%	6%
	Designated Safeguarding Leads	48%	48%	3%	0%
	Situational Learning	75%	21%	4%	0%
Specialist Safeguarding Courses	Safeguarding Across Faiths and Culture	73%	20%	7%	0%
	Safer Recruitment	18%	64%	18%	0%
	Working with Resistance	80%	0%	0%	20%

Rating of the Training Overall

Rating Scale	Excellent - 4	Good - 3	Satisfactory - 2	Poor - 1

The tables below detail how the delegates rate the quality of the training content and the knowledge and skills of the trainers.

- All of the training was rated as good or higher with the average scores ranging from 3.1 to 3.6

How would you rate the training overall?		
	Course Title	**Average Score**
Essential Safeguarding Courses	Multi-Agency Safeguarding Training	3.4
	Designated Safeguarding Leads	3.5
	Situational Learning	3.1
Specialist Safeguarding Courses	Safeguarding Across Faiths and Culture	3.6
	Safer Recruitment	3.6
	Working with Resistance	3.4

Qualitative Comments - What Will You Implement From This Training to Improve Your Practice?

At the end of each session delegates are asked to details what they will implement from the training; these comments are used during levels three and four of the evaluation process.

The main themes emerging from the training sessions detailed in this report are:

- Knowing how to **making a Referral** using the **thresholds** and **MARF** (multi-agency referral form)
- **Recording information** and providing as much information as possible to **support referrals**
- **Sharing information** with teams / colleagues (eg LADO contact details)
- Increased **knowledge and understanding** of safeguarding (E.g. reporting incidents, local policies and procedures, Lambeth services and how they work)
- Thinking about **Information Sharing** with other agencies
- Awareness of organisational **policies and procedures** and the need to review these
- Commitment to **display the Lambeth thresholds chart** so it is accessible to all staff
- Being aware of **changes to legislation and new guidance**
- Increase **regularity of supervision** meetings
- Challenge staff and **be curious**
- **Discuss in case supervision** meetings with staff
- Always **look at the bigger picture** before **making a judgement**
- Endeavour to **request references as soon as possible** rather than once an offer is made
- Continuing to check our **single central record is up to date** including new staff who have joined
- Check that all staff have an good **understanding** of a **safe environment**
- Ensure **children and Young People feel respected** and part of the investigation / process
- Better understanding of **what to expect from other agencies**
- Using the **communication model** for managing conflict

Evaluation Data Comments

The evaluation data is promising and indicates that:

- Delegates are leaving sessions with an increased knowledge and understanding of safeguarding
- Over 70% of delegates say there is a high probability that the learning will impact on their practice
- Over 80% of delegates say they expect to use their new knowledge and skills within a month of attending training
- The content of the training and the knowledge and skills of the trainers are of a high standard

Multi-agency Mini Practice Weeks

Mini 'Practice Week' is an approach to embedding and understanding quality practice and involves our partner agencies within the LSCB and takes place over 2 days. The approach links case reviews with observation of practice, direct conversations with frontline practitioners and their managers, multi-agency partners, parents and carers and children wherever possible.

The LSCB agreed that the mini practice week would focus on 'Pre-Birth children'.

Findings from a number of Serious Case Reviews emphasise the vulnerability of infants to maltreatment and neglect and the high risk of fatality. When agencies are able to anticipate safeguarding risks for an unborn baby, such concerns should be addressed through a pre-birth assessment.

A common finding in the sample of cases of babies subject to a serious case review was that there had been failings in the pre-birth assessment process and, consequently, in the resulting actions. Shortcomings ranged from cases where no pre-birth assessment had been carried out, to other cases where the pre-birth assessment was delayed, over-optimistic or of poor quality.

The aim of the Mini Practice Week is to foster a culture of transparency and mutual learning between our multi-agency partners; frontline staff and managers at all levels and develop a common understanding of:

- What good practice looks like and the journey of improvement required to reach the vision from a multi-agency and multi- disciplinary perspective, in relation to our safeguarding practice with unborn babies and our practice with working with both parents.
- The effectiveness of selected models of intervention within Lambeth (Outlined within Lambeth's 'Heart of Practice')
- The efficiency of local procedures and systems to support and enable good social work and multi-agency practice.

Seven case reviews were completed (pre-audited by independent auditors in Lambeth Children's Social Care). Cases were allocated jointly to a children's social care senior manager and a multi-agency partner. Reflective case discussions with social workers and supervising managers were arranged as part of the mini practice week process, along with phone calls to parents, carers, providers and other partners.

The findings from the mini practice week have proved both insightful and informative regarding our multi-agency practice for unborn babies. A summary of key strengths and areas requiring improvement:

Areas of Strengths	Areas Requiring Improvements
Assessments and Plans were evidenced to be of a 'good' standard when started within the CAT Service.	Equality of Practice: Key planning/ thinking about the diversity of the family, language, religion, cultures, mental health, learning difficulties, emotional and social needs to support effective care planning, risk assessment and ensure children have the best opportunity to remain with their birth families.
Evidence of fathers being approached, considered and consulted as part of the assessment process and care planning in all cases within CAT and FSCP	Tracking of pre-birth children within FSCP Service to ensure our safeguarding practice is robust and timely.
Evidence of partner agencies being very proactive- good safeguarding work evidenced from Midwives with mothers	Escalation, both internal within CSC and from partner agencies was not evidenced to be sufficiently effective.
Evidence of Midwives escalating cases of concerns- although identified not to the sufficient level of management.	Multi-agency working needs to improve with personal advisors in our cases with young mothers
Evidence of good management oversight both within CAT and FSCP in some cases.	The need for greater consistency of management oversight across all managers within FSCP.
	The use of evidence base research within our assessment analysis and planning with unborn babies.

Going forward: a true partnership approach

The Lambeth Safeguarding Children Board has played a critical role in improving the quality of inter-agency work to safeguard children and young people. Over the past three years, it has supported a culture of learning, support and challenge to all those involved in helping and protecting children.

The Children and Social Work Act 2017 has, however, altered requirements about the way in which agencies should work together to safeguard children. The new Working Together requires that the three statutory agencies (health, police and the local authority) review and, where appropriate, make changes to multi agency safeguarding arrangements in their area. We are not now required to have a local safeguarding children's board (LSCB) and areas have correspondingly greater licence to determine how they should organise themselves to support high quality practice and to improve outcomes for children.

The three statutory partners are expected to have greater accountability for delivering high quality safeguarding practice. The Lambeth Safeguarding Partnership will include:

- The Lambeth Safeguarding Children Partnership (LSCP) Executive
- A safeguarding children forum which will bring together statutory and voluntary sector agencies
- An Independent Scrutineer (instead of an Independent Chair)

For a more detailed overview of the arrangements, please visit lambethsaferchildren@org.uk.

These new arrangements 'go live' at the end of September 2019.

Abbreviations

- ASC (Adult's Social Care)
- MASH (Multi Agency Safeguarding Hub)
- MASE (Multi Agency Sexual Exploitation)
- Integrated Referral Hub (Safeguarding 'Front Door')
- DV (Domestic Violence)
- DA (Domestic Abuse)
- FGM (Female Genital Mutilation)
- CCE (Child Criminal Exploitation)
- CSE (Child Sexual Exploitation)
- CP (Child Protection)
- CDOP (Child Death Overview Panel)
- CCG (Clinical Commissioning Group)
- CSC (Children's Social Care)
- IRH (Integrated Referral Hub) – our 'front door' for children's safeguarding referrals
- MARF (Multi Agency Referral Form)
- NFA ('no further action')
- RHI (return home interview)
- TAF (Team Around the Family)
- YPaR (Young People at Risk) – one of our priority areas focusing on ensuring children and young people in Lambeth are free from the risk of CSE, going missing from home, care and/or education, serious youth violence, gangs, county lines and/or radicalization
- YTD (Year to Date)