Report to Children's Services and Education Scrutiny Board

8 January 2024

Subject:	The effectiveness of the Sandwell Children's Safeguarding Partnership's response to serious child safeguarding incidents
Director:	Director of Children and Education (DCS), Michael Jarrett
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1 Recommendations

1.1 That the Board considers and comments upon Sandwell Children's Safeguarding Partnership's (SCSP) compliance to its statutory functions for responding to serious child safeguarding incidents and the procedures in place around Child Safeguarding Practice Reviews;

1.2 That the Board notes the emerging themes, the action and activities undertaken to implement lessons learned and reduce the likelihood of reoccurring incidents.

2 Reasons for Recommendations

2.1 The premise of the Sandwell Children's Safeguarding Partnership (SCSP) sees nothing as more important than children's welfare. Every child deserves to grow up in a safe, stable and loving home. Children who need help and protection deserve high quality and effective support. This requires individuals, agencies and organisations to be clear about their own and each other's roles and responsibilities and how they work

together to safeguard and promote the welfare of all children across Sandwell.

2.2 Whilst it is parents and carers who have primary care for their children, local authorities, working with partner organisations and agencies, have specific duties to safeguard and promote the welfare of all children in their area. The SCSP have specific duties to ensure that there are joint responsibilities encompassing the local multi-agency arrangements for the purposes of safeguarding and promoting the welfare of all children, including the actions to be taken if they believe a child has suffered or is likely to suffer significant harm, through to having robust processes in place following a child related incidents where abuse and/or neglect is known or suspected to be a causal factor, and a child has died or been seriously harmed.

2.3 In compliance with the requirements for undertaking rapid reviews as outlined in Chapter 5 of Working Together 2023, timescales for the statutory review processes are set in this guidance and monitored by the NCSPRP. All Rapid Reviews have been submitted to the NCSPRP within the prescribed 15 working days timescale, with the NCSPRP concurring with the decision of the SLPR panel in 18 of the 20 serious incidents considered.

2.4 Where LCSPRs have been commissioned, these should be completed through to publication within 6 months, however due to other competing processes i.e. criminal and/or coroner's investigations this is not always possible. The SCSP have published 6 of the 13 LCSPRs in full. 3 LCSPRs are currently embargoed awaiting the conclusions parallel proceedings and 3 remain in progress.

2.5 The SCSP framework for undertaking this function is highly regarded both regionally (in shaping the regional guidance and devising a toolkit for undertaking the duties in response to serious safeguarding incidents) and nationally where Sandwell has been referenced as an area of good practice for this function and cited by the NCSPR in their annual report for 2020/21.

3 How does this deliver objectives of the Corporate Plan?

	Best start in life for children and young people The aim and work of the SCSP is about building a strong, competent, confident workforce who children and families are able to trust and rely upon, where practitioners have the skills and expertise to adapt their response to secure engagement by being alert and recognising where parents or carers may not be acting in the best interest of the child or where children may be experiencing abuse, neglect, and exploitation as a result of actions by parents, carers or other individuals in their lives.
	Strong resilient communities With a focus on improving relationships with community groups, the work of the SCSP has a foundation based on approaching families and their wider networks and communities with empathy, respect, compassion, and creativity. Through the use of strengths-based approaches and effective tools to improve working relationships with parents and carers, there is an improving picture of what is working well and how their strengths could support them to effect positive/sustainable change.

4 Context and Key Issues

4.1 Working Together to Safeguard Children abolished Local Safeguarding Children's Boards with the introduction of Local Safeguarding Partnerships (LSPs) in 2018, giving equal responsibilities to 3 statutory agencies (Local Authorities, Police and ICBs) for agreeing the local multi-agency safeguarding arrangements. Sandwell have added a fourth equal statutory partner, Sandwell Children's Trust, who deliver the children's social care functions on behalf of the council. These four key agencies are known locally as Sandwell Children's Safeguarding Partnership (SCSP).

4.2 The four leading partners at SCSP must agree on ways to co-ordinate their safeguarding functions; act as a strategic leadership group in supporting and engaging other partners and stakeholders; and implement local and national learning including from serious child safeguarding incidents, the process for undertaking rapid and local child safeguarding practice reviews and setting out the arrangements for embedding learning across organisations and agencies as defined in Chapter 5 of the recently published Statutory guidance Working Together 2023.

4.3 When a serious child safeguarding incident becomes known, the SCSP must consider whether the case meets the criteria and threshold for a local review. If it is determined that the criteria is met to undertake a local child safeguarding practice review, a serious incident notification and rapid review must take place.

4.4 Serious Child Safeguarding Incidents are defined as cases in which:
a) abuse or neglect of a child is known or suspected and

b) the child has died or been seriously harmed

4.5 Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development, as well as impairment of physical health and/or cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred

4.6 On behalf of the local authority and the SCSP, SCT has the initial duty to notify the DfE, Ofsted, the National Child Safeguarding Practice Review Panel (NCSPRP) and the SCSP of all serious incidents that meet the above criteria.

4.7 A Serious Incident Notification (SIN) must be completed by SCT within 5 working days of becoming aware of the incident and is the catalyst that activates a Rapid Review. This must be undertaken by the elected Sandwell Learning from Practice Reviews panel (SLPR) on behalf of the SCSP and a decision reached as to whether or not the case has the potential for further learning using the following criteria:

1. The case highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
2. The case highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
3. 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
4. The case is one the NCSPRP has considered and has concluded a local review may be more appropriate.

4.8 In considering whether or not further learning is required, the SLPR panel must also have regard to circumstances where:
a) There are causes for concern about the actions of a single agency
b) There has been no agency involvement and this gives cause for concern
c) More than one local authority, police area or ICB is involved, including in cases where families move around
d) The case may raise issues related to safeguarding or promoting the welfare of children in institutional settings.

4.9 The decision of the SLPR panel and the outcome of rapid reviews must be shared with the NCSPRP within 15 working days of receiving the initial SIN.

4.10 Since the inception of the SCSP on 1st April 2019, and up to December 2023, there have been 20 serious child safeguarding incidents across Sandwell which have been referred and scrutinised through the Rapid Review process.

4.11 Of the 20 cases considered by the LPRP, 13 (65%) have met the criteria for further learning and improvement activity, known as a 'Local Child Safeguarding Practice Review' (LCSPR). A breakdown by year is as follows:

Table 1.

Year	Number of Rapid Reviews	Number resulting in LCSPR
2019-20	4	3
2020-21	8	5
2021-22	2	1
2022-23	3	2

2023-24 *current year	3	2

4.12 LCSPRs are intended to identify learning and improvements, both within Sandwell and potentially beyond. Where the NCSPRP have concurred with the decision of the SLPR panel that further learning can be obtained, the SCSP must commission and complete a LCSPR and publish within 6 months unless they consider it inappropriate to do so. In such a circumstance, they must, as a minimum publish the recommendations and actions that are considered appropriate to publish.

4.13 Across the 13 LCSPRs that have been initiated over this period, there are evidential themes that have emerged as categorised under the headings as follows:

4.14 The SCSP have robust systems and structures in place to manage and oversee each stage of its functions in response to serious child safeguarding incidents and have highlighted the above themes based on the findings from reviews in Sandwell.

4.15 For each LCSPR, the SCSP maintains a summary of any recommended improvements to be made by individuals or organisations to safeguard and promote the welfare of children, with action plans clearly outlining what is required of the SCSP and agencies both collectively and

Emerging Theme	Reoccurring in no. of LCSPRs
Under 1s	7/13
Child from Black and minoritised ethnic background	6/13
Mental ill health of parents/carers	10/13
Issue with information sharing/communication	13/13
Neglect	10/13
Core safeguarding procedures/processes *(e.g. application of thresholds, quality of assessments, plan progression)*	10/13
Substance/alcohol misuse (child or parent)	8/13
Domestic abuse	7/13

individually, and by when, and focuses on improving outcomes for children.

4.16 The emerging themes following serious safeguarding incidents as referenced above can be tracked to the activities being undertaken across the SCSP workstreams, and in some areas have been elevated for specific pieces of work (e.g. neglect, pre-birth work, cultural competence).

4.17 Evidence and examples of actions resulting from the learning from reviews are:

- The development of a Cultural Competence Framework and associated training (to be rolled out in early 2024) to support professionals to have greater cultural awareness and sensitivity when engaging with families from all backgrounds;
- dedicated position (2year fixed term) supporting the Early Help Partnership and Sandwell Community Voluntary Organisations (SCVO) in strengthening the community links, roles and responsibilities for safeguarding to improve engagement with families, including families from minoritised backgrounds as influenced by a survey undertaken with young people, parents/carers and professionals;
- development of the Sandwell Unborn Baby Network to identify and provide support at the earliest possible stage to vulnerable pregnant mothers who are not subject to statutory services;
- introduction of the Tackling Neglect subgroup to lead on the partnership strategy, associated training and embedding of the Graded Care Profile 2 assessment tool (GCP2) to better identify and respond to child neglect;
- commissioning by the Domestic Abuse Strategic Partnership of 2 additional workers for women's refuges to provide support to children and families (Family Support Worker and Empowerment and Engagement Co-ordinator);
- support the introduction of the '*Infants Crying is Okay, Never Shake the Baby*' (ICON) programme across Sandwell to help new parents cope with crying babies in the early days of parenthood;
- strengthening of links between the work of SCSP and the Child Death Overview Panel, including representation at all Joint Agency

Response meetings following the sudden unexpected death of a Sandwell child (this is unique to the Black Country);

- extend the SCSP Multi agency Training catalogue, adding specific courses such as 'Hidden Men.' Webinars have been introduced upon publication of LCSPRs to share the learning with frontline practitioners and first line managers. Learning from all reviews has had a significant influence on updating of existing courses such as Core Working Together and introducing new materials to support practitioners, such as 'Techniques for supporting with challenging conversations as well as use of language/labelling (e.g. moving away from terms such as 'disguised compliance' and 'hard to reach families).

5 Implications

Resources:	There are no specific financial implications arising from this report. There is dedicated capacity to support all functions related to the statutory review process and SLPR functions via the Practice and Quality Review Officer role funded from Partners' annual financial contributions.
Legal and Governance:	In accordance with Working Together 2023, LCSPRs must be published in full (unless there are compelling reasons not to do so). Copies of LCSPRs are ratified by the SCSP and reports are shared with the Chief Executive of Sandwell MBC, Chief Executive of Sandwell Children's Trust, Leader of the Council, DfE, Ofsted, Secretary of State and NCSPRP, Police and Crime Commissioner and the Integrated Commissioning Board LCSPR reports are also made publicly available on the SCSP and NSPCC websites.
Risk:	There are no risk implications arising from this report. Although, where LCSPRs are in the public domain there is the potential for reputational risks. Mitigation

	strategies are always considered throughout the publication planning process.
Equality:	This report is for information only and the actions contained within the Board's plan will have their own Equality Impact Assessment (EIA) as required.
Health and Wellbeing:	At times when children suffer serious injuries or death as a result of abuse or neglect, understanding not only what happened but also why it happened can help prevent reoccurrences, improve our responses in the future and support partners in keeping children safe which underpins their right to have good health and wellbeing.
Social Value:	As a partnership our vision is for all children to be safe at home and in their communities, where they are loved, cared for and have the stability to grow healthily and to achieve their ambitions. The values which underpin the work of the SCSP are captured in the statements below: We will put children at the heart of what we do Together we will make Sandwell safer for children We will always listen, learn and improve We will have respect for each other and recognise and respond positively to difference We will be positive about the future, and have aspirations for Sandwell's children, be solution focused, committed and innovative.
Climate Change	There are no direct associated implications in relation to climate change.
Corporate Parenting	This report and associated activity of the safeguarding partnership board is considered at the Corporate Parenting Board as appropriate.

6 Appendices:

2022/23 Sandwell Children's Safeguarding Partnership Annual Report

7. Background Papers

Working Together 2023