Public Document Pack

Children and Families Scrutiny Panel

Thursday, 27th January, 2022
at 5.30 pm

PLEASE NOTE TIME OF MEETING

Virtual

In light of the current Covid Omicron variant surge this meeting will now be held virtually via Microsoft Teams. As a matter of law to be a legally constituted meeting it must be held physically. As it is not considered reasonable to do that at the moment it is being treated as a consultation meeting. Council officers will then take decisions under delegated powers to decide on the matters on the committee's agenda after having due regard to the committee's views and recommendations.

Members

Councillor Guthrie (Chair)
Councillor Bell
Councillor Laurent
Councillor Mitchell
Councillor Paffey

Appointed Members

Nicola Brown, Primary Parent Governor
Catherine Hobbs, Roman Catholic Church
Francis Otieno, Primary Parent Governor
Vacancy - Secondary Parent Governor
Rob Sanders, Church of England

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PUBLIC INFORMATION

CHILDREN AND FAMILIES SCRUTINY PANEL

Role of this Scrutiny Panel: To undertake the scrutiny of Children and Families Services in the City, including the Multi Agency Safeguarding Hub (MASH), Early Help, Specialist & Core Service, looked after children, education and early years and youth offending services, unless they are forward plan items. In such circumstances members of the Children and Families Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.

Terms Of Reference:-

Scrutiny of Children and Families Services in the City to include:

- Monitoring the implementation and challenging the progress of the Council's action plan to address the recommendations made by Ofsted following their inspection of Children's Services in Southampton and review of Southampton Local Safeguarding Children Board (LSCB) in July 2014.
- Regular scrutiny of the performance of multi-agency arrangements for the provision of early help and services to children and their families.
- Scrutiny of early years and education including the implementation of the Vision for Learning 2014 – 2024.
- Scrutiny of the development and implementation of the Youth Justice Strategy developed by the Youth Offending Board.
- Referring issues to the Chair of the LSCB and the Corporate Parenting Committee.

Public Representations

At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

Access – access is available for the disabled. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Mobile Telephones:- Please switch your mobile telephones to silent whilst in the meeting

Use of Social Media:- The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting.

By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.

Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.

Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Business to be Discussed

Only those items listed on the attached agenda may be considered at this meeting.

QUORUM The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

Rules of Procedure

The meeting is governed by the Council Procedure Rules and the Overview and Scrutiny Procedure Rules as set out in Part 4 of the Constitution.

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take

Southampton: Corporate Plan 2020-2025 sets out the four key outcomes:

- Communities, culture & homes - Celebrating the diversity of cultures within Southampton; enhancing our cultural and historical offer and using these to help transform our communities.
- Green City - Providing a sustainable, clean, healthy and safe environment for everyone. Nurturing green spaces and embracing our waterfront.
- Place shaping - Delivering a city for future generations. Using data, insight and vision to meet the current and future needs of the city.
- Wellbeing - Start well, live well, age well, die well; working with other partners and other services to make sure that customers get the right help at the right time.

Dates of Meetings: Municipal Year

2021	2022
17 June	27 January
22 July	31 March
30 September	
4 November	
25 November	

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or

b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having an 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

1 APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

CONSULTATION MEETING

In light of the current Covid Omicron variant surge this meeting will now be held virtually via Microsoft Teams. As a matter of law to be a legally constituted meeting it must be held physically. As it is not considered reasonable to do that at the moment it is being treated as a consultation meeting. Council officers will then take decisions under delegated powers to decide on the matters on the committee's agenda after having due regard to the committee's views and recommendations.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING) (Pages 1 - 12)

To approve and sign as a correct record the Minutes of the meetings held on 30 September 2021 and 4 November 2021 and to deal with any matters arising, attached.

7 THEMATIC SERIOUS CASE REVIEW: NON-ACCIDENTAL INJURY (Pages 13 - 74)

Report of the Independent Chair of the Southampton Safeguarding Children

Partnership briefing the Panel on the Non-Accidental Injury Thematic Serious Case Review, the recommendations and progress to date.

8 SOUTHAMPTON SAFEGUARDING CHILDREN PARTNERSHIP ANNUAL REPORT 2020/21 (Pages 75 - 104)

Report of the Independent Chair of the Southampton Safeguarding Children Partnership (SSCP) requesting that the Panel receive the SSCP Annual Report to inform agenda planning and questioning.

9 QUALITY ASSURANCE BRIEFING (Pages 105 - 182)

Report of the Executive Director for Children and Learning recommending that the Panel note the quality assurance arrangements in place for the Southampton Children and Learning Service.

10 CHILDREN AND LEARNING – PERFORMANCE (Pages 183 - 208)

Report of the Service Director - Legal and Business Operations, recommending that the Panel consider and challenge the performance of Children and Learning Services in Southampton.

11 MONITORING SCRUTINY RECOMMENDATIONS (Pages 209 - 214)

Report of the Service Director - Legal and Business Operations, enabling the Panel to monitor and track progress on recommendations made at previous meetings.

Wednesday, 19 January 2022 Service Director – Legal and Business Operations

To approve and sign as a correct record the Minutes of the meetings held on 30 September 2021 and 4 November 2021 and to deal with any matters arising.

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SOUTHAMPTON CITY COUNCIL
CHILDREN AND FAMILIES SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 30 SEPTEMBER 2021

Present: Councillors Guthrie (Chair), Bell, Laurent, Mitchell (except agenda items 1-8) and Dr Paffey
Appointed Members: Rob Sanders

15. **APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)**

The apologies of the Cabinet Member for Education – Councillor J Baillie were noted.

16. **STATEMENT FROM THE CHAIR**

The Chair noted that the Executive Director of Wellbeing – Children and Learning had invited members to contribute their thoughts on the draft Children and Young Peoples Strategy as part of the consultation process.

17. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the minutes of the meeting held on 17 June 2021 be approved and signed as a correct record.

18. **EXCLUSION OF THE PRESS AND PUBLIC - EXEMPT PAPERS INCLUDED IN THE FOLLOWING ITEM**

The Chair moved that if members did not have any specific matters for consideration in respect of the exempt Appendices 2, 3, and 5 the following agenda item could be considered without disclosing information that was subject to an obligation of confidentiality and therefore it would not be necessary to exclude the press and the public from the following agenda item.

RESOLVED that the Panel would consider the following agenda item without reference to the exempt appendices and therefore the press and the public would not be excluded from the following agenda item.

19. **EDUCATIONAL ATTAINMENT IN SOUTHAMPTON**

The Panel considered the report of the Service Director, Legal and Business Operations, which set out the provisional 2020/21 Key Stage exam results in Southampton.

The Cabinet Member for Children's Social Care, Councillor P Baillie; and Southampton City Council Officers, Rob Henderson, the Executive Director Wellbeing (Children and Learning); and Clodagh Freeston, Service Manager, Education Strategy, Planning, and Improvement; were present and, with the consent of the Chair, addressed the Panel.

In discussions with the officers, the Panel noted the following:

- The Oasis Academies had not published or shared their exam result data with the Local Authority.
- Periods of school closure due to the coronavirus pandemic had impacted the implementation of measures to improve performance and had also impacted on the availability of data to measure improvement. The Progress 8 data was not available for evaluation of the exam results in relation to the intake.
- Local Authority Officers visited all schools maintained by the Council on a regular basis to ensure that schools offer sufficient support and used funding in a way that provided good value. Whilst it was acknowledged that children's education had been affected by the pandemic, Officers have found that schools have been able to flex to ensure that the curriculum was as wide and varied as possible and children were being assessed and supported to help them make adjustments to progress in their education.
- Sharing best practice was a function of the education forums operating in the city.
- Data on school attendance had not yet been submitted by schools.
- The Council monitored and tracked school admissions and pupil moves closely, all reports of off rolling were investigated and if evidence of off rolling was found the schools were challenged.
- There had been an increase in the number of children Electively Home Educated.

RESOLVED:

1) That the Executive Director would engage with the leadership of Oasis Community Learning to encourage them to reverse their policy not to share school attainment data with local authorities.
2) That, if available, the Panel would be provided with an overview of the disparity between KS4/5 projected and awarded grades at Southampton schools and colleges.
3) That the latest available school attendance data for Southampton schools would be circulated to the Panel.
4) That available KS4 attainment data for Southampton children who were home educated would be circulated to the Panel.
5) That, to develop understanding of the attainment of Southampton's care experiencing children and young people, the Virtual School Annual Headteacher Report would be circulated to the Panel.

20. **POST 16 PROVISION, PARTICIPATION AND NEET**

The Panel considered the report of the Service Director, Legal and Business Operations, which set out the provisional 2020/21 Key Stage exam results in Southampton.

The Cabinet Member for Children's Social Care, Councillor P Baillie; and Southampton City Council Officers, Rob Henderson, the Executive Director Wellbeing (Children and Learning); and Clodagh Freeston, Service Manager, Education Strategy Planning, and Improvement; were present and, with the consent of the Chair, addressed the Panel.

In discussions with the officers, the Panel noted the following:

- On pg. 27 of the report pack, it stated that 75% of students attending City College come from disadvantaged backgrounds, however the correct figure was in fact approx. 40%-50%.
- Whilst some of the 6th Form provision in the City was outstanding the funding for 6th form provision means that small 6th forms in schools were not very economically viable and were therefore not always delivering the quality of 6th Form provision our children need.
- Merging provision for post 16 education had been explored in the past and the Department for Education had carried out another review of provision in the area and were due to publish the review in 2022. However, the situation was complex, and it had proved difficult to achieve the investment required for improvement.
- The Council had engaged with the Department for Education and local further education providers as a strategic partner to influence the development of a road map that would provide a long-term sustainable solution for post 16 provision in the City.
- There was a capital programme for Special Educational Needs and Disability (SEND) which included post 16 provision and focussed on increasing capacity in local schools and special provision within the city.
- The pandemic had exacerbated the issue – but some cities, such as Bristol and Coventry had seen NEET rates fall in 2021. The Panel questioned what had happened in these cities that had not happened in Southampton?
- Analysis would be carried out to understand why measures implemented to improve engagement had been successful for young people in Year 12, but this had not filtered through to Year 13.
- The number of young people whose destination was unknown was high and included young people who may have moved out of the City and cannot be contacted.
- Three Engagement Workers had been employed to support young people who were Not in Education, Employment or Training (NEET) to be ready to engage, to deliver targeted work to prevent young people becoming NEET and to help and to help track down young people whose destination was unknown.

RESOLVED:

1) That analysis would be undertaken of Post 16 performance to identify the reasons behind the attainment gap, particularly the achievement of A*/A grades, between Southampton Further Education providers and national performance.
2) That, research to learn from best practice in reducing NEET levels, would include liaison with Bristol City Council and Coventry City Council to identify how they had been able to reduce NEET levels during the pandemic.
3) That analysis would be undertaken to improve our understanding of the reasons behind the rise in NEETs between Yr12 and Yr13 in Southampton.
4) That the Panel would be provided with data which enabled comparisons to be made between the level of 'unknowns' in Southampton and other areas.

21. **CHILDREN AND LEARNING - PERFORMANCE**

The Panel received the report of the Service Director, Legal and Business Operations, which recommended that the Panel considered and challenged the performance of Children and Learning Services in Southampton.

Robert Henderson, Executive Director Wellbeing (Children and Learning), Southampton City Council; and, Julian Watkins, Service Manager, Children and Learning Department, Southampton City Council were present and, with the consent of the Chair, addressed the Panel.

In discussions with the officers, the Panel noted the following:

- Demand at the front door remained high, despite school holidays. August figures were 20% higher than previous year.
- The number of Section 47 enquiries was low at 59 in August. A restorative approach had been adopted which worked with families to help them work out who they could rely on for support in their community rather than relying solely on services provided from an external source. This had reduced the number of cases escalating to Section 47 when an assessment plan was already in place for a family or a referral to an early help service would be more appropriate.
- The Multi Agency Safeguarding Hub had dealt with 100% of referrals within 1 working day
- Southampton was part of a voluntary Unaccompanied Assylum Seeking Children (USAC) scheme along with 17 other Local Authorities, which includes guidance that 0.07% of 0-17 population should be USAC. Southampton had so far received less than that number and was capable of meeting the challenges of receiving more USAC if necessary.
- Southampton had received a cohort from the Afagan Resettlement Scheme, these families had been accommodated and did not include any UASC.
- Sunderland's Children's Services was rated as Outstanding by Ofsted following incremental improvements from an inadequate judgement in 2015. The situation and background of different councils made it difficult to draw direct comparisons, however the Destination 22 review of the children and families service in Southampton included similar improvements that had been successful in Sunderland.
- Positive news was reported regarding the recruitment of Assistant Team Managers within each of the six Protect and Court Teams and Newly Qualified Social Workers joining from September

RESOLVED:

1) That feedback would be provided on the relatively high levels of missing children in August 2021 in comparison to August 2020. (EH5-QL)
2) The number of Single Assessments completed had been low compared to other similar areas. As posed by the commentary (EH3), the Panel requested clarity as to whether the figure was a reflection that our Early Help offer was working well to prevent risk with families escalating, or, that professionals were not aware of some families in need and were therefore not referring them into the service.

22. **MONITORING SCRUTINY RECOMMENDATIONS**

The Panel received the report of the Director, Legal and Business Operations which enabled the Panel to monitor and track progress on recommendations made at previous meetings.

The Panel noted that all the requested information had been provided and utilised to inform the discussion of the agenda items.

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SOUTHAMPTON CITY COUNCIL
CHILDREN AND FAMILIES SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 4 NOVEMBER 2021

Present: Councillors Guthrie (Chair), Bell, Laurent and Dr Paffey

Apologies: Councillors Mitchell
Appointed Members: Catherine Hobbs and Rob Sanders

23. **APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)**

The apologies of Councillor Mitchel and Appointed Member Rob Sanders were noted.

Appointed Member Claire Rogers had stood down from sitting on the Panel.

24. **KEY PERFORMANCE INDICATORS - SPECIAL EDUCATIONAL NEEDS AND DISABILITIES**

The Panel noted that the Service Manager - Special Educational Needs and Disability, Tammy Marks was unable to be present in person due to reasons relating to the transmission and incidence of coronavirus.

RESOLVED that consideration of this item would be deferred to the next meeting of the Panel.

25. **CHILDREN AND ADOLESCENT MENTAL HEALTH SUPPORT - CHILDREN LOOKED AFTER**

The Panel considered the report of the Chair of the Children and Families Scrutiny Panel, which recommended that the Panel considered the appended briefing paper on mental health support for children and adolescents in Southampton and discussed the content with the invited guests.

Robert Henderson, Executive Director of Children and Learning, Southampton City Council; Alasdair Snell, Operations Director, Child and Family Services West - Solent NHS Trust; and Chantal Homan, Service and Quality Manager, Solent NHS Trust were present and, with the consent of the Chair, addressed the Panel.

In discussions with the officers, the Panel noted the following:

- Factors which influenced the higher rate of mental health needs in the City were the high level of deprivation and the high level of domestic abuse in the City.
- Children needed services that delivered more than just the Children and Adolescent Mental Health Support Service (CAMHS) and investment in strong partnership working was required.
- The I-Thrive framework was a national approach looking at the whole system of intervention to provide a forum to look at what role everyone can play in the prevention and early promotion of mental health and well-being.

- Mental Health and Wellbeing services had been developed to include a broader range of pathways for support in addition the specialist support of the CAMHS service, which included Mental Health Support Teams in schools, a specialist Building Resilience and Strength service and workshops with parents and carers to encourage them to think about how they can support young people and family outreach services as research had shown that intervention was most effective when the whole family received support.
- The Mental Health Support Teams in Schools would cover 90% of the whole city's school and college population by January 2022, their mandate would be to promote a whole school approach to mental health and increase the tool kit for teachers through a solution focussed reflective forum.
- Autism and ADHD required more that just a CAMHS assessment and support service. Pathways had been streamlined to make them more effective at getting the right support to children based on need, by reinforcing the focus on early intervention and providing schools with the level of expertise to provide support early and prevent the needs from escalating.
- There had been investment in dedicated resources for meeting the emotional and mental health needs of children who are looked after, this included staff in specialist CAMHS teams dedicated to working with Looked After Children as well as specialist CAMHS practitioners based within the Children's Services Teams.
- There were also workstreams to:
    - develop a Shared Training and Assessment for Wellbeing (STrAWB) initiative,
    - review the consultation model to ensure the service was accessible to teachers, carers, social workers, and children alike
    - develop an emphasis around emotional and mental health with children and families in Strength and Difficulties Questionnaires that were used in assessments by Children's Services.
    - develop a digital offer for self-lead support

RESOLVED: That, reflecting the overview of the innovative STrAWB initiative that was referenced in the Virtual Headteachers Annual report, the Panel requested details relating to how this initiative would work with other services that support the mental health of Southampton's care experienced children and young people.

26. **CHILDREN'S AND LEARNING SERVICE IMPROVEMENT PLAN**

The Panel received the report of the Executive Director of Children and Learning, which provided the Panel with and update on progress against the revised Children and Learning Improvement Plan.

Southampton City Council Officers, Robert Henderson, Executive Director for Children and Learning; Steph Murray, Deputy Director for Children and Learning: and Jo Feeney, Performance Manager for Children and Learning
were present and, with the consent of the Chair, addressed the Panel.

In discussions with the officers, the Panel noted the following:

- The improvement plan was clearly gaining momentum, with some good partnership working and governance from the Improvement Board. The key

priorities of the improvement plan were included in meetings with Service Leads and Team Managers.

- A new set of Key Performance Indicators (KPI) had been developed that were bench marked with the national statutory indicators and will track the journey of the child from referral through to fostering or adoption or leaving care.
- Some of the new KPI's would have to wait for Care Director to go live as PARIS doesn't have the capacity to capture that data. A new performance infographic tool was also being developed, which may include digital access to the data.
- The new set of KPI's would be utilised in assurance audits and stretch and challenge sessions with Service Leads, both of which were being carried out on a weekly basis.
- Care director would be launched in Jan- April, allowing any structural changes from the Destination 22 consultation to be incorporated.
- The new audit and performance reports would be developed taking into consideration feedback and comments from the Panel.
- Feedback from the Support and Challenge advisor to the service had indicated the service was moving in the right direction.
- This year the service had focused on getting the staffing structure in order and had embarked on the Destination 22 consultation.
- Next year the service would be focused on getting the leadership and management team in place to provide the strategic drive to improve delivery.

RESOLVED: That, to provide greater context to the Children's Social Care reduction model and targets, the Panel would be provided with information that presented the data and performance trends over a longer period.

27. **MONITORING SCRUTINY RECOMMENDATIONS**

The Panel considered the report of the Director, Legal and Business Operations which enabled the Panel to monitor and track progress on recommendations made at previous meetings.

The Panel noted that all the requested information had been provided and utilised to inform the discussion of the agenda items.

RESOLVED that regarding Post 16 Education, Employment and Training Provision and Participation, the Panel requested a precis of the key findings from the Not in Employment, Education or Training (NEET) conversation with Bristol City Council and Coventry City Council.

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DECISION-MAKER:	CHILDREN AND FAMILIES SCRUTINY PANEL
SUBJECT:	THEMATIC SERIOUS CASE REVIEW: NON-ACCIDENTAL INJURY
DATE OF DECISION:	27 JANUARY 2022
REPORT OF:	INDEPENDENT CHAIR OF THE SOUTHAMPTON SAFEGUARDING CHILDREN PARTNERSHIP

CONTACT DETAILS				
Independent Chair	**Title**	**Independent Chair of the Southampton Safeguarding Children Partnership**		
	Name:	**Derek Benson**	Tel:	**023 8083 2468**
	E-mail	**Derek.Benson@hants.gov.uk**		
Author:	**Title**	**Southampton Safeguarding Partnership Manager**		
	Name:	**Debbie Key**	Tel:	**023 8083 2468**
	E-mail	**Debbie.key@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
BRIEF SUMMARY		
To brief the Panel on the Non-Accidental Injury Thematic Serious Case Review, the recommendations and progress to date.		
RECOMMENDATIONS:		
	(i)	That the Panel note the attached Serious Case Review Report, and Partnership Response, and discuss progress against the endorsed recommendations with invited representatives from Southampton Safeguarding Children Partnership's statutory safeguarding partners.
REASONS FOR REPORT RECOMMENDATIONS		
1.	In line with statutory guidance the Local Children Safeguarding Board (now known as the Southampton Safeguarding Children Partnership) in March 2018 commissioned a serious case review into the effectiveness of multi-agency working in safeguarding regarding three infants. Reviews such as these are not about apportioning blame. They are about learning. The report author has made a number of recommendations which have been accepted and endorsed by the Southampton Safeguarding Children Partnership. The Panel are asked to scrutinise progress on implementing the endorsed recommendations.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Criteria met for Serious Case Review	
DETAIL (Including consultation carried out)		

3.	The Non-Accidental Injury Thematic Serious Case Review and Partnership Response were published on 25th November 2021.
4.	The Thematic Serious Case Review considers the circumstances of three infants. Two were seriously harmed and one died. Due to the similarities in the age of the babies, the background of their parents and the timespan of the incidents occurring it was decided to consider the cases together.
5.	The Thematic Serious Case Review, attached as Appendix 1, identifies the findings, learning and recommendations. There is also good practice noted within the report.
6.	The Partnership Response, attached as Appendix 3, details the recommendations and the actions / progress made.
7.	The decision to publish the Thematic Serious Case Review was made by the independent chair of the partnership, in consultation with the statutory safeguarding partners (NHS Southampton City Clinical Commissioning Group, Hampshire Constabulary and Southampton City Council). The Department for Education and National Child Safeguarding Practice Review Panel were notified prior to publication as required. The National Panel, in their feedback to the SSCP considered the report to be a good example of a high quality review.
8.	Recommendations and agency activity are monitored on behalf of the Safeguarding Children Partnership through the Serious Incident and Learning Group. Actions for the SCC Children and Learning Service will also be monitored through the Improvement Plan, which provides single agency assurance.
RESOURCE IMPLICATIONS	
Capital/Revenue	
9.	None at this stage
Property/Other	
10.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
11.	Statutory Guidance, “Working together to safeguard children and young people 2015” and subsequent version 2018.
Other Legal Implications:	
12.	None
RISK MANAGEMENT IMPLICATIONS	
13.	The Serious Case Review is about improving practice and identifying learning opportunities to reduce the risk of such events re-occurring.
POLICY FRAMEWORK IMPLICATIONS	
14.	The recommendations and learning from this report are important in achieving better outcomes for children in need of safeguarding in Southampton.

	The 2021-2025 Corporate Plan sets out the following regarding wellbeing in the city: “We want a city in which people can start well, live well, age well, and live happy and fulfilling lives. We will be a city that prevents and intervenes early, promotes wellbeing, and allows people to live independently for longer, enjoying their lives and all our great city has to offer.”

KEY DECISION?	**No**	
WARDS/COMMUNITIES AFFECTED:	All	
SUPPORTING DOCUMENTATION		
Appendices		
1.	SSCP Serious Case Review - Overview Report.	
2.	SSCP 6 Step Briefing	
3.	SSCP Partnership Response – Thematic Review – Non Accidental Injury	

Documents in Members’ Rooms

1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?		**No**
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	

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Serious Case Review

Overview Report

A Thematic Review Concerning the Non-Accidental Injury of Three Infant Children

Lead Reviewer
Moira Murray
November 2021

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1. Introduction

1.1.1 On the recommendation of the Serious Case Review Group, a decision was taken in March 2018 by the Independent Chair of the Southampton Safeguarding Children Board (hereafter referred to as the Southampton Safeguarding Children Partnership) to commission a Serious Case Review into the death of one baby and serious injuries to two others. All three cases were considered individually by the Serious Case Review Group, which decided that they met the criteria for Serious Case Review under Working Together 2015[1].

1.1.2 All the babies were male and at the time of the injuries and death, were aged between 6 to 10 weeks. Because there were similarities in the age and background of their parents, and due to all three incidents occurring within a two-month period, in order to maximise the opportunity for learning and improvement of professional practice, it was decided that it would be appropriate to consider all three cases together.

Purpose

1.1.3 This Serious Case Review[2] is a thematic review with an analysis of common issues concerning non-accidental injury to babies whose parents were teenagers or young adults. The review is presented as one report, which will also include an assessment of particular circumstances pertinent to each individual case.

2. Who were the three babies?

Circumstances leading to the commissioning of this Serious Case Review

2.1.1 For the purposes of anonymity, the three babies subject to review are known as:

- Baby Connor
- Baby Danny
- Baby Ethan

2.1.2 **Baby Connor** was born in December 2017 and died at the age of six weeks in February 2018.

2.1.3 At the time of Baby Connor's death, he was living with Mother in a flat, which was part of a supported, independent living unit for parents and babies. It was not a Mother and Baby Unit and was not staffed 24 hours a day. Partners were allowed to visit 3 nights a week, however it is known that Father may have been residing at the flat with Mother. The Unit where Baby Connor was living was well known to Police because of concerns about residents engaging in parties, drug and alcohol use and anti-social behaviour.

[1] All three incidents occurred in January or February 2018.
[2] Known as Child Practice Safeguarding Reviews, Working Together 2018

2.1.4 Police were called by ambulance staff attending Baby Connor early in the morning of 11 February 2018. On arrival Baby Connor was not breathing and paramedics were undertaking CPR. Bruising was noted to his legs and arms, but primarily to his thighs and under his arms. Baby Connor was taken to Southampton General Hospital but was declared deceased. A post-mortem examination found that he had suffered bilateral and complex fractures to the skull, as well as other fractures to his leg and collar bone.

2.1.5 On 21 December 2018, Father was convicted of murder and sentenced to life imprisonment. Mother was convicted of child cruelty and sentenced to 30 months imprisonment. Father was aged 17 at the time Baby Connor died and Mother was 19 years old.

2.1.6 **Baby Danny** was born in October 2017. When he was 10 weeks old, on an evening in early January 2018 Police were contacted by Children's Social Care Out of Hours Service to inform them that they had been called to attend Southampton General Hospital. Baby Danny had been brought into the hospital that morning by ambulance. Father reported that he had given Baby Danny his feed early in the morning and shortly afterwards he had struggled to breath and became floppy.

2.1.7 On arrival at hospital Baby Danny was no longer floppy and presented as a well-baby, however further examination revealed swelling to the fontanel, which indicated swelling to the brain. A CT scan revealed bi-lateral retinal haemorrhaging and a subdural hematoma. There were no other signs of external injuries.

2.1.8 Prior to his birth Baby Danny was subject to Child Protection Planning under the category of neglect. He was deemed to be at risk of significant harm due to concerns in relation to Mother's mental ill heath, self-harm, volatile behaviour and unpredictability.

2.1.9 Baby Danny is now placed with foster carers on a Special Guardianship Order. The CPS decided that no charges should be brought against his parents.

2.1.10 **Baby Ethan** was born in October 2017. In January 2018, when he was 10 weeks old, he was taken to the GP Surgery by his parents. During a medical examination, Baby Ethan was found to have bruises and marks all over his body (25 in all). These injuries were considered to be non-accidental. Police and Children's Social Care attended the surgery and Mother and Father were arrested.

2.1.11 On arrival at Southampton General Hospital, in addition to the bruising, a skeletal survey revealed that Baby Ethan had suffered fractures to the proximal and distal metaphyses of the left tibia.

2.1.12 On discharge from hospital Baby Ethan was placed with foster carers. His parents were charged with causing or allowing serious injury to a child. Father was convicted of this offence and was sentenced to a term of imprisonment. Mother was acquitted.

3. The Process of the Serious Case Review

3.1.1 The Terms of Reference, purpose, methodology for the review and details of the Lead Reviewer can be found in Appendices 1 - 3.

Practitioner Event

3.1.2 A practitioner event was held on 3 April 2019. Prior to arranging the event, the Police and Crown Prosecution Service were contacted to ensure that by holding such an event any outstanding criminal proceedings would not be compromised. Confirmation was received that the event could proceed, and 20 practitioners attended. The purpose of the event was to consider key questions and themes arising from the review and to provide an opportunity for those attending to reflect on events, professional practice and to assist the Lead Reviewer in forming her analysis of the issues arising from this case.

3.1.3 The event proved helpful to the Lead Reviewer and the consensus from those attending was that it proved useful and beneficial to their understanding of the cases and events leading to the death and serious injury of the three babies.

3.1.4 The Lead Reviewer would like to express her thanks to all those who attended the event and who contributed to this Serious Case Review. Most especially, the assistance provided by the Southampton Safeguarding Partnership support staff, which ensured that the event and the review process as a whole was smooth, efficient and professional.

3.2 Scope and Terms of Reference

3.2.1 The full Terms of Reference and Scope for the Review can be found at Appendix 1.

3.2.2 **The time period under review for each child is:**

Baby Connor: 11/05/2017 -11/02/2018

Baby Danny: 10/03/2017 – 6/01/2018

Baby Ethan: 4/04/2017 – 10/01/2018

3.2.3 The start date for each review is the date the Mother's pregnancy became known to agencies. The end date is the date of the death/injury to the child.

Analysis issues

3.2.4 This review will consider the issues that could have a bearing on the circumstances of these cases and will include:

- Support offered to young parents
- Assessment of parenting skills and risk to the unborn baby
- Impact of mental health issues, self-harming behaviour and substance misuse on parenting capability
- Impact of lack of good parenting experiences on young parents
- Impact of homelessness
- Anger management and domestic abuse
- Robustness of decision making concerning the child protection process
- Evidencing of the child's lived experience within the family
- Over optimism on the part of professionals as to the parents' capacity to care
- Involvement of Police and Criminal Justice.

3.3 Involvement of the Families

3.3.1 Statutory Guidance: Working Together to Safeguard Children (2015), requires that families should be invited to contribute to a Serious Case Review. Southampton Safeguarding Children Partnership informed the families in October 2018 that a Serious Case Review was being undertaken. Only Baby Danny's parents met with the Lead Reviewer. Due to the Covid Pandemic the meeting took place virtually in November 2020. The meeting proved helpful to the review and the views of the parents are reflected in the report. The Lead Reviewer would like to thank the parents for taking the time to meet with her and for talking about Baby Danny.

Developing a picture of the lives of Baby Connor, Baby Danny and Baby Ethan

4.1.1 The purpose of this section of the review is to provide a background history of each baby and his parents. Key events for each child are included and evidence of their lived experience within the family. Relevant information concerning the background of each family, which falls outside the period under review is also included.

4.1.2 The information included in the report is taken from documentation provided by agencies participating in the review. Baby Danny is an exception, as when interviewed, his parents provided their views to the Lead Reviewer on the way in which agencies worked with them, as well as some additional information concerning themselves and Baby Danny. The views of Baby Danny's parents are reflected in the sections of the report concerning this child.

Baby Connor
Mother

4.1.3 It is believed that Baby Connor's parents had been in a relationship when Mother was almost 17 and Father was just 16. When she became pregnant, Mother was living at home with Maternal Grandmother and her two younger siblings. Maternal Grandmother was supportive of the pregnancy.

4.1.4 There had been some previous concerns about Mother, however, Children's Social Care's main focus of involvement was with Mother's younger sibling, who had special needs.

4.1.5 When Mother was 12 years old, she attended the Emergency Department (ED) having taken an overdose following an argument with Maternal Grandmother. She was admitted overnight and assessed as not having mental health concerns. Six months later, in April 2012, Mother attended the ED again. She was drunk and was admitted overnight. A safeguarding proforma was completed by the hospital and having been assessed by a paediatrician and CAMHS, Mother was discharged.

4.1.6 In April – June 2014 Mother was not attending school due to bullying and low self-esteem and there was also concern that she may have been subject to grooming for the purpose of Child Sexual Exploitation. This was investigated by Children's Social Care and Maternal Grandmother gave assurance that this was not the case. A Strategy Discussion took place, but no further action resulted.

4.1.7 Children's Social Care was contacted by ED staff in March 2016, when Mother and Father were admitted with smoke inhalation following a house fire at Paternal Grandmother's flat, whilst she was not in attendance. They escaped serious injury having been rescued by firefighters. At the time of her admission to hospital, it was noticed that Mother had a large bruise to her upper left arm and multiple bruises to lower legs. When asked about the bruising Mother said she couldn't remember how it had happened and that all was fine. Maternal Grandmother expressed her concern about the relationship with Father.

4.1.8 Mother's relationship with Father was volatile and there were concerns that she was subject to domestic abuse. Police had recorded three incidents in 2016 which were domestic abuse related involving Mother and Father. They were all recorded as verbal domestic arguments and a Child and Young Person Report (CYPR), safeguarding notification was submitted on each occasion.

4.1.9 In 2017, Maternal Grandmother and the family were an open case to Children's Social Care. This was because of concerns about the significant special needs of Mother's 13 year old sibling, and had at times been violent towards herself and Mother.

4.1.10 When she was 7 weeks pregnant Mother booked for midwifery care and it was recorded that it was "*an unplanned pregnancy but happy, Boyfriend supportive, will live at home."* (Source: Primary Care IMR). Due to the age of the parents, care

was completed by East NEST (Needing Extra Support Team) and a referral was made to both the Family Nurse Partnership (FNP) and the Hospital Maternity Safeguarding Team. During the antenatal period there were no missed appointments and no concerns were raised concerning Mother's presentation or appropriateness at appointments. Father was present for some of the antenatal appointments. Mother was said to be emotionally well during pregnancy and in the postnatal period.

4.1.11 In August 2017, the first visit was undertaken by the Family Nurse. At the time Mother and Father were living with Maternal Grandmother, her stepfather and siblings. Children's Social Care had supported a referral to housing for Mother to secure her own accommodation, because of the risk presented to Mother and her unborn child from her sibling. The FNP recorded excellent engagement by Mother throughout her pregnancy and both she and Father appeared to be excited about the baby, had prepared well for the arrival, showed good insight into the risks that Mother's younger sibling might pose and was keen to secure her own accommodation, although they were also aware that this was a 'big step'. (Source: Solent NHS Trust)

4.1.12 By mid-November 2017, Mother was residing at a supported accommodation unit for young parents. Father was noted to be considering an apprenticeship. In mid-December two appointments with the Family Nurse were cancelled and when a meeting did take place in January 2018, 4 days after Baby Connor's birth, at the parents request, it was in a café. It was known by the Family Nurse that Father was residing at the young parent accommodation unit.

4.1.13 During the following weeks until the death of Baby Connor, the Family Nurse attempted six visits, but only managed to gain access to him and the parents on three occasions. The last visit taking place just over a week before he died, by which time the family had moved to another supported, independent living unit for parents and babies. Visits were cancelled by Mother, or the Family Nurse could not gain access to the property, nor could contact be made with Mother by phone. When the Family Nurse did gain access, no concerns were recorded about Baby Connor's care. During the last visit, it was noted that Mother was tired, Baby Connor was more unsettled at night and that there was decreased contact with Maternal Grandmother. By the time he was 6 weeks old Baby Connor had not been registered with a GP.

Father

4.1.14 There was a long history of involvement by statutory agencies with Father and his family. Father and his siblings had been subject to Child Protection Plans for emotional and physical abuse and were under a Public Law Outline (PLO) process for a number of years. There were also concerns about neglect. Paternal Grandmother had a history of alcohol and substance abuse, with periods of severe intoxication, as well as being subject to domestic violence.

4.1.15 Father's school attendance was poor, and his behaviour became increasingly violent when he reached adolescence. He was referred to CAMHS in 2017 but was not considered to meet the criteria for the provision of service.

4.1.16 Until the death of Baby Connor, Father had no previous convictions. However, Police were in receipt of nine incidents concerning Father from January 2017 until February 2018. These concerned reports of criminal damage at Paternal Grandmother's home, (which was reported to the Multi-Agency Safeguarding Hub (MASH) on 23/01/2017); domestic disputes between Father and Paternal Grandmother, and between Father and Mother; being present when Mother was assaulted by her sibling, being under the influence of alcohol and substance misuse, noise complaints and aggressive behaviour whilst staying at the independent living unit for parents and babies.

4.1.17 There was a notification of Father being involved in an aggressive incident, 6 days after Baby Connor's birth, when Police were called to Southampton General Hospital because of his behaviour towards ambulance staff. Father was under the influence of prescription drugs at the time.

Baby Connor's lived experience within the family

4.1.18 Baby Connor was born in hospital without complication. Mother had attended antenatal appointments and the parents were said to be excited about his birth. Whilst Mother engaged with midwifery appointments and the FNP when living with Maternal Grandmother, this began to deteriorate once she moved out of the family home. During the first weeks of his life Baby Connor lived with Mother in supported accommodation unit for mothers and babies. Father visited regularly and was staying overnight.

4.1.19 Whilst at this supported unit, Mother and baby were not considered to be at risk and, following the completion of the unit's 'My Safety and Support Plan' Mother and Baby Connor moved to an Independent Living Unit, which offered less support to parents. Once there, Mother began to fail to attend review sessions and concerns began to be raised with staff by other residents about arguments between her and Father.

4.1.20 Little is known about the quality of Baby Connor's short life. When the Family Nurse visited in late January 2018 Mother was described as 'slightly tearful' due to tiredness as Baby Connor had not slept for two nights. Father had been staying over to offer support. Money was a problem, as appropriate benefits had not been received and the FNP issued a 'Basics Voucher'. The Family Nurse noted that Father handled Baby Connor well, was gentle and caring and supported his head appropriately. There is, however, no description available to the review of whether Baby Connor was well fed and dressed, or whether he was generally a contented baby. The review has learnt that is it not usual for a Family Partnership Nurse to record such information, as only concerns about a baby's care is noted. (NB Practice has changed since the review was commissioned).

4.1.21 When the Family Nurse made her last visit before Baby Connor died, she noted that Mother said he was becoming more unsettled at night and she was increasingly tired. Mother reported that a complaint had been made by another resident about the noise from her flat and that she was having decreased contact with Maternal Grandmother.

4.1.22 By this time, Baby Connor was five weeks old, but had not been registered with a GP. There is no information available as to whether Baby Connor's six to eight-week check had been arranged, nor whether it was questioned as to why he had not been registered with a GP.

4.1.23 At the end of January 2018, Police Officers attended an incident which concerned another resident at the unit. It was during the arrest of this resident that the officers were told that Baby Connor had been seen with blood coming from his mouth. Banging and shouting was heard coming from Mother's flat. Mother requested that Father leave, which he did at the request of the officers. The flat appeared clean and tidy and no further concerns were reported. Although Father was arrested, he was then de-arrested and returned to the accommodation. Unfortunately, the concerns expressed by the resident about Baby Connor seen bleeding from his mouth were not investigated at the time by the attending officers. See Para 5.1.20.

4.1.24 At the practitioners event, information was shared that on the night that Baby Connor died, there had been a party involving drugs and alcohol. There had been an argument between Mother and Father relating to jealousy, which resulted in domestic violence and then violence to Baby Connor.

4.1.25 At the criminal trial of both parents, distressing evidence was given of the injuries which Baby Connor suffered and the actions resulting in his death. Father confirmed that he had taken ecstasy and drunk vodka and lager shortly before his son's death.

4.1.26 The picture which emerges from the limited information available about Baby Connor's short life is one of domestic arguments between young and inexperienced parents, living in an environment where alcohol and drugs were prevalent. Little is known about his day to day experience, but given the toxic mixture of immature parents, limited engagement with professionals, substance misuse and violence, Baby Connor was a vulnerable child who was seriously at risk of harm, which tragically resulted in his violent and painful death.

Baby Danny
Mother

4.2.1 Mother was 18 years old when Baby Danny was born.

4.2.2 When she was 10 years old, Maternal Grandmother died. Mother had experienced a traumatic childhood. She was placed with Maternal Great Grandmother, until 2013 when Mother became a Looked After Child by another authority. Mother had

numerous foster care placements and was first admitted to hospital when she was 12 years old, because of self-harming behaviour, which was to continue throughout her teenage years. Concerns began to emerge about Mother being at risk of Child Sexual Exploitation. Mother was placed in secure accommodation and subsequently admitted to a hospital for children with mental health needs.

4.2.3 Mother became known to Police, in the main for assaulting care staff and serious self-harming behaviour. As a Looked After Child she had experienced 35 different placements. Mother was sectioned under the Mental Health Act, 1983, on numerous occasions because of the serious risk she presented to herself, as a result of extreme self-harming behaviour

4.2.4 In March 2017 a referral was made to Southampton Children's Social Care from the Children's Services Care Leavers Team in the local authority where Mother had been looked after. Mother was now residing in Southampton having been recently discharged from hospital having been Sectioned under the Mental Health Act. She had been diagnosed as having a personality disorder, complex PTSD which manifested itself through flashbacks, dissociative episodes, feelings of hopelessness, low mood, anxiety and suicidal thoughts. Mother was in the early stages of pregnancy.

4.2.5 Mother had met Father via the internet. Within 8 weeks of knowing each other, Mother became pregnant, and they had moved in together. Mother was seen by midwifery services in March 2017, where further concerns were raised about her being overweight, cannabis use, cigarette smoking and high alcohol consumption. Mother was on medication for her mental illness, which was reviewed throughout her pregnancy. It was noted on the midwifery assessment form that Father had mental health and substance difficulties. Mother was referred to the Specialist Midwife. (Source: Solent NHS Trust Scoping document).

4.2.6 There were also concerns about the condition of the accommodation in which the parents were living.

4.2.7 On 24 November 2020, the parents met with the Lead Reviewer and when asked whether she had any anxieties or fears about being pregnant, Mother agreed that she felt frightened about having a baby. '*She didn't feel she was ready for a baby but as the pregnancy progressed, she started to feel ready for it.'* Mother explained that she had only just left care when she found out she was pregnant with Baby Danny. Given her experience of being a Looked After Child, Mother did not trust Children's Social Care to become involved with her pregnancy.

4.2.8 Prior to and throughout her pregnancy, the Care Leavers Team was involved with Mother and visited her and Father regularly. They were also part of the Child Protection and Discharge Planning Meetings. During the meeting with the Lead Reviewer, Mother explained that at this time she was having to learnt to trust different people in a way that she had never done so before. Mother said she had moved to Southampton to live with Father and had been asked by Children's Services to register with a new GP Surgery and request a referral for local Perinatal Mental Health Services. Mother told the Lead Review she had done so but was told that she did not

meet the criteria for the service. At a Child Protection Conference, Mother said it was inferred that she refused to go to the GP to seek this referral.

4.2.9 The Lead Reviewer asked if Mother had challenged this suggestion, and Mother explained that she '*struggled with communication at the time and when she did manage to communicate it probably did not come across in the most articulate way.'* Mother went on to say that she felt she was never really listened to by professionals and that she was seen as argumentative rather than trying to make a point. Mother told the Lead Reviewer that she was '*a lot calmer now and has worked on her communication.'*

4.2.10 In May 2017 Mother attended the Emergency Department because of self-harming behaviour, however, she did not stay to be seen and Father said he was dressing the wound at home. A week later, the Family Nurse undertook a recruitment visit and was advised by Mother that she had not self-harmed recently.

4.2.11 In June 2017, Mother and Father came under the care of the FNP. Mother was expressing anxiety about her ability to care for the baby. Concerns were also noted about the condition of the flat. It was considered that Mother was engaging well with the FNP. Mother was referred to the Perinatal Mental Health Team by the midwife.

4.2.12 In the first two weeks of July the Family Nurse visited Mother at home. Father was at work. Mother said she found it difficult to get up and walk around the flat before 3pm. The flat was described as cluttered and untidy. At the second visit the flat was described as cluttered, and Mother was smoking heavily. The Family Nurse noted concerns that Mother was struggling to meet her own needs and questioned the level of support needed after the baby was born. She planned to follow up with the Social Worker.

4.2.13 In mid-July the Perinatal Mental Health Team visited Mother at home. It was concluded that there was nothing that could be additionally offered, which was not already being provided by the FNP.

4.2.14 At the end of July 2017, an Initial Child Protection Conference (ICPC) decided that the unborn baby should be subject to a Child Protection Plan. A Legal Planning Meeting was held, which recommended: further perinatal assessment, non-negotiable mental health assessment of Mother and a capacity to care assessment of the parents.

4.2.15 The GP informed the Social Worker in early August 2017 that the Adult Mental Health Team would not consider Mother appropriate for their service as she had already been seen by Perinatal Mental Health Team, who had concluded that she was not mentally ill. The Social Worker made a telephone call to the Perinatal Mental Health requesting that Mother was offered support, as had been recommended in the parental assessment, however, the response was that this could only be offered if Mother was deemed to be mentally ill during her pregnancy.

4.2.16 Although Mother engaged well with the FNP, during the later stages of her pregnancy, there appears to have been little contact with Father, who was working. Toxicology tests relating to mother proved negative for alcohol and substance misuse. Mother had also stopped smoking. Child Protection visits were undertaken, and home conditions were considered 'good enough.' At a Core Group meeting in September 2017, the parents advised that Paternal Grandmother would be staying with them for two weeks after the baby was born to support with his care.

4.2.17 Baby Danny was born by emergency caesarean section in October 2017. He spent 4 days on the neonatal unit for observation as he was showing signs of withdrawal and was jittery, potentially as a result of Mother's mental health medication.

4.2.18 Following Baby Danny's birth, midwifery staff were concerned that Mother was regressing to childlike behaviour and was not caring for herself. There were also concerns about her high level of dependency on Father and what would happen when he returned to work. During the meeting with Baby Danny's parents and the Lead Reviewer, Mother denied this was the case.

4.2.19 On 30 October 2017, a discharge planning meeting was held. Concerns were raised about the hostile manner in which the parents communicated with staff and there was also a report of a smell of cannabis in Mother's room, which the parents denied. This was something which the parents also strenuously denied when they met with the Lead Reviewer. At time Mother agreed to a toxicology text, the results of which were negative. Father was not tested.

4.2.20 It was noted at the planning meeting that Mother and Father were responding well to Baby Danny and Father was caring for him overnight as Mother was drowsy due to medication. Because of Mother's mental health, Father was allowed to stay with her and Baby Danny overnight[3].

4.2.21 Baby Danny was discharged to his parents care on 30 October 2017, on the basis of them signing a contract of expectations drawn up at the Planning Meeting. The contract stipulated that Mother was not to have unsupervised contact with Baby Danny and that Father was to be the main carer. It also stated that professionals would visit every day for the first two weeks. From information provided to the review, it is not known who the professionals were, nor whether the visits took place. A Family Group Conference was to be arranged and pre-proceedings plans were to commence. A further assessment of Mother by the Perinatal Team was to be undertaken to assess risk. Father gave up his job to care for Baby Danny.

4.2.22 When meeting with the Lead Reviewer, Father stated that *'he thought it was outrageous that professionals expected him to be awake 24/7. He felt he couldn't go to the toilet unless he took Baby Danny with him and felt that it was unmanageable for him to have eyes on 24/7 as he needed to sleep.'* Mother agreed that it put '*unnecessary strain on Father and that he had to give up work pretty much overnight'.* Both parents considered they had no choice but to sign the agreement if Baby Danny was to come home with them. They explained that Father was earning a good wage

[3] The Trust occasionally allows partners to stay overnight, where mothers are experiencing difficulties.

and once he began caring for Mother and Baby Danny, the family faced severe financial difficulties. They had to wait six weeks for benefit payments to come through and were reliant on the Family Nurse who organised a food parcel from the local church. The Support Worker from the Care Leavers Team also gave them a voucher for a food bank.

4.2.23 The Lead Reviewer asked Baby Danny's parents whether the allocated Social Worker was aware of their financial situation at that time. Both said that the Social Worker told them to ask Paternal Grandmother for financial assistance and said that '*they needed to make ends meet or Baby Danny wouldn't be allowed to go home with them*.' Mother explained that this came across as '*threatening.*' Father said he had some holiday pay owed to him but both parents had to borrow money to ensure they had a roof over their heads and to pay for gas and electricity. They had to ask *'family for help to get nappies, baby milk and food as Christmas presents.'*

4.2.24 A Child Protection Review Meeting in mid-November 2017 was not quorate and the Social Worker was not in attendance. It was noted at the meeting that Mother became agitated when holding Baby Danny and that Father was responsible for the entirety of the baby's care. A Home Visit and Core Group Meeting at the end of November 2017 decided that the parents were showing signs of good parenting. They appeared to be '*providing good enough care to Baby Danny and were attentive and responded to his cues.*' Baby Danny remained subject to a Child Protection Plan, and PLO and Family Group Conference procedures. By this stage Father was not working and there had been a breakdown in the relationship between his brother and partner, which meant the support offered to Father by the couple in caring for the baby whilst he had some respite was no longer available. Financial pressures were also recognised, given that Father was now the main carer.

4.2.25 Until 6 January 2018 when Baby Danny was injured, visits by the Family Nurse and Social Worker continued. He was brought to his 6 week check with the GP and on Christmas Eve 2017 was taken to the Emergency Department when the parents were worried about him being unwell following his immunisations and that his head had a 'sunken soft spot'. On examination no concerns were noted, and the parents were reassured.

4.2.26 The Family Nurse last saw Baby Danny on 27 December 2017, when he was alert, kicking and had been fed. His fontanel appeared normal.

Father

4.2.27 Father was 27 at the time of Baby Danny's birth. Little information is available about Father's background. He was working at the time he and Mother met and claimed to be a paramedic. It is known that he lied about this. Prior to moving in together into privately rented accommodation, Father was facing homelessness. Father was seen to be supportive to Mother during her pregnancy and cared for her when she had episodes of self-harm. At the practitioners event it was stated that no assessment was undertaken of Father and his suitability to care for a baby (and for Mother).

4.2.28 Apart from what was registered at the time Mother had her midwifery assessment, there is no information available concerning Father's mental health. Some concerns have been noted as to the relationship between the parents. Following Baby Danny's injury and removal from his parents, the Care Leavers Team shared with mental health services that Mother was considering moving to a refuge due to Father's controlling and coercive behaviour. Mother also stated that Father was disappointed that the baby was not a girl, as 'he likes young girls' and that he had girlfriends aged 14/15 before he met Mother. This information was shared with police.

4.2.29 Prior to being arrested for the injury to Baby Danny, Father had no previous allegations or convictions against him.

Baby Danny's lived experience within the family

4.2.30 Baby Danny was born at full term via emergency caesarean section. His weight was within normal parameters. No concerns were noted by the Family Nurse when she visited him and the parents for the first time in hospital, after his birth.

4.2.31 When meeting with the Lead Reviewer, Father described Baby Danny as '*fantastic*.' Mother said *'he was so easy that she worried she was doing something wrong. He was so tiny that she was initially terrified*. Mother felt she was being constantly watched in hospital and everything she did with Baby Danny seemed to be wrong. When they got home, everything was so much better. Father explained that '*Baby Danny loved cuddles, he loved holding him and he was a little bundle of joy. Baby Danny made him smile and he would sit and cuddle him. Baby Danny was so easy to look after'*. Mother commented that she felt '*a lot of judgement from her family about her holding the baby too much'.*

4.2.32 When Baby Danny returned home it was on the premise that Father would be supervising his care 24 hours a day. Initially, Father's relatives were offering support with his care and consideration was given at the Family Group Conference in early November 2017 as to who, from the wider family, would be able to care for him if his parents could not do so. Three extended family members attended this meeting.

4.2.33 The new birth visit by the Family Nurse found that all appeared 'normal'. Baby Danny had good tone and reflex and was feeding well. Mother was gaining confidence and appeared gentle and caring. Father was doing the night feeds as Mother was not waking, because of her medication.

4.2.34 A home visit a week later in mid-November by the Family Nurse found Baby Danny thriving and Mother caring for him in a gentle manner, with support from Father. Baby Danny was also being cared for one day a week by Father's brother's partner. This was a recommendation of the Family Group Conference and was with a view to the couple being assessed to offer future overnight care to Baby Danny. This arrangement broke down after a family disagreement.

4.2.35 The home conditions in which Baby Danny spent the first weeks of his life were described as 'cluttered and untidy', but good enough. Finances were a problem, given

that Father had resigned from his job, but apparently plenty of baby clothes and equipment had been bought in preparation for his birth.

4.2.36 It is known that often the curtains were drawn in the flat and Mother did not like to leave the property. Thus, unless Baby Danny was taken out by Father, he spent most of his days inside the flat with his parents. When speaking with the Lead Reviewer both parents denied that his was the case.

4.2.37 By the end of November 2017, Mother told her Personal Adviser from the Care Leaver's Team that she was very happy, that Baby Danny was making a squeaky noise when he was happy and was sleeping better at night time. She was taking her medication and not self-harming.

4.2.38 Given Mother's history of self-harm, mental illness, trauma, alcohol and substance misuse and her lack of experience of positive parenting herself, it was more than optimistic that at the age of 18 she would be able to protect and care for her baby. The reliance on Father as a 24 hour a day, 7 day a week carer for Baby Danny, whilst also having to supervise Mother, was unrealistic. Such a task would have been difficult, if not impossible for most new parents, however, given the lack of background information concerning Father, particularly knowledge of his own childhood experiences, the risk of Baby Danny being at risk of significant harm was greatly increased.

Baby Ethan

Mother

4.3.1 In March 2016, when Mother was 15, a referral was received by Children's Social Care after she disclosed being hit by Maternal Grandmother following a verbal argument. Mother's attendance at school was poor. At this time Mother was living with Maternal Grandmother, Stepfather and her younger sibling who was disabled.

4.3.2 In November of the same year, a further referral was made to Children's Social Care by the school as Mother was refusing to return home and was living with Father's family.

4.3.3 By February 2017, Mother was 16 and was known to be pregnant with Baby Ethan and in May 2017, Children's Social Care allocated the case for a single assessment of the unborn baby. Following the single assessment, a S.47 investigation was recommended. During this time, Mother was living with Father and his extended family.

4.3.4 In June 2017, Mother and Father moved to live with Maternal Grandmother. Shortly afterwards, Father moved back to Paternal Grandmother's home and it was said that the relationship with Mother was over. By September 2017, the parents were back together.

4.3.5 A pattern developed throughout Mother's pregnancy and after Baby Ethan's birth of the parents moving between Maternal and Paternal Grandmother's home. At the time of Baby Ethan's injuries, he was living with his parents in a flat, the tenancy of which had been secured with the help of Paternal Grandmother.

4.3.6 During her pregnancy Mother was booked for maternity care with the Needing Extra Support Team (NEST). Regular visits were undertaken by the same NEST midwife and on the whole Mother's attendance at antenatal appointments was good. A referral was made to the FNP by midwifery staff in early April 2017. The Family Nurse managed to complete 8 antenatal visits to Mother, Father was present at 3, and 3 home visits postnatally, at which Father was present at one. There was a lack of engagement with the FNP by both parents and at times it was apparent that when they were living with Paternal Grandmother, she would falsely deny that Mother was available when the Family Nurse telephoned.

4.3.7 During her pregnancy Mother presented to hospital on five occasions for reduced foetal movements. Although nothing abnormal was found, on one of these occasions when she attended a hospital outside Southampton whilst visiting Paternal Grandfather, staff raised concerns about Father smelling of cannabis. A referral was made to Children's Social Care and a professionals meeting was convened in September 2017.

4.3.8 Following the professionals meeting in September 2017, when concerns were also expressed about the parents lack of engagement with agencies, and their capacity to deal with the needs of a new born baby, an Initial Child Protection Conference (ICPC) was recommended.

4.3.9 The ICPC in October 2017 decided that Child Protection Planning was not required, and a Child in Need Plan was agreed. This was on the basis that Mother stated she was no longer in a relationship with Father. The case was allocated to a Student Social Worker and the FNP was involved. After Baby Ethan was born in October 2017, Mother took her own discharge on 31 October, against medical advice. Clinicians wanted her to remain in hospital to monitor her and baby.

4.3.10 There was a lack of engagement with agencies including the FNP by Mother following Baby Ethan's birth. He was not brought for his 6 week check and hearing test. By the end of November, it was known that Mother was back with Father, whom it was believed influenced her contact with agencies. Concerns were raised by Children's Social Care about this development and a single assessment was to be completed with the likely outcome that the case would return to ICPC.

4.3.11 During December 2017, Mother did not return calls from the Student Social Worker and Baby Ethan was not seen until 22 December. A Duty Social Worker made a home visit to Paternal Grandmother's home. Home conditions were described as good and Baby Ethan was seen and appeared well, although asleep for most of the visit.

4.3.12 The next time Baby Ethan was seen by a professional was 10 January 2018, when he was brought to the GP Surgery.

Father

4.3.13 Prior to Mother becoming pregnant with Baby Ethan, Father and his family were known to Children's Social Care and Police.

4.3.14 Father was 15 years old when Mother became pregnant with Baby Ethan.

4.3.15 In 2012 Father suffered a brain injury following a road traffic accident. This had left him with anger management problems, which at times resulted in him displaying aggressive behaviour. School attendance was poor and Children's Social Care was aware that Father had caring responsibilities for his stepfather, Paternal Grandmother's partner, who was terminally ill.

4.3.16 In January 2017, when Father was 15, the school, which both he and Mother attended contacted Police as neither had attended school since the beginning of December 2016. Father and Mother were later found at Paternal Grandmother's home and had been hiding in the loft when teachers had previously visited. Mother was living at the address.

4.3.17 Police were called to Paternal Grandmother's address in February 2017 when Father was threatening Paternal Grandmother with a knife and threatening to harm himself. Father had been drinking, which had exacerbated his behaviour. A referral was made to Children's Social Care. A single assessment was completed in April 2017, which identified Father taking on caring responsibilities for Paternal Step-Grandfather, poor school attendance, self-harm and lack of care provided by Paternal Grandmother. Father was made subject to a Child in Need Plan.

4.3.18 Following Father's brain injury, attempts were made by CAMHS to identify specialist services for his condition, however he did not engage.

4.3.19 In September 2017, Children's Social Care closed Father's case (as a Child in Need) due to non-engagement. However, other agencies continued to be involved because of Mother's pregnancy.

Baby Ethan's lived experience within the family

4.3.20 It was reported by the Midwifery Team at a discharge planning meeting following Baby Ethan's birth that Mother was coping well with him. The parents were not together, but Father and Paternal Grandfather had visited. Following their discharge, Mother and Baby Ethan lived with Maternal Grandmother. Mother was seen by the Family Nurse and was said to be loving and caring towards Baby Ethan. He was alert and starting to smile, formula feeding well and thriving. At this time Mother was engaging with professionals.

4.3.21 Once Paternal Grandmother provided the means for Mother and Father and Baby Ethan to live independently, unsupported in private rented accommodation, contact with professionals deteriorated and monitoring of Baby Ethan proved increasingly difficult**.** Mother cancelled a visit by the Family Nurse at the beginning of November

2017 and two further visits were met with no reply. Baby Ethan was seen by the Family Nurse on 15 November 2017 and was noted to be smiling and appeared well.

4.3.22 Access was gained by the Family Nurse on 28 November 2017 when both parents and Baby Ethan were present. Mother was handling Baby Ethan with care, but Father became angry when contraception was discussed.

4.3.23 By mid-December 2017 the Family Nurse escalated her concerns with the Student Social Worker and with the Named Nurse for Safeguarding that the baby had not been seen for three weeks. A further visit was attempted, but although the Family Nurse could hear a baby crying there was no reply.

4.3.24 Children's Social Care had experienced similar problems to the FNP in gaining access to Baby Ethan and were planning to undertake a single agency assessment with a view to proceeding to an ICPC. Baby Ethan was not brought for his 6 week check with the GP and neither was he brought for two hearing test appointments. (He was subsequently discharged from the service). On 13 December 2017, the GP was very worried about Baby Ethan missing his 6 week check and informed the Student Social Worker of these concerns.

4.3.25 A Duty Visit was arranged by Children's Social Care after contact from the GP, the Family Nurse and the Safeguarding Midwife had all raised concerns about Baby Ethan not being monitored. The first visit was not successful and Maternal Grandmother was told that Police would be requested to assist if the baby was not seen.

4.3.26 On 22 December 2017 a Duty Social Worker gained access to Baby Ethan at Paternal Grandmother's address. Home conditions were described as good, Baby Ethan was sleeping but appeared well. The Family Nurse attempted two home visits after this visit, but without success.

4.3.27 By 8 January 2018 Children's Social Care decided that the case required progression to ICPC. However, on 10 January 2018 the GP contacted the Student Social Worker to say that Baby Ethan had arrived for his 6 week check, now 4 weeks late, and was seen with bruising, thought to be Non-Accidental Injuries (NAI). The GP considered that baby Ethan could wait for child protection medical, however the Team Manager insisted that an ambulance was called to transport Baby Ethan to hospital. The Police also arrived at the Surgery and arrested both parents.

4.3.28 On arrival at hospital, Baby Ethan was found to have 25 bruises to his body and a broken tibia in two places.

4.3.29 The age, immaturity and volatile nature of the parents relationship put baby Ethan at risk of significant harm. The lack of engagement and refusal to allow access by professionals to their baby meant that little was known of what life was like for Baby Ethan whilst in his parents care. When he was seen, it was said that he was well cared for and thriving. However, these occasions were very much dependent on the parents and members of both extended families agreeing to allow Baby Ethan to be seen. It is disturbing, that Mother and Father brought Baby Ethan to his delayed 6 week check when he had sustained substantial bruising and a broken tibia. Whether they

considered that the injuries would raise professional concern is not as yet known, however, it is fortunate that Baby Ethan was seen and the risk of him sustaining further injury was eliminated.

5 Key Themes and Analysis of Practice

5.1.1. At the time the Southampton Safeguarding Children Partnership made the decision to commission a thematic Serious Case Review, it was apparent that there were a number of significant similarities in the three cases. These can be summarised as:

- All were young parents
- All had experienced childhood trauma and/or Adverse Childhood Experiences
- All the babies were male and of White British ethnicity
- All three babies had received significant injuries, which resulted in the death of one child
- All of the incidents occurred within the same two-month period
- At least one of the parents of each of the children had exhibited violent behaviour in the past
- Alcohol and cannabis misuse featured in all three cases
- All the young parents had experienced homelessness

5.1.2 Having reviewed the information provided and constructed a narrative, it is evident that there are a considerable number of key themes emerging from this Serious Case Review, which are important to the improvement of practice. This section of the review will consider each of the themes in turn and will comment on professional practice at the time.

The importance of recognising parents as children/recently children themselves

5.1.3 Recent research[4] shows that the brain continues to develop through childhood and adolescence, even into the late 20s and 30s in some brain regions. White matter increases, grey matter decreases. These changes are thought to be caused by important neurodevelopmental processes that enable the brain to be moulded and influenced by the environment. When a risk is taken the brain's positive reward system gets activated. In adolescents, that activation is higher during risk taking than in adults.

5.1.4 These findings are particularly important when considering the events which led to the serious injuries sustained by these three very young babies. In all of the cases the parents engaged in risk taking activities, for example alcohol and substance misuse, risk of sexual exploitation and lack of stable accommodation. In the case of Baby Connor his parents were living in accommodation where parties, alcohol and drug use were prevalent features of the lives of the young parents living in the unit.

5.1.5 It is important for professionals to be aware of research findings concerning the workings of the adolescent brain if an informed understanding is to be developed and

[4] Blakemore Sarah-Jayne *Inventing Ourselves: The Secret Life of the Teenage Brain*, *2018*

maintained of the additional risk posed to young parents themselves and, more importantly to their babies and children.

5.1.6 It is also important for professionals to consider adolescent decision making with regard given to the Mental Capacity Act, 2005. The Act states clearly that mental capacity does not mean a young adult needs to make good decisions and indeed should be permitted to make decisions, even if others feel such decisions are not in their best interests. However, when a young adult is caring for another child as their parent safeguarding procedures will always be paramount in any decision making made by professionals.

5.1.7 Such findings are of particular significance when considered in light of the vulnerability, immaturity and limited life experience of all of the parents of the three babies. This is evidenced by the following:

- In two of the three cases the mother of the baby was a child herself when she became pregnant and in the third, the mother of Baby Danny, had only just reached 18.

- The fathers of the children, with the exception of Baby Danny's father, were under the age of 18. Baby Connor's father was 16 and in the case of Baby Ethan, Father was 15 when Mother became pregnant and had been a Child in Need himself until a month before Baby Ethan was born.

- All of the mothers, and from what is known, two of the fathers, had experienced difficulty at school and their attendance had been poor. Given the number of placements Baby Danny's mother had as a Looked After Child, together with her admissions to psychiatric hospital, with the resulting disruption to her education, it is surprising, and to her credit that she was literate.

- Two of the mothers had engaged in self-harming behaviour and in the case of Baby Danny's mother she had experienced a traumatic childhood prior to becoming a Looked After Child, which was further compounded by having 35 placements and being Sectioned under the Mental Health Act, 1983 on three occasions.

- The susceptibility of the parents to child exploitation featured in two of the three cases. Baby Connor's Mother was thought to be at risk of child sexual exploitation whilst at school and the mother of Baby Danny had been subject to sexual exploitation and violent sexual assault, not least because of her vulnerability due to her mental ill health.

- Although support was offered to the mothers throughout their pregnancy by midwives and the FNP, the reality of giving birth at such a young age and becoming a parent when still a child, can be and is a difficult, traumatic and frightening experience. It is not clear from the information provided to the review that this was fully explored with the mothers.

- Baby Connor's parents expressed excitement on learning that they were going to have a child, however, the consequences of looking after a baby independently, in accommodation with limited support, proved to be tragic for Baby Connor and for his parents.

- Prior to the birth of Baby Danny, Mother had displayed childlike behaviour and after his birth midwifery staff were concerned about Mother holding onto a comfort blanket when she required treatment following a caesarean section. Whilst recognising that Baby Danny's Mother had suffered significant trauma for most of her life, her experience as a young person of giving birth and the aftermath of having a caesarean section cannot be underestimated. The concerns of the midwifery staff on the postnatal ward were shared and known by professionals prior to Mother and Baby Danny being discharged from hospital, they went home.

- The heightened anxiety which can be experienced by a young, pregnant mother was illustrated by baby Ethan's mother attending the Emergency Department on five occasions, fearful that she could not feel a foetal heartbeat. Whilst anxious and concerned about her unborn child, once Baby Ethan was born, Mother ceased to engage with professionals, to the detriment of her baby's health, wellbeing and safety.

5.1.8 All of the above highlights the need for professionals working with young teenage parents to recognise that in the first instance they are children themselves. This is not always easy, given the difficulty, which is so often encountered when attempting to engage with young people. However, this review has attempted to illustrate that if this fundamental principle is not embedded in professional practice the risk to the babies and children of young parents is severely heightened and can lead to tragic consequences.

The need for comprehensive assessment of parenting skills and risk to the unborn baby

5.1.9 In none of the three cases is there evidence of comprehensive assessment of parenting capability and the risk presented to the unborn baby.

5.1.10 In the case of **Baby Connor,** no assessment was undertaken of either parent by Children's Social Care. The focus of social work involvement was on Mother's younger sister who had special needs. There had been referrals prior to Mother's pregnancy to Children's Social Care about Mother's lack of school attendance, risk of child sexual exploitation, and in 2016, contact had been made by hospital staff from the ED when both Mother and Father were admitted with smoke inhalation following a house fire. None of these resulted in an assessment, although information from Solent NHS suggests that Mother was an open case to Children's Social Care (see below para.5.1.15)

5.1.11 Baby Connor's Maternal Grandmother had said that she would offer support to her daughter and given the involvement of the FNP, it seems to have been assumed that

an assessment by Children's Social Care was not required. This decision was made in the knowledge that the family was well known to statutory agencies, with Father and his siblings having been subject to Child Protection Plans in the past, due to neglect. At the time Mother became pregnant, Paternal Grandmother and her children were an open case to Children's Social Care. Paternal Grandmother had a history of alcoholism, substance misuse and suspected drug dealing. It was known that Father was Mother's partner and the father of her unborn child, but there was no sharing of these concerns between the Social Worker for Paternal Grandmother and the FNP.

5.1.12 Both Father and Paternal Grandmother were well known to Police. When Police attended Paternal Grandmother's home, a Child and Young Person Report (CYPR, subsequently replaced by PPN1) was submitted on each occasion. The incidents included arguments between Mother and Father, excessive alcohol consumption on the part of Paternal Grandmother and Father, and violent behaviour between Paternal Grandmother and Father.

5.1.13 Whilst Police Officers attending these incidents followed procedure by submitting CPYRs/PPN1s, there was *"no assessment of the recent history nor family context and an apparent lack of understanding as to why they were submitting a PPN1……..an ongoing theme with PPN1s is that officers are frequently assessing incidents in isolation and not considering the context when assessing risk or considering exactly what the actual risks are…..There is also the potential that officers are not considering older teenagers as children at risk*." (Source: Police IMR)

5.1.14 When Baby Connor's Mother was first seen by midwives at the antenatal booking in June 2017, social risk factors were noted, and a concerns form was sent from the Community Midwife to the Maternity Safeguarding Team. However, it was not reviewed by the Maternity Safeguarding Team until mid- September 2017. The reason for the delay is not documented. It was at this booking that a referral was made to the FNP.

5.1.15 Further information was requested by the Maternity Safeguarding Team from Children's Social Care in September 2017. This showed that the case was open because of the special needs of Mother's sibling, but the Team Manager had requested that Mother's case be closed. Information concerning Father was shared with midwifery, which should have been recognised as increasing the risk to the unborn baby. A referral to MASH should have been considered but this did not happen. The recommendation from the Maternity Safeguarding Team was for Mother to remain under enhanced midwifery care, to offer an Early Help Assessment and to liaise with the FNP. However, the Early Help Assessment referral was not made.

5.1.16 Mother and Father were registered at different GP surgeries and no information was shared about Father's childhood history between practices. The GP Practice for Mother was aware of the risk presented by Mother's younger sibling and that it was initially proposed that Mother would reside at Maternal Grandmother's home. There was however no exploration of the safeguarding risk presented to the unborn child or to Baby Connor had Mother continued to live at the family home. The GP knew that Mother was under the care of the FNP and there was little involvement with the Practice thereafter.

5.1.17 Information provided to the review from the FNP states that: *"there is evidence of excellent engagement throughout the pregnancy with the Family Nurse. [Mother] and [Father] appeared to be excited about the baby, prepared well for the arrival, showed good insight into the risks that [Mother's] younger sister might pose to her and her unborn baby and was keen to secure her own accommodation although aware this was a big step."* There is no information from the IMR of a formal risk assessment of parenting capacity or risk to the unborn baby undertaken by the Family Nurse. This is particularly concerning. Once Mother moved into her own accommodation and contact with the Family Nurse significantly decreased, Baby Connor was not monitored, he was not brought to appointments and was not registered with a GP at the time of his death.

5.1.18 The assessment made of Mother, when she was pregnant, for her suitability for admission to the supported accommodation unit, showed that the only risk identified was that of her younger sibling. No risks concerning Father were identified, however it is not known to the review as to what the assessment consisted of. Once resident at the unit, the 'My Support Plan' for Mother, used at the time, was completed by staff as there was no engagement by Mother. No information is available as to whether Mother's non-engagement was questioned or whether it was usual practice for staff to complete a form on behalf of a mother.

5.1.19 Based on the assessment by the housing provider, Mother was deemed suitable to move to the independent living unit 18 days after she gave birth to Baby Connor, scoring the lowest possible risk score on the 'My Safety and Support Plan.' Once there, Mother attended three out of the five support sessions offered and at the last meeting in February 2018, before Baby Connor died on 11 February 2018, the arguments between Mother and Father were discussed. There is no indication that the risk to Mother and Baby Connor was considered to be increased because of the parents arguing.

5.1.20 There is no reference in the IMR submitted to the review by the provider of the supported Independent Living Unit, to Police visiting the Unit in January 2018 after 3am having received a complaint about noise involving another resident and Mother. Whilst investigating the incident, officers heard banging coming and shouting coming from Mother's flat. Mother and Father were arguing, and Mother requested that Father left. A PPN1 was completed for Baby Connor and the DASH[5] risk assessment completed with Mother. She answered no to most questions and therefore the incident was assessed as 'standard risk'. It was during the arrest of another resident that the officers were informed that on two occasions Baby Connor had been seen with blood coming from his mouth. This disclosure was not investigated by the officers attending and is the subject of further investigation, by the Independent Office for Police Conduct (IOPC).

5.1.21 Information provided to the review explains that when one of the two officers attending the incident returned to the flat of Baby Connor's parents to complete a domestic risk assessment with Mother, he found Father in the flat, holding Baby

[5] DASH risk assessment: Domestic Abuse Stalking and Honour Based Violence used by Police

Connor. Father was drunk and his behaviour argumentative. The Officer was concerned about how Father was holding Baby Connor who was crying. Father said: '*he hadn't done anything'* and thought the officer was implying he had hurt the baby. The Officer was not concerned for Baby Connor's wellbeing and put Father's behaviour down to inexperience. Unfortunately, none of this information was recorded in the PPN1, which with the information provided by the other resident about Baby Connor bleeding from his mouth was a significant omission. If this information had been included in the PPN1, it could have possibly resulted in a Grad A assessment by MASH ('*unexplained injuries or suspicious injuries to a child under 4)* which would have resulted in a referral to the Child Abuse Investigation Team (CAIT). (Source: Police IMR)

5.1.22 The need for professional curiosity by Police Officers visiting premises because of domestic abuse, is paramount. The importance of careful exploration, documentation and the reporting of concerns is crucial if children are to be safeguarded. The incident detailed above required further investigation and was a missed opportunity. It is a lesson learned arising from this review and is reflected in **Recommendation 3**.

5.1.23 Throughout her life as a Looked After Child the mother of **Baby Danny** had been subject to assessment. The concerns about her mental health, history of severe self-harming behaviour, alcohol and cannabis misuse were well documented and known when Mother moved to Southampton within weeks of becoming pregnant. Once the pregnancy was confirmed as viable, a Social Worker from Southampton Children's Social Care visited the offices of the local authority where Mother had been looked after to read their care records. Information was shared between the two local authorities. The care records were not reviewed by Social Workers subsequently involved in Baby Danny's case, so it is not clear how much of this detail was known to them.

5.1.24 In July 2017, a Section 47 assessment was initiated which resulted in the convening of an ICPC. The outcome of the ICPC, was for the unborn Baby Danny to be subject to a Child Protection Plan, category neglect. Legal advice was taken at the meeting.

5.1.25 A report concerning Mother was presented at the ICPC by the South East Care Leavers Team, which included the following:

5.1.26 "*I have concerns about Mother's ability to parent a child and keep herself and a child safe…….. [Mother] will need to be assessed very carefully and fully assessed once the baby arrives to ensure [she] is able to meet the child's needs and keep him safe. [Mother] will need to attend parenting workshops to ensure her child's developmental needs are being met."*

5.1.27 In August 2017, a legal planning meeting followed the ICPC, which requested a further mental health assessment of Mother. A Review Child Protection Conference was due to take place at the end of October 2017 but was cancelled as Baby Danny arrived early. A pre-discharge meeting was held on 30 October, at which concerns were expressed by the South East Care Leavers Team about Mother being able to manage with a child, to which Mother nodded her agreement.

5.1.28 Concerns were also expressed by the midwife as to how Mother would manage a baby and the midwifery staff from the ward explained the difficulty in obtaining Mother's cooperation with Baby Danny's care, that she smelt of cannabis when returning from smoking outside, having left him without a blanket and he was cold. Mother disputed this, however the midwife attending the meeting advised that she had concerns about Mother being able to provide any care to her baby.

5.1.29 The decision to allow Baby Danny to be discharged home into the care of his parents was made on the basis of Mother signing a contract of expectations, confirming that she was not to care for Baby Danny without supervision from Father. Mother was not happy about this but signed the agreement. Children's Social Care confirmed that further assessments would be completed in respect of Mother and Father, and that the legal planning process would continue.

5.1.30 However, it is evident that there was no further assessment undertaken of either parent's ability or capacity to care for Baby Danny. Little was known of Father's background. What is known is that he and Mother met on-line and within days of meeting, they were inseparable. Father lied about his profession, claiming to be a paramedic, and quickly assumed caring for Mother when she self-harmed. Yet he was deemed to be the protective factor for Baby Danny, having sole responsibility for his care and supervision.

5.1.31 Prior to Baby Danny's birth and on his discharge from hospital, the Family Nurse recorded that the parents engaged well with the Programme. However, it is evident from the information provided to the Serious Case Review that there was a lack of comprehensive, informed assessment of the parenting abilities of Mother and Father. The Family Nurse was aware that Mother was not engaged with the Perinatal Mental Health Team; that there were serious concerns about whether Mother had ceased drinking and using cannabis; that she did not like to go out of the flat and thus Baby Danny remained inside with Mother; that there were financial pressures on the family due to Father giving up his employment to care for mother and baby and that Father was expected to supervise Mother and ensure that Baby Danny was not put at risk.

5.1.32 Whilst Mother did co-operate with a mental health assessment late in her pregnancy, with regular input thereafter from the Community Mental Health Team (CMHT), there is no documented evidence of liaison between the Family Nurse and CMHT, or the GP. It appears that the content of the CMHT assessments was not shared or discussed either at the Child Protection Conferences or outside of meetings in multi-agency liaison. It is questionable whether the Mental Health Worker was invited to the Child Protection Conferences as she did not appear on the list of attendees.

5.1.33 Given Mother's history of chronic self-harm, mental illness, lack of parenting in her own childhood and recognition that she herself could not look after a baby, it could be argued that further assessment of Mother was not necessary to decide whether it was safe to discharge Baby Danny into her care. Given that so little was known about Father, for a decision to be taken at the pre-discharge planning meeting that he was a suitable parent, with the skills and capability to care for his child and supervise

Mother, without an evidence-based assessment of him, was not only poor but also dangerous practice, which sadly proved to be the case when Baby Danny was found to have sustained a serious head injury.

5.1.34 In the case of **Baby Ethan**, no comprehensive assessment was undertaken of the parents ability to parent, nor was there an assessment of the risk posed to their baby.

5.1.35 Father had been subject to a Child in Need Plan a month prior to Baby Ethan's birth, due to lack of school attendance and anger management issues as a result of a brain injury. An ICPC was convened in October 2017 because of concerns about the lack of agency engagement by the parents and questions about their ability to care for a new born baby. The decision was taken that as Mother was no longer involved in a relationship with Father, the case did not warrant a Child Protection Plan and was suitable for Child in Need procedures.

5.1.36 The case was then allocated to a student social worker. Given the known history of concerns about both Mother and Father, not least Father's controlling and volatile mood and behaviour, greater consideration should have been given to an assessment of parenting ability, which also involved a comprehensive exploration of the relationship between Mother and Father. This required qualified social worker involvement and the case should not have been allocated to a student. The fact that Mother was living with Maternal Grandmother prior to Baby Ethan's birth, whilst maintaining that her relationship with Father was over, meant that there may have been an element of complacency that the risk to the unborn baby was low. Insufficient consideration was given to the probability of the couple resuming their relationship, and what in turn, this meant for the safety and well-being of their child.

The importance of support for young parents

5.1.37 The IMR concerning Baby Connor submitted to the review by the provider of the supported Independent Living Unit states that: *"[Mother received support from a Family Nurse practitioner. She had no Social Services involvement. Our role was to assess [Mother] for housing and to provide her with suitable accommodation based on her tenancy readiness…..We do not provide parenting skills but support clients to access parenting skills where needed….Our staff did not raise any concerns relating to [Mother's] parenting skills and [Mother] and [Father] appeared to be attentive and caring parents".*

5.1.38 This statement not only raises serious concerns as to the responsibilities and expectations of the housing provider to young parents, it also brings into focus the nature of the 'support' offered to the parents and by which agencies. It is evident from information submitted to this review, that there was a perception on the part of professionals referring young parents to this service provider that the support offered was more substantial than it was in reality. The unit in which Baby Connor's mother was first placed was not a Mother and Baby Unit, with staff on duty 24/7. It was staffed during office hours, and limited support was offered. Once Mother moved into the Independent Living Unit, the support available was as described above in para 5.1.37.

5.1.39 The need for agencies to work together, as well as having a clear understanding of the context of the support offered and responsibility held by each agency for the safeguarding and well-being of young, vulnerable parents and their children, is a fundamental finding of this review. It is clear that there was a higher expectation of the provider by agencies using this facility of the care, monitoring and support available to young parents.

5.1.40 Whilst there was Children's Social Care involvement in the lives of Baby Danny and Baby Ethan, there was none in the case of Baby Connor. There had been Children's Social Care involvement with Baby Connor's extended families, but once Mother was pregnant and after the baby was born, the only support which the parents received was from the FNP.

5.1.41 Information provided by Solent NHS Trust to the review, describes the FNP as follows:

> *"The FNP is a voluntary home visiting programme, standard contacts are offered weekly for 4 weeks initially then fortnightly until the child is born. Then weekly contacts are offered for 6 weeks followed by fortnightly contacts until the child is 21months then monthly contacts until 24 months.*
>
> *FNP is structured - in that the tools it uses and the nature and number of visits is prescribed, based on years of research, evidence, successful implementation and constant evaluation - but it is also flexible. Within this structure, nurses deliver a highly personalised intervention based around the specific strengths and needs of each client.*
>
> *As part of FNP delivery facilitators which cover a wide range of topics including lifestyle and positive health changes, relationships, communication skills, medical information, life plans and goal setting, becoming a parent, focusing on the child's care and development, cues and responsiveness are shared with clients (and partners if present) during contacts. These are kept by the clients for their own records and for them to use as a resource. [In the case of Baby Connor] these have not therefore been available to form part of this review within the SystemOne records.*
>
> *Family Nurse Partnership is a voluntary home visiting programme, by focusing on their strengths, FNP aims to enable young parents to:*
>
> - *Develop good relationships with and understand the needs of their child*
> - *Make choices that will give their child the best possible start in life*
> - *Believe in themselves and their ability to succeed*
> - *Mirror the positive relationship they have with their family nurse with others".*

5.1.42 During the course of their engagement with Baby Connor's parents the two Family Nurse Partnership nurses involved in the case, assessed that they engaged well before and after the baby's birth. An appropriate number of appointments were kept, until Mother moved to the Independent Supported Housing Unit.

5.1.43 No pre-birth referral to social care was felt necessary as both parents were considered to be making appropriate choices, engaging with services and showed good signs of preparing for their baby both emotionally and physically.

5.1.44 Mother was seen to be keeping herself safe from her sister by moving into supported accommodation. The parents observed care of Baby Connor during contacts after delivery was loving and caring and he was thriving. The Family Nurse was aware of a little of Father's background but was not aware of the lengthy involvement of Children's Social Care, and the history of Child Protection concerns with Paternal Grandmother, and this was not disclosed by Father. The Family Nurse could only access information on the electronic recording system for health professionals (SystemOne), if there was an open referral, (as was the case for Mother). Father did not have an open referral, which meant that the Family Nurse was not aware of his history of violent outbursts. Since the death of Baby Connor, where is it is known that a partner is living with a pregnant mother, a form has been devised and used by FNP, which seeks to ascertain with consent access to a father's medical history.

5.1.45 It has also emerged in the course of this review that the provider of the Independent Living Unit, would only ascertain information concerning the father of a baby, if he was known to be living with the mother. If he was only visiting, such information would not be sought. The service provider has recognised this as an area which requires attention if safety for mothers and children living in their accommodation is to be improved.

5.1.46 The FNP was informed of Baby Connor's father arriving at the hospital Emergency Department drunk, violent and under the influence of Paternal Grandmother's medication, but the Family Nurses involved did not realise that the medication was prescribed and if taken by anyone other than the patient was an illicit drug. The incident was discussed with Mother on the telephone, who said she was aware that Father was drunk and had banged his head. It was planned to discuss the matter with Father, but Baby Connor died before this happened.

5.1.47 The Family Nurse was aware that Father had caused a disturbance at the independent living unit and in the two weeks up until Baby Connor was fatally injured, it was apparent that Mother was less engaged. When Mother was seen, she complained of feeling increasingly tired and that she was having decreased contact with Maternal Grandmother since moving into the unit.

5.1.48 Whether the Family Nurse assessed that Mother was in need of additional support in the care of Baby Connor is not known. Her next visit to the family was due to take place the week beginning 12 February 2018, by which time Baby Connor had already died.

5.1.49 It is evident that the FNP was not aware of the details of Father's background, nor was sufficient information shared by the housing provider about the arguments between Mother and Father and of the complaints made by other residents. The Police PPN1 submitted at the time of Police attendance at the end of January 2018, lacked detail of the alleged injury to Baby Connor's mouth. If this had been included, a more concerning picture would have been presented of child protection issues related to

Baby Connor. The sharing of all information concerning the safety and well-being of children, particularly in respect of very young vulnerable babies, between agencies is fundamental if children are to be protected from significant harm. Unless information referred into the MASH results in a Section 47 investigation, such information would not be reviewed by Children's Social Care. This is a lesson learnt from many Serious Case Reviews and sadly this review is no exception. **See Recommendation 10**

5.1.50 The assessment by the housing provider that Mother and Baby Connor were suitable to move to the Independent Living Unit has already been addressed above. However, how the decision was reached that Mother did not require additional support and supervised care, within 18 days of arriving at the supported living unit, is subject to question. It would seem from the information provided to the review that there was a lack of robust assessment of the support needs of mothers and the risk presented to babies by staff undertaking such assessments, none of whom were qualified social workers or health professionals. This finding is concerning and is reflected in **Recommendation 4.**

5.1.51 Baby Danny was subject to a Child Protection Plan, but how much support was offered to his parents by Children's Social Care is not clear. The plan was that Child Protection visits were initially to be undertaken on a daily basis by the Social Worker, however, this level of monitoring was not maintained after the first days of Baby Danny's discharge from hospital and was soon reduced to weekly and then fortnightly by mid-December. From information available, Baby Danny was not seen by a Social Worker after 14 December 2017, nor was there any contact until 6 January 2018, when the hospital contacted Children's Social Care to inform them that Baby Danny had been brought to hospital by ambulance in an unresponsive condition and that NAI was a possibility.

5.1.52 Given the known history of Mother and the pressures placed on Father having to care for Baby Danny and supervise Mother, the level of involvement by Children's Social Care was unacceptable, and is a lesson learned from this review. **See recommendation 2(a)**

5.1.53 There were regular and frequent visits by the Family Nurse to Baby Danny and his parents. The engagement by the FNP has already been explored in detail. Whatever support was being offered to Father, given the enormity of his responsibilities to Mother and Baby Danny, it would not have been sufficient to meet the requirements to keep Baby Danny safe. This was confirmed when Baby Danny's parents met with the Lead Reviewer, given they stated that whilst they received support from the Family Nurse, little if any assistance was provided to them or Baby Danny by their allocated Social Worker.

5.1.54 Whilst Baby Ethan was on a Child in Need Plan, the case was allocated to a student social worker. Given the complexities of Father's family history, his violent and aggressive behaviour resulting from a serious brain injury; that he had been a Child in Need himself just a month prior to baby Ethan's birth; the concerns noted about Father's cannabis use; the pattern of Mother moving from Maternal Grandmother's home to Paternal Grandmother's home and the lack of engagement with the Family

Nurse after Baby Ethan's birth, should have resulted in the case being escalated to one of Child Protection. It is evident that it was inappropriate for a student social worker, on placement to be given a case of this complexity and risk and is a lesson learned from this review. **See recommendation 8**.

Recognition of the risk posed by fathers in the lives of babies and children

5.1.55 In all three cases the importance of the risk of father's behaviour to the wellbeing and safety of these very young babies can be said to have been underestimated or was unknown by professionals.

5.1.56 In the case of Baby Connor and Baby Ethan the volatility of father's behaviour was known to Children's Social Care and to CAMHS professionals. This information was not known to the Family Nurses when they began working with the family and was not sufficiently explored once it was known that father was a constant in the life of the mother and baby. The need for professional curiosity, as well as information sharing concerning the childhood and life experiences of fathers, together with concerns about anger management, substance misuse and mental health is a pre-requisite if children are to be protected from significant harm.

5.1.57 Unlike Baby Connor and Baby Ethan, little was known about the background of Baby Danny's father. This was a concern in itself, given the way in which the parents met on-line and the immediacy of them moving into together when Mother became pregnant. The decision of the pre-discharge planning meeting and the subsequent Child Protection Conference to allow Father to assume, what was essentially, sole responsibility for caring for Baby Danny and Mother, 24/7 was misguided and inappropriate. To place such an expectation on any parent would be difficult, however, given Mother's behaviour and mental health needs, it proved to be dangerous to the health and well-being of Baby Danny.

The impact of mental health issues, self-harming behaviour and substance misuse on parenting capability

5.1.58 All of the parents engaged in using cannabis, some to a greater extent than others. Alcohol use by parents also featured in all three babies lives. This is a theme, which is prevalent throughout this review.

5.1.59 In the case of the father of Baby Connor, the Police IMR makes an important point, in that *"upon analysing the information within Police systems there was a general absence of recognition of alcohol misuse. Evidence is that officers <u>may</u> [emphasis of IMR author] have assumed, because Father was 16, this type of alcohol use was perhaps the norm. What is concerning is that Father was putting himself at risk of harm i.e. laying in the road, being out during the very early hours of the morning and displaying violent and aggressive behaviour. Crucially there was a real absence of the risk alcohol misuse posed to Baby Connor."*

5.1.60 Cannabis misuse by parents has become a feature of the day to day work of social care and health professionals. Such use and misuse cannot be treated with complacency. Cannabis misuse by parents is also increasingly featuring in Serious Case Reviews. The importance of professionals taking account of the impact of alcohol and substance misuse on the capacity of parents to care for their children, but also on the well-being of the children themselves, must not be underestimated. **See Recommendation 5**.

5.1.61 The review has highlighted that the brains of adolescents are usually still developing until the age of 25 and in some instances until 30. It is known that risk taking is more prevalent in adolescents. This lack of maturity combined with alcohol and substance misuse had a profound effect on the ability of these young parents to safeguard and care for their babies.

5.1.62 Similarly, self-harming behaviour is another feature of this review. Two of the three mothers were known to self-harm. The propensity to self-harm by the Mother of Baby Connor, was not a dominant feature of her behaviour, however, the degree of self-harm perpetrated by Baby Danny's mother was chronic and extreme. Her vulnerability to self-harm and the subsequent impact on her ability to care for her baby was not given sufficient significance by professionals, because Father was seen as the protective factor.

5.1.63 The mental health of parents featured in all three cases and is a theme arising from the review. For all three babies the mental health of Father was a concern. What little was known about Baby Danny's father included information that he had experienced depression, but no detail was known as to when, its extent or severity. If an assessment had been undertaken of Father's ability to parent, this aspect could have been explored and a risk assessment made of his capacity to keep Baby Danny safe.

5.1.64 Neither the father of Baby Connor nor Baby Ethan, both of whom had anger management issues, engaged with CAMHS professionals, although in the case of baby Ethan, CAMHS staff were aware that he was about to become a father/was a father. As a result of non-engagement both cases were closed. The need to take account of the mental health of fathers when assessing the parenting capacity and abilities of parents is an important theme arising from this review and is a recommendation. **(Recommendation 2).**

5.1.65 The mental health of Baby Danny's Mother has been documented throughout this review. What is surprising, is that despite being sectioned three times, during her pregnancy and was on medication for her mental health, Mother did not meet the criteria for a mental health assessment or intervention. Whilst there was some dissent, most notably by the South East Leaving Care Team and midwifery staff on the postnatal ward, the decision of the pre-discharge meeting to allow Baby Danny to return home with his parents from hospital raises real and serious concerns for the Lead Reviewer. In essence by taking such a decision, the NAI to this baby was predictable and preventable.

The impact of a lack of good parenting experiences on young parents

5.1.66 The history of a lack of good parenting experienced by at least five of the six parents has been evidenced throughout the review.

5.1.67 The absence of a stable, caring home environment, coupled with poor school attendance had a profound effect on all the young parents featured in this review, and in turn their ability to parent their own children. Because of the lack of good parenting by Maternal and Paternal Grandparents, there was in turn an absence of support from extended family members. This essentially meant that apart from the provision of the FNP service, all the parents were left to parent the babies themselves. There is no evidence of parenting classes and child development information being made available.

Over optimism on the part of professionals as to the parents' capacity to care

5.1.68 The review has found that there was over optimism on the part of the majority of professionals involved with these young families and is evidenced in detail in previous sections of the report. A lack of robust, comprehensive parenting assessment in all of the cases is at the centre of why these small, vulnerable babies were seriously injured and, for one resulted in his tragic death.

Impact of Homelessness

5.1.69 All of the parents experienced homelessness and it is a theme of this review. The lack of a safe, stable caring environment for all three babies increased their vulnerability and risk of significant harm.

Anger management and domestic abuse

5.1.70 The propensity for violence and lack of anger management by a parent was prevalent in all three cases. For Baby Connor and Baby Ethan, it was father who presented the most risk and in the case of Baby Danny, there was a long history of aggressive and dangerous behaviour on the part of mother. These factors were well known to Children's Social Care and should have been given greater significance at the IPCPs, Core Groups and Review Conferences.

5.1.71 In the case of Baby Ethan, the Police IMR author makes a very important finding concerning the need for professionals to be cognisant of identifying the risks of coercive and controlling behaviour. Father's behaviour was highlighted at the ICPC. However, the risk to the unborn baby was seen as reduced because the couple were no longer in a relationship and resulted in unborn Baby Ethan being made subject to a Child in Need Plan. Once the case became one of Child in Need, Police were no longer represented at the Core Group meetings. *"Bearing in mind concern regarding [Father's] mental health, [Mother's] description of being alienated from friends due to his behaviour, the fact it was understood that he influenced her to miss school and not engage with ante-natal provision",* should have prompted the police conference attendee to submit a fresh PPN1 identifying the risks of coercive and controlling

behaviour highlighted at the ICPC. "*Furthermore, there needed to be consideration as to how the presence of this may impact [Mother's] capacity to remain out of a relationship with[Father], which in turn could make it difficult for her to adhere to the outline Child in Need plan. In addition, consideration could have been given to the police proactively completing a DASH risk assessment (Mother was over 16 years old at this point) as a part of this PPN1 to enable a full assessment by MASH sergeants of the potential risk with consideration as to whether a criminal investigation was required".*

5.1.72 The University of Bristol's research findings on violence in teenage relationships[6] undertaken between 2005 – 2009 clearly show that physical, sexual and emotional forms of teenage partner violence constitute a major child welfare issue. More recent information provided by Dr Christine Barter[7] makes reference to teenage partner violence in two Serious Case Reviews. "*In 2016 two serious case reviews occurred due to the deaths of 'Lucy' and 'Jayden', aged 16 and 17 respectively, who were murdered by their partners. The reviews showed that both young women experienced very high levels of coercive control alongside other forms of intimate violence. The review into the death of 'Lucy', who was pregnant at the time, documented a relationship which started when she was 15 and quickly became controlling and abusive, with her teenage partner banning her from going out alone or seeing friends and family, stopping her wearing make-up and telling her how to dress, accompanied by incidents of physical violence. Jayden's abusive relationship followed a similar path."*

"The serious case reviews also highlight that Lucy and Jayden experienced additional vulnerabilities and challenges. However, professionals in both cases failed to see them as children requiring protection with significant risks in their lives and instead positioned them as difficult adolescents. Research has identified a range of risk factors which increases a young person's vulnerability to relationship abuse including: domestic violence and child abuse; attitudes which normalise violence including gender roles; anti-social peers; psychological factors – including low-self-esteem; bullying; early sex, and alcohol and drug use"[8].

5.1.73 Whilst the controlling behaviour of the fathers in this Serious Case Review did not result in the death of their partners, the concerns highlighted by the Police IMR author concerning the behaviour of the Father of Baby Ethan resonate with the two Serious Case Reviews described above. As Dr Barter asserts "*Professionals need to recognise the impact of these risk factors and understand that being in a controlling and abusive relationship will have an impact on a young woman's ability to recognise the abuse, and affect their decision making".*[9]

[6] Conducted by Christine Barter (Senior Research Fellow 2005-present), Professor David Berridge (Professor 2005-present), Dr Melanie McCarry (Research Associate/Lecturer 2004-2013), Ms Marsha Wood (Research Associate 2003-present) and Ms Kathy Evans (Research Associate 2006-2009).

[7] February 2017 Dr Christine Barter is a Reader in Young People and Violence Prevention in the Connect Centre for International Research on New Approaches to Prevent Violence and Harm, at the University of Central Lancashire http://www.safelives.org.uk/practice_blog/violence-young-people%E2%80%99s-relationships-%E2%80%93-reflections-two-serious-case-reviews

[8] ibid

[9] ibid

5.1.74 Information has been provided to the review as to current Police practice, which shows that Hampshire Constabulary is delivering Safelives Domestic Abuse Matters training to all frontline officers and staff, which provides information relating to the identification of coercive and controlling behaviour. Police conference attenders have attended this training. This is learning for all agencies involved in this review and is reflected in recommendation 2, which also explores the establishment of a DASH system and checklist for young people under 16.

Robustness of decision making concerning the child protection process

5.1.75 This review has highlighted the lack of robustness of decision making concerning the protection of these three babies and is a theme arising from this Serious Case Review, as illustrated below.

5.1.76 There was no child protection process for **Baby Connor** and thus no involvement by legal services. This was despite Father being subject to Child Protection procedures in 2015, followed by a Child in Need Plan. The lengthy history of safeguarding concerns in relation to Father should have alerted Children's Social Care, as the lead agency for Child Protection to undertake a Section 47 investigation, once it was known that Father was going to be a parent. Unfortunately, this did not happen, and the focus of social work involvement was in securing accommodation for Mother away from the family home due to the risk presented by her younger sibling. This demonstrated a lack of professional curiosity on the part of agencies about Father's background and the risk his behaviour may have presented to the unborn baby.

5.1.77 The lack of robustness, if not naivety, of the Child Protection Plan for **Baby Danny** has already been the subject of lengthy discussion in this review. Given Mother's known history and vulnerability, and the significant lack of information concerning Father, consideration should have been given to having a Legal Gateway Meeting prior to Baby Danny's discharge from hospital. Whilst Public Law Outline (PLO) meetings did take place, (the purpose of which is to obtain advice as to whether the 'threshold criteria' for a care order under section 31 Children Act 1989 have been met), once Baby Danny had been discharge to the care of his parents, the parents agreed to continue to engage with the Child Protection Plan, with mental health services, parenting courses, capacity to care assessments, assessments of family members and with the FNP. It was recorded that the parents were engaging with all professionals, that the family was visited regularly by different professionals and attended regular review meetings. Thus, it would appear that the threshold criteria were not met. What is not documented is an assessment of risk presented to Baby Danny and consideration given to his lived experience in the care of his parents. It is apparent from information provided to the review that the frequency of visits undertaken by the social worker fell short of expected statutory child protection practice and the monitoring of Baby Danny was left essentially to the Family Nurse.

5.1.78 In the case of **Baby Ethan,** the decision of the ICPC to make the unborn baby a Child in Need was based on Mother residing with Maternal Grandmother and the ending of the relationship between the parents. The Police ceased to be involved once the case was no longer one of Child Protection. The Child in Need Plan made no consideration

of any involvement of Father, assessment of him in case of future contact, arrangements for future contact or medical information concerning his mental health. There was no consideration given to the possibility of the couple reuniting; nor was there any understanding of the pressures on Maternal Grandmother and the previous poor relationship between Mother and Maternal Grandmother. The case was allocated to a student social worker and management oversight was by a temporary manager whilst the permanent manager was on leave. Legal advice was not sought during the ICPC or the Child in Need process.

6 Key Learning arising from this Serious Case Review

6.1.1 The need for professionals to recognise adolescent parents as children themselves, whose brains are still developing, is an important lesson arising from this review. Training focusing on brain development, risk taking behaviour by adolescents and the impact of these factors on their parenting ability would be beneficial to professionals working with young parents. The review has been informed that adolescent brain development is a key element of FNP evidence based training. Thus, those Family Nurses working with young parents, should have been equipped with such understanding. **Recommendation 1.**

6.1.2 Comprehensive, robust assessment of risk factors, in addition to the parenting abilities of young parents, is key if children are to be protected from significant harm. This is particularly important when decisions are made to move mothers and babies from supported accommodation to independent living units where there is a lack of monitoring by staff and substantial support to residents.

6.1.3 The need for suitably qualified staff working with young parents in independent housing is a pre-requisite if the risk posed to young babies by immature, vulnerable parents is to reduce. It is not sufficient for the current service provider to state that their responsibility is to offer intermediate accommodation and to simply signpost young parents to appropriate support services.

6.1.4 The review has been made aware that significant concerns have been raised by Police about the number of times and the reasons why they are required to attend the independent living unit provision in Southampton. If a tragedy such as that of Baby Connor is to be prevented in future, the provision of independent living accommodation needs to include professionally qualified social care staff to support the parents and babies residing at this unit.

6.1.5 Recognition of the need for appropriate support to young parents is a finding from the review. In all three cases the involvement of the FNP was seen as the main support to the parents. Additional social work support and Early Help intervention was also required.

6.1.6 Cases involving vulnerable parents of young babies should not be allocated to student social workers.

6.1.7 The propensity for domestic abuse, controlling and violent behaviour in teenage relationships has been highlighted in the review. Professional awareness needs to be raised about these issues and consideration needs to be given to introducing a DASH risk assessment and checklist for under children under 16 years old.

6.1.8 The review has illustrated that informed, evidence based decisions and challenge, as well as professional curiosity and robust child protection planning, with advice from legal services, is required at ICPCs and Child Protection Conferences.

6.1.9 As is a finding in so many Serious Case Reviews, it is also the case in this review that the need for comprehensive information sharing amongst agencies is fundamental if professionals working with families are to be fully conversant with and understand the risk of significant harm presented to children. This did not happen in the three cases subject to review.

6.1.10 It is however, recognised that is three years since the review was commissioned. Since then, it is important to note that improvements to information sharing have taken place across the partnership. The review has been informed that the FNP now has a stronger relationship with the MASH and an information sharing agreement is in place for MASH practitioners to request information concerning fathers/partners where there are concerns. (**Recommendation 2**).

6.1.11 FNP also now ask fathers and involved partners if they will agree to having records open on System 1 (health recording system) to link with the baby. Whilst this is dependent on gaining the permission of those concerned, if it is provided, then the FNP has access to information across the health economy, e.g. CAMHS, GP records where System 1 is used. Solent Trust are also involved in conversations with Children's Social Care, Police and Information Governance Teams as to how the sharing of PPN1 can be more robust with health, whilst fulfilling their statutory and Information Governance requirements. Such changes in practice are to be commended and should improve information sharing between agencies, which can only serve to benefit the protection of children.

7 Good Practice

7.1.1 The following good practice has been identified in this review:

- The decision of the Southampton Social Worker to visit the offices of Children's Social Care in another local authority to review their records concerning the past history of Baby Danny's Mother was good practice.
- The dissent by representatives of the Leaving Care Team and midwives from the postnatal ward with the decision of the pre-discharge meeting to allow Baby Danny to go home with his parents was good practice.
- The decision of the Team Manager to overrule the view of the GP that Baby Ethan could wait for a child protection medical and insist that an ambulance was called to transport him to hospital, was good practice.

8. Conclusions

7.1.2 The decision of the Southampton Safeguarding Partnership to adopt a thematic approach when commissioning the review has enabled the readers of this report to gain an insight into the difficult and often complex situations, which professionals from different disciplines face on a daily basis when working with young, vulnerable parents.

7.1.3 The report has highlighted significant themes which run throughout all three cases subject to review. These have been discussed in detail, but for the purposes of clarity can be summarised as:

- The importance of recognising parents as children/recently children themselves;
- The need for comprehensive assessment of parenting skills and risk to the unborn baby;
- The importance of support for young parents;
- The impact of mental health issues, self-harming behaviour and substance misuse on parenting capability;
- Over optimism on the part of professionals as to the parents' capacity to care;
- The impact of a lack of good parenting experiences on young parents;
- Recognition of the risk posed by fathers in the lives of babies and children;
- Impact of Homelessness;
- Anger management and domestic abuse;
- Robustness of decision making concerning the child protection process.

7.1.4 It is hoped that the findings of this review will provide a useful reflection of practice for all those working with young parents. However, it is fundamental to any professional when working with such parents to ensure that the safety, welfare and well-being of vulnerable small babies remains their first priority.

8 Recommendations for consideration by Southampton Safeguarding Partnership

Due to the thematic nature of this review, there are more recommendations than would normally be anticipated.

Recommendation 1 **(a) All agencies to ensure that professionals working with young parents are aware of the need to recognise that in the first instance parents under 18 years of age are children themselves.** **(b) This would be achieved by the provision of training concerning the research findings into the brain development of adolescents, risk taking behaviour and the impact of these factors on their parenting ability.**
Recommendation 2 **(a) Whilst dependent on the information parents may wish to share, agencies are to be reminded that wherever possible the life history of fathers, including their own childhood experience of parenting, needs to be documented and shared**

with all professionals involved in working with young, vulnerable parents. Use of the information sharing agreement between the FNP and the MASH is to be encouraged.

(b) The research findings of the University of Bristol (as referenced in this report) on violence in teenage relationships and its consequences for the welfare of mothers and babies should be disseminated to all agencies working with young parents.

(c) Police to continue to recognise that domestic abuse can occur in teenage relationships and use the DASH (Domestic abuse, stalking and harassment) risk assessment, as well as the child at risk element of the safeguarding notification, to assess and share that risk with the relevant partner agencies.

Recommendation 3
Police Officers attending incidents of domestic abuse where children are present should be reminded of the crucial importance of professional curiosity; as embodied in careful exploration, documentation and the reporting of concerns, to ensure that children can be protected from significant harm.

Recommendation 4
The Safeguarding Partnership should consider reviewing as a matter of urgency the appropriateness and safety of the service currently provided to young parents and babies living in supported housing accommodation.

Recommendation 5
Assurance needs to be provided to the Safeguarding Partnership that the seriousness and significant risk of substance and alcohol misuse on the ability of young parents to care for and safeguard their baby/child is fully understood by all professionals by:

(a) Providing training which emphasises the risk of parental substance misuse (especially cannabis) to young babies, and the potential impact on them.
(b) Reviewing the Threshold Assessment Framework so that cannabis/substance use is included.
(c) When undertaking any assessment, cannabis/substance use by a parent is taken into account.

Recommendation 6
The FNP should be required to review standards of record keeping, ensuring inclusion of the development of babies and children and not simply a focus on concerns. This will ensure a complete picture of a child's lived experience in the care of their parent/s is captured.

Recommendation 7
Agencies to be made aware that where a baby is not registered with a GP Practice by the time of their six week developmental check professionals need to consider this as a safeguarding concern.

Recommendation 8 **Careful consideration should be given to which cases are allocated to Student Social Workers. Good quality supervision needs to be provided to the student to ensure that where concerns that a baby/child may be at significant risk of harm, the case can be reallocated when such concerns arise.**
Recommendation 9 **Chairs of Pre-discharge meetings and Initial/Review Child Protection Conferences should be reminded of their responsibility to ensure that any decision made needs to be evidence based, open to challenge and professional curiosity, and results in robust child protection planning, with advice from legal services.**
Recommendation 10 **The Safeguarding Partnership to ensure that all agencies recognise their responsibility to partners to share information concerning the safety and well-being of children, particularly in respect of very young, vulnerable babies if they are to be protected from harm. This can be achieved, by ensuring that once received by the MASH, the pathway already in place for such information to be shared with other agencies is utilised, even if the criteria for a Section 47 referral is not met at the point of initial grading.**

Appendix 1:
Terms of Reference: Non Accidental Injury in Infants - Thematic Review

Reason for review
This thematic review has been commissioned due to three cases involving serious non accidental injury/death of babies aged between six to ten weeks. All three incidents occurred within a two month period. Each case was considered by the SCR Group and met criteria for Serious Case Review under Working Together 2015.

Purpose
This will be a thematic review and analysis of common issues regarding non accidental injury to babies whose parents are teenagers or young adults. The review will be presented as one report which will also include an assessment of particular circumstances pertinent to each individual case.

Period under review
The review will reference the three cases, known as Baby Connor, Baby Danny and Baby Ethan.

The period under review for each child is:
Baby Connor is 11/05/2017 – February 2018
Baby Danny is 10/03/2017– January 2018
Baby Ethan is 4/04/2017 – January 2018

The start date for each review is the date the Mothers' pregnancy became known to agencies. The end date is the date of the injury/death of the child.

This review will request relevant background and contextual information regarding key factors and significant events about the family that was ***known or knowable by the agency at the start of the review period***.

However, it is also important to include any relevant agency knowledge outside of the period of review. To include the time prior to the review period regarding the family background and any other important and relevant information.

The lead reviewer is Moira Murray.

The lead reviewer will work with a panel of agency representatives. Members to include:

- Police
- Social Care
- CCG
- Solent NHS
- UHS
- Education
- Housing
- Legal Services

Analysis issues

This review will consider all issues that could have a bearing on the circumstances of these cases and will include:

- Support offered to young parents
- Assessment of parenting skills and risk to unborn baby
- Impact of mental health issues, self harming behaviour and substance misuse on parenting capability
- Impact of lack of good parenting experiences on young parents
- Impact of homelessness
- Anger management and domestic abuse
- Robustness of decision making concerning child protection process
- Evidencing the child's lived experience within the family
- Over optimism on the part of professionals as to the parent's capcity to care
- Involvement of Police and Criminal Justice

Involvement of staff
The lead reviewer will consider from summary information provided the involvement of relevant staff in this case to ensure any possible learning opportunities are identified and acted upon.

Involvement of families
The lead reviewer will notify the family members of the review and they will be invited to participate as and when appropriate.

Methodology
The methodology for this review will consist of:

- Proportionate IMRs for each individual case (specific template for IMR authors to follow)
- A panel of representatives from relevant agencies
- A review of relevant multi agency policies, procedures and processes that are in place
- Facilitation of multi-agency learning event, to explore key themes arising with partner agencies
- This will be chaired by an Independent Reviewer who will produce a report outlining key findings and multi-agency recommendations. This will be presented to the LSCB.
- The Independent Reviewer will request details and further information where necessary to support analysis and scope of the review. This may involve minutes of meetings, written assessments made and other relevant information.
- Learning from the review will be disseminated with multi agency partners.

Addendum – Analysis questions for IMR
When answering the following questions, please try to take into account how and why decisions were reached at the time, as well as what decisions were made.

Parents
Was appropriate assessment made of:

- The parents' capacity and capability to care for an unborn baby? (to include consideration of their own parenting experience)
- Their needs as young people?
- What support was put in place to enable them to care for their baby? (to include the role of the Family Nurse Partnership, Mother and Baby Unit). Was this sufficient?

Was sufficient consideration given to and assessment made of:

1. The mental health needs of Mother and/or Father?
2. Self-harming behaviour and suicide ideation?
3. Disengagement/withdrawal from education?
4. The effect of alcohol and substance misuse on their ability to parent?
5. The seeming acceptance by professionals of the use of cannabis by the parents, and the effect this had on their ability to parent?
6. The possible involvement of young parents with a network of older adults misusing/dealing drugs?
7. The effect of homelessness?
8. Criminal activity?
9. Domestic abuse?

Were the views of the parents listened to when their own doubts may have been expressed about their ability to care for their unborn baby?

Voice of the Child

- Was there appropriate, robust pre-discharge planning after the baby was born?
- What was a typical day like for a baby in the household?
- Was there appropriate engagement with professionals to ensure that the baby's health and wellbeing was monitored and promoted?
- Was there disguised compliance on the part of the parents?

Child Protection and Legal Processes

- What were the reasons for the unborn baby/baby (and where appropriate, siblings of Mother and Father) to be made subject to a Child in Need Plan, rather than a Child Protection Plan?
- Where appropriate, why was the baby 'stepped down' from a Child Protection to a Child in Need Plan?
- Was there sufficient escalation of concerns?
- Was the Child Protection/Child in Need Plan robust, monitored and reviewed?
- Was the involvement of Legal Services, i.e. PLO process, timely and appropriate? Could intervention have been earlier?

General

- Was the case looked at holistically, from the perspective of the child?
- Were professionals over optimistic in the belief that the baby could be safely and well cared for by the parents?
- What are the criteria for 'good enough' home conditions?
- Was there good information sharing between and within agencies?
- What do we learn from this case?

Appendix 2

The Process of the Serious Case Review

The mandatory criteria for carrying out a Serious Case Review as set down in Working Together to Safeguard Children (2015), is as follows:

(a) abuse or neglect of a child is known or suspected; and

(b) either:

(i) the child has died; or
(ii) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

The purpose of a Serious Case Review is to undertake an independent appraisal of practice, whilst also recognising the complex circumstances in which professionals are working. A review also seeks to understand the role of all agencies involved with a family, to identify improvements which are needed and to consolidate good practice. It is not about apportioning blame.

A Serious Case Review seeks to encourage:

- a culture of continuous learning and improvement across organisations that work together to safeguard and promote the welfare of children, and that
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

For the purposes of transparency all Serious Case Reviews are required by the Department of Education to be published. The Lead Reviewer is aware of the sensitivity of the information contained in this report and the distress that it may cause to family members. There has been an attempt to balance the need for agencies to learn lessons from this review and the need to manage the distress of the families concerned. All personal information has therefore been anonymised, and pseudonyms have been used to refer to key family members and those connected with the three babies.

It is expected that Southampton Safeguarding Children Partnership will translate the findings from this review into programmes of action, leading to sustainable improvements and the reduction of risk of death, serious injury or harm to children. Some agencies have already taken steps to improve practice as result of the untimely death and injury of these babies. The review acknowledges and references where this has happened.

Agency IMR Reports

The following agencies were requested to contribute to this review:

Baby Connor	Baby Ethan	Baby Danny
• Police • Local Authority Children and Families Service • GP • Hospital NHS Foundation Trust including maternity • 0-19 Services; Health Visiting, FNP • Secondary School • Local Authority Education Welfare • Ambulance Service • Local Authority Housing and Homelessness Team • Commissioned Housing Provider	• Police • Local Authority Children and Families Service • Secondary School • Hospital NHS Foundation Trust including maternity • Local Authority Housing and Homelessness Team • GP • 0-19 Services; Health Visiting, FNP, CAMHS	• Police • GP • Mental Health Services: perinatal mental health and Adult Mental Health Team • Local Authority Children and Families Service including Care Leavers Team • Local Authority Adult Social Care • Hospital NHS Foundation Trust including maternity • 0-19 Services; Health Visiting, FNP, CAMHS • Local Authority Housing • Local Authority Education • Local Authority Legal Services

The Serious Case Review Panel included members of the following agencies:

- Police
- Social Care
- Local Clinical Commissioning Group including Primary Care
- Solent NHS Trust
- Hospital NHS Foundation Trust Southampton
- Education
- Housing
- Legal Services
- Integrated Commissioning Unit

Appendix 3

The Serious Case Review Author/Lead Reviewer

Moira Murray is a social worker by training and has been the chair and author of numerous Serious Case Reviews over the past eleven years. She has also undertaken safeguarding audits for local authorities, the NHS, the Foreign & Commonwealth Office and the BBC. She was a non-executive board member of the Independent Safeguarding Authority for five years and in 2012 was appointed Safeguarding Manager for children and vulnerable adults for the London Olympic and Paralympic Games. Most recently she was the Senior Casework Manager for the Church of England National Safeguarding Team.

In the past, Moira Murray has been commissioned by Southampton Safeguarding Partnership to undertake several Serious Case Reviews. As a result, she has had previous professional contact with some of the SCR Panel Members and IMR authors involved in this review. However, she has had no involvement with any of the three cases subject to review, and had no knowledge of, or prior involvement with the babies of their families, before her appointment as the review independent author.

Thematic Serious Case Review
6 Step Briefing

The Background

In March 2018 the Southampton Safeguarding Children's Board (hereafter known as the Southampton Safeguarding Children Partnership) commissioned a Serious Case Review into the death of one baby and serious injuries to two others. Due to the similarities in the age of the babies, the background of their parents and the timespan of the incidents occurring it was decided to consider all three cases together.
The thematic Serious Case Review gives an analysis of common issues concerning non-accidental injury to babies whose parents were teenagers and young adults. The review is presented as one report with an assessment of circumstances pertinent to each case

The Review

The review was conducted by an independent reviewer. The review considers a number of areas including; support offered to young parents, assessments of parenting skills and risk to the unborn baby, impact of mental health issues and substance misuse on parenting capability, impact of lack of good parenting experiences, the impact of homelessness, anger management and domestic abuse, robustness of decision making concerning the child protection process, evidencing the child's lived experience within the family, over optimism on the part of professionals and the involvement of police and Criminal Justice.

Key Themes

- All were young parents, and all had experienced childhood trauma and/or Adverse Childhood Experiences
- All the babies were males and of White British ethnicity
- All three babies had received significant injuries, which resulted in the death of one child
- All of the incidents occurred within the same two-month period
- At least one of the parents of each of the children had exhibited violent behaviour in the past
- Alcohol and cannabis misuse feature in all the cases
- All the young parents had experienced homelessness

Key Learning Points

- The need for professionals to recognise adolescent parents as children themselves, whose brains are still developing, is an important lesson arising from this review. Training focusing on brain development, risk taking behaviour by adolescents and the impact of these factors on their parenting ability would be beneficial to professionals working with young parents.
- Comprehensive, robust assessment of risk factors, in addition to the parenting abilities of young parents, is key if children are to be protected from significant harm. This is particularly important when decisions are made to move mothers and babies from supported accommodation to independent living units where there is a lack of monitoring by staff and substantial support to residents.
- The need for suitably qualified staff working with young parents in independent housing is a pre-requisite if the risk posed to young babies by immature, vulnerable parents is to reduce. It is not sufficient for the current service provider to state that their responsibility is to offer intermediate accommodation and to simply signpost young parents to appropriate support services.

Key Learning Points continued

- The review has been made aware that significant concerns have been raised by Police about the number of times and the reasons why they are required to attend the independent living unit provision in Southampton. The provision of independent living accommodation needs to include professionally qualified social care staff to support the parents and babies residing at this unit.
- Recognition of the need for appropriate support to young parents is a finding from the review. In all three cases the involvement of the Family Nurse Partnership (FNP) was seen as the main support to the parents. Additional social work support and Early Help intervention was also required.
- Cases involving vulnerable parents of young babies should not be allocated to student social workers.
- The propensity for domestic abuse, controlling and violent behaviour in teenage relationships has been highlighted in the review. Professional awareness needs to be raised about these issues and consideration needs to be given to introducing a DASH risk assessment and checklist for under children under 16 years old.
- The review has illustrated that informed, evidence-based decisions and challenge, as well as professional curiosity and robust child protection planning, with advice from legal services, is required at Initial Child Protection Conferences and Review Child Protection Conferences
- As is a finding in so many Serious Case Reviews, it is also the case in this review that the need for comprehensive information sharing amongst agencies is fundamental if professionals working with families are to be fully conversant with and understand the risk of significant harm presented to children. This did not happen in the three cases subject to review.
- It is however, recognised that is three years since the review was commissioned. Since then, it is important to note that improvements to information sharing have taken place across the partnership. The review has been informed that the FNP now has a stronger relationship with the MASH and an information sharing agreement is in place for MASH practitioners to request information concerning fathers/partners where there are concerns
- FNP also now ask fathers and involved partners if they will agree to having records open on System 1 (health recording system) to link with the baby. Whilst this is dependent on gaining the permission of those concerned, if it is provided, then the FNP has access to information across the health economy, e.g. CAMHS, GP records where System 1 is used. Solent Trust are also involved in conversations with Children's Social Care, Police and Information Governance Teams as to how the sharing of PPN1 can be more robust with health, whilst fulfilling their statutory and Information Governance requirements. Such changes in practice are to be commended and should improve information sharing between agencies, which can only serve to benefit the protection of children.

Good Practice

- The Southampton Social Worker to visit the office of another local authority to review their records concerning the past history of one of the parents was good practice.
- The dissent by members of a Leaving Care Team and midwives from the postnatal ward with the decision of the pre-discharge meeting to allow one of the babies to go home with his parents was good practice.
- The Team Manager who ensured that one of the babies did not wait for a child protection medical and insisted that an ambulance was called to transport him to hospital, was good practice

The Recommendations

Recommendation 1

(a) All agencies to ensure that professionals working with young parents are aware of the need to recognise that in the first instance parents under 18 years of age are children themselves.

(b) This would be achieved by the provision of training concerning the research findings into the brain development of adolescents, risk taking behaviour and the impact of these factors on their parenting ability.

Recommendation 2

(a) Whilst dependent on the information parents may wish to share, agencies are to be reminded that wherever possible the life history of fathers, including their own childhood experience of parenting, needs to be documented and shared with all professionals involved in working with young, vulnerable parents. Use of the information sharing agreement between the FNP and the MASH is to be encouraged.

(b) The research findings of the University of Bristol (as referenced in this report) on violence in teenage relationships and its consequences for the welfare of mothers and babies should be disseminated to all agencies working with young parents.

(c) Police to continue to recognise that domestic abuse can occur in teenage relationships and use the DASH (Domestic abuse, stalking and harassment) risk assessment, as well as the child at risk element of the safeguarding notification, to assess and share that risk with the relevant partner agencies.

Recommendation 3

Police Officers attending incidents of domestic abuse where children are present should be reminded of the crucial importance of professional curiosity; as embodied in careful exploration, documentation and the reporting of concerns, to ensure that children can be protected from significant harm.

Recommendation 4

The Safeguarding Partnership should consider reviewing as a matter of urgency the appropriateness and safety of the service currently provided to young parents and babies living in supported housing accommodation.

Recommendation 5

Assurance needs to be provided to the Safeguarding Partnership that the seriousness and significant risk of substance and alcohol misuse on the ability of young parents to care for and safeguard their baby/child is fully understood by all professionals by:

(a) Providing training which emphasises the risk of parental substance misuse (especially cannabis) to young babies, and the potential impact on them.
(b) Reviewing the Threshold Assessment Framework so that cannabis/substance use is included.
(c) When undertaking any assessment, cannabis/substance use by a parent is taken into account.

The Recommendations

Recommendation 6

The FNP should be required to review standards of record keeping, ensuring inclusion of the development of babies and children and not simply a focus on concerns. This will ensure a complete picture of a child's lived experience in the care of their parent/s is captured.

Recommendation 7

Agencies to be made aware that where a baby is not registered with a GP Practice by the time of their six week developmental check professionals need to consider this as a safeguarding concern.

Recommendation 8

Careful consideration should be given to which cases are allocated to Student Social Workers. Good quality supervision needs to be provided to the student to ensure that where concerns that a baby/child may be at significant risk of harm, the case can be reallocated when such concerns arise.

Recommendation 9

Chairs of Pre-discharge meetings and Initial/Review Child Protection Conferences should be reminded of their responsibility to ensure that any decision made needs to be evidence based, open to challenge and professional curiosity, and results in robust child protection planning, with advice from legal services.

Recommendation 10

The Safeguarding Partnership to ensure that all agencies recognise their responsibility to partners to share information concerning the safety and well-being of children, particularly in respect of very young, vulnerable babies if they are to be protected from harm. This can be achieved, by ensuring that once received by the MASH, the pathway already in place for such information to be shared with other agencies is utilised, even if the criteria for a Section 47 referral is not met at the point of initial grading.

Further reading and resources

Thematic Serious Case Review, Southampton Safeguarding Children Partnership

Blakemore Sarah-Jayne *Inventing Ourselves: The Secret Life of the Teenage Brain, 2018*

International Research on New Approaches to Prevent Violence and Harm, at the University of Central Lancashire http://www.safelives.org.uk/practice_blog/violence-young-people%E2%80%99s-relationships-%E2%80%93-reflections-two-serious-case-reviews

Children living in households where there is substance misuse

HIPS Unborn Baby Protocol

Family Approach Toolkit

Southampton Safeguarding Children Partnership Response

Thematic Review – Non-Accidental Injury

Three Serious Case Reviews were commissioned by the Southampton Safeguarding Children Partnership during 2018. These were combined into a thematic review due to the similarity of some of the issues that were apparent. The thematic review considers the circumstances of three infants within three families.

The independent review brought together the contribution of several agencies and professionals that had been or were involved with the infants and their families. Several areas of learning and improvement and recommendations have been made for Southampton Safeguarding Children Partnership to continue to take forward.

The Safeguarding Partners in Southampton have endorsed the recommendations and will work to ensure the recommendations continue to be implemented and the learning understood by colleagues who work to safeguard children.

This document provides the responses of the Southampton Safeguarding Children Partnership and individual partner agencies to recommendations made to them.

Recommendation 1 **(a) All agencies to ensure that professionals working with young parents are aware of the need to recognise that in the first instance parents under 18 years of age are children themselves.** **(b) This would be achieved by the provision of training concerning the research findings into the brain development of adolescents, risk taking behaviour and the impact of these factors on their parenting ability.**
Agency training programs for professionals working with young parents includes the need to recognise that parents under 18 years of age are children themselves. The training provided includes reference and information about brain development and risk-taking behaviour. Some services such as Solent NHS Trust, Family Nurse Partnership, Health Visiting Teams, received enhanced training in this area. Children and Learning Services have provided assurance that if there are specific risks to a young person who may themselves be a parent, their needs are assessed by a separate social worker. Should a parent, who is under the age of 18, and their child, require a child in need, child protection, or looked after child care plan, these plans will be created and reviewed through separate processes, but the meetings may be combined in order to reduce the number of meetings the parent is being asked to attend. The needs and wishes of the parent, will be considered during the consideration and planning of these processes.

Services have specific checks and balances in their work and contact with young parents to ensure the right level of support is provided. This includes for example from Hamshire Constabulary – their Child Centred Policing Strategy, with the first principle "Treating every child as a child first". From the Midwifery Services at the University Hospital Southampton Foundation trust, if under 18 years a young parent will be routinely referred to the Needing Extra Support Team Midwife

There is multi agency commitment to trauma informed approaches, and this is evident in several agencies, including Hampshire Constabulary.

Recommendation 2

(a) Whilst dependent on the information parents may wish to share, agencies are to be reminded that wherever possible the life history of fathers, including their own childhood experience of parenting, needs to be documented and shared with all professionals involved in working with young, vulnerable parents. Use of the information sharing agreement between the FNP and the MASH is to be encouraged.

(b) The research findings of the University of Bristol (as referenced in this report) on violence in teenage relationships and its consequences for the welfare of mothers and babies should be disseminated to all agencies working with young parents.

(c) Police to continue to recognise that domestic abuse can occur in teenage relationships and use the DASH (Domestic abuse, stalking and harassment) risk assessment, as well as the child at risk element of the safeguarding notification, to assess and share that risk with the relevant partner agencies.

Health provider colleagues, including Solent NHS Trust and University Hospital Southampton Foundation Trust currently where possible and appropriate link fathers to the child on our electronic health records and actively seek information regarding fathers. Children's Social Care Services actively seek information regarding fathers and the Information Sharing Agreement (ISA) in place between MASH and Safeguarding Partners is utilised to ensure fathers details included within the referral are researched according to the ISA. It is noted as an area for development for agencies to include father's details in referrals. Hampshire Constabulary considers it essential that officers and staff attending incidents gather information relating to other adults and children present. This enables a thorough assessment of risk and the provision of key information to partners.

The research findings from the University of Bristol are being shared with agencies working with young parents through mechanisms including a bespoke briefing document. This will be shared widely and is available on the SSCP website. Agencies also share learning through their own individual training and communication.

Hampshire Constabulary are continuing to ensure officers understand more regarding domestic abuse in adolescent relationships, this is complemented by the Child Centred Policing Strategy which sees children as children first in all encounters. For those age 16 and above who are experiencing domestic abuse a DASH risk assessment is mandatory. The DASH features as a part of the Police Safeguarding Notification (PPN1) as a combined risk assessment tool and can therefore also identify any children involved as children at risk as well as victims/perpetrators of domestic abuse. This continues to be scrutinised via the work of the constabulary's Domestic Abuse champion network and the relevant scrutiny panels for both Domestic Abuse and the PPN1 - this is further built into the constabulary's training offer.

Recommendation 3

Police Officers attending incidents of domestic abuse where children are present should be reminded of the crucial importance of professional curiosity; as embodied in careful exploration, documentation and the reporting of concerns, to ensure that children can be protected from significant harm.

Hampshire Constabulary has developed an online training POD (policy optimisation drop) which explores themes such as professional curiosity and disguised compliance – this is available to officers and staff to access in their training and briefing sessions.

As identified police officer and staff response in domestic abuse incidents continues to be scrutinised via the work of the constabulary's champion network and the relevant scrutiny panels for both Domestic Abuse and the PPN1 - this is further built into the constabulary's training offer. The Domestic Abuse champion network will review between 60 – 450 incidents per month based on a series of themes with a proposal in place to audit domestic abuse in adolescent relationships where police have attended, and domestic abuse is a feature.

Professional curiosity has also been previously addressed in face-to-face training (Sandstories) delivered to the Child Abuse Investigation team in 2019 which looks at disguised compliance and professional curiosity. Further funding was made available to deliver this more broadly to specialist teams in 2021/2022 (this was due to take place in 2020 however delayed due to Covid restrictions).

As identified in the previous recommendations the Child Centred Policing Strategy covers a wide range of themes within which professional curiosity is present. The documentation of any concerns would routinely be via the PPN1 safeguarding notification, the continuous improvement plan for the PPN1 is addressed above and in previous sections.

A HMIC child focussed inspection in June 2021, identified the need for a clear training plan for MASH staff, to ensure they were equipped with identifying and managing risk effectively in all cases referred to them. The delivery of this training programme is aimed for completion by the end of 2021.

Recommendation 4

The Safeguarding Partnership should consider reviewing as a matter of urgency the appropriateness and safety of the service currently provided to young parents and babies living in supported housing accommodation.

The **Integrated Commissioning Unit (Southampton City Council and CCG)** has undertaken an extensive review of young peoples and young parents housing/supporting lodgings provision in preparation for re-procurement in 2022. This includes the quality and safeguarding reporting requirements of all providers and the oversight measures put in place.

The review also included how the level of risk identified for a young person is appropriately matched to housing provision and the level of support required in addition to fulfilling the basic housing need- this extends to young parents.

The supported housing local authority risk assessment guidance has been updated to include reference to young parents.

Safeguarding training has also been updated and completion is being tracked by workforce development team.

The SSCP have been updated in relation to progress. It is noted two actions have been impacted in terms of timescales due to the impact of COVID-19 and work on communications and training for the multi-agency workforce remains to be completed. The SSCP are assured the remaining actions while there may be some delay in completion remain in control to be completed.

Recommendation 5

Assurance needs to be provided to the Safeguarding Partnership that the seriousness and significant risk of substance and alcohol misuse on the ability of young parents to care for and safeguard their baby/child is fully understood by all professionals by:

(a) Providing training which emphasises the risk of parental substance misuse (especially cannabis) to young babies, and the potential impact on them.
(b) Reviewing the Threshold Assessment Framework so that cannabis/substance use is included.
(c) When undertaking any assessment, cannabis/substance use by a parent is taken into account.

This recommendation has ensured agencies promote and encourage attendance at training opportunities on this subject. Some agencies also include reference to the impact of parental substance misuse within their own safeguarding training pathways**.**

The Continuum of Need (Threshold Assessment Framework) is under review through the MASH Strategic Group and is due to be considered by the SSCP in December 2021. It includes parental and adolescent substance misuse, along with adolescent parents.

Relevant agencies have provided assurance that assessments are structured to consider cannabis, substance use by parents. Advice is available to staff through line management and

named/designated safeguarding professionals. The Children and Learning Service also assure the identification of risks and concerns are part of the Quality Assurance Framework.

Recommendation 6

The FNP should be required to review standards of record keeping, ensuring inclusion of the development of babies and children and not simply a focus on concerns. This will ensure a complete picture of a child's lived experience in the care of their parent/s is captured.

The Family Nurse Partnership (FNP) are committed to ensuring high quality of record keeping. Supervisors regularly discuss in team meetings and supervision the importance of documenting formulations as well as observations, what is reported and always holding the child's perspective. Case based presentations and including additional section in supervision about the experience of the child have supported with this. A quality of records audit is planned to support this work and provide assurance that learning has been embedded.

FNP delivery includes additional Ages and Stages Questionnaire developmental assessments in addition to mandated Healthy Child Programme contacts to review development as part of the offer to every family.

Recommendation 7

Agencies to be made aware that where a baby is not registered with a GP Practice by the time of their six-week developmental check professionals need to consider this as a safeguarding concern.

Solent NHS Trust is in the process of developing guidance to support practitioners on what action is required when a baby is not registered with a GP by six-weeks.

UHSFT: The need to register your baby with a GP is discussed at defined touch points during the postnatal period such as on discharge from hospital and from maternity services

Southampton Children & Learning Services: Should a professional refer to MASH a baby that was not registered at a GP within the first 6 weeks, they would take into consideration all other elements of concerns for the child and their family members to ensure that a full risk assessment could be undertaken within the process.

The CCG will work with GP Practices to ensure that there is a robust system in place to maintain a log of births following receipt of birth notifications, which can be used to track baby registrations. Practices to aim to have all babies registered by 6 weeks of age or, at the latest, on the day of the '6-week check'. This check should ideally be carried out at 6-8 weeks of age to tie-in with the maternal postnatal check. Due to unforeseen events or reasons given by parents, occasionally the check might be postponed but this should be no later than 12 weeks. A GP should be made aware if this is the case, if there has been failed contact with the parents of an as yet unregistered baby, or if a 6-week check has been refused.

The CCG will ensure that this guidance is disseminated as part of the current process of sharing learning from reviews and reinforced in training and supervision sessions.

Recommendation 8 **Careful consideration should be given to which cases are allocated to Student Social Workers. Good quality supervision needs to be provided to the student to ensure that where concerns that a baby/child may be at significant risk of harm, the case can be reallocated when such concerns arise.**
There is now a Principal Social Worker in position within Children Services that oversees the Practice Development Team (PDT). An advanced practitioner within the PDT has the role of Practice Consultant and oversees the student programmes. Student Social Work and newly qualified social worker programmes ensuring the process includes robust supervision and support for students and newly qualified social workers so that risk is adequately assessed, and cases transferred to qualified or more experienced workers appropriately. For student social workers, they have placement review meetings, and supervision by the practice supervisor is overseen by the practice educator, who picks up if there are any issues of inappropriate work allocated.
Recommendation 9 **Chairs of Pre-discharge meetings and Initial/Review Child Protection Conferences should be reminded of their responsibility to ensure that any decision made needs to be evidence based, open to challenge and professional curiosity, and results in robust child protection planning, with advice from legal services.**
Southampton Children & Learning Services: Team Manager, Assistant Team Managers, and experienced social workers chair post-birth pre-discharge meetings, they are aware of their responsibility to ensure safe decisions are made for the child in question and welcome challenge from the network and professional curiosity. There is a clear HIPS escalation Policy for professionals who do not feel that their views or concerns have been fully weighted in decision making, or if they feel the plan does not provide sufficient safety. Managers can seek legal advice when they are considering whether legal threshold are met. Child Protection Conference Chairs are independent of the case holding team and management and are therefore able to be a critical friend to the case holding service, professional network and family when considering the balance of risks and protective factors and creating a plan to address the risks and concerns in a timely and robust manner. Senior Management oversight of child protection conference minutes and plans takes place every 2 months and reviews several cases to quality assure the standard of practice.
Recommendation 10 **The Safeguarding Partnership to ensure that all agencies recognise their responsibility to partners to share information concerning the safety and well-being of children, particularly in respect of very young, vulnerable babies if they are to be protected from harm. This can**

be achieved, by ensuring that once received by the MASH, the pathway already in place for such information to be shared with other agencies is utilised, even if the criteria for a Section 47 referral is not met at the point of initial grading.
Solent NHS Trust: FNP are in the process of updating the working protocol for information sharing with children social care to ensure that it is robust and includes/ considers the learning from this review. Southampton Children & Learning Services: There is a clear information sharing agreement in place between MASH and safeguarding agencies. Hampshire Constabulary: As previously highlighted as a part of continuous improvement to the PPN1 safeguarding notification form (which is shared with partners when risk is identified), a number of work streams have been put in place. This includes the PPN1 scrutiny panel which looks at the quality of police PPN1s and identifies any gaps in or good practice. This is to be combined with a detailed training programme which will be delivered across the constabulary via webinars and other training mechanisms. Hampshire Constabulary works closely with partner agencies within the MASH to share information regarding children at risk of harm. Existing force policy is that all child related safeguarding matters will be passed across to the attention of relevant child service departments, so that a multi-agency risk assessment can then be completed, irrespective of whether that review then leads to further formal action by those agencies. This methodology, which also includes immediate referrals to relevant schools for any child subject to a missing episode or domestic abuse incident, is currently subject to further discussion with several Local Authority areas, who are concerned on the proportionality of these automatic police referrals. The ability to meet this increased demand are matched by the equally valid concerns raised around any person making a single agency assessment of risk, when other relevant information may be readily available to them within other organisations but that they have chosen not to request. The CCG work with all agencies to ensure that Safeguarding procedures are robust and implemented. The CCG has regular meetings with MASH and other Children's Services Teams to review this and ensure that information sharing agreements are appropriate and are followed.

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DECISION-MAKER:	CHILDREN AND FAMILIES SCRUTINY PANEL
SUBJECT:	SOUTHAMPTON SAFEGUARDING CHILDREN PARTNERSHIP ANNUAL REPORT 2020/21
DATE OF DECISION:	27 JANUARY 2022
REPORT OF:	INDEPENDENT CHAIR OF THE SOUTHAMPTON SAFEGUARDING CHILDREN PARTNERSHIP

CONTACT DETAILS				
Independent Chair	**Title**	**Independent Chair of the Southampton Safeguarding Children Partnership**		
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STATEMENT OF CONFIDENTIALITY

BRIEF SUMMARY
The Annual Report provides the Panel with an update on the work of the Southampton Safeguarding Children Partnership (SSCP) during 2020/21. The Annual Report is a requirement of the statutory guidance "Working Together to Safeguard Children" 2018. The SSCP Annual Report was published on 2nd December 2021 and is attached as Appendix 1. The Panel are recommended to consider the SSCP Annual Report and present any questions on the content.

RECOMMENDATIONS:		
	(i)	The Panel receive the SSCP Annual Report to inform the work of the Panel.

REASONS FOR REPORT RECOMMENDATIONS	
1.	To ensure the information contained in the report is used to support the work of the scrutiny function.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None

DETAIL (Including consultation carried out)	
3.	The SSCP 2020/21 Annual report, attached as Appendix 1, was published on 2nd December 2021. The Independent Chair of the Partnership will be in attendance at the meeting to answer questions from the Panel relating to the contents of the report and the SSCP.

RESOURCE IMPLICATIONS

Capital/Revenue	
4.	None
Property/Other	
5.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
6.	The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
7.	The Annual Report is a requirement of the statutory guidance "Working Together to Safeguard Children" 2018.
RISK MANAGEMENT IMPLICATIONS	
8.	Consideration of the 2020/21 SSCP Annual Report will help to target the work of the Scrutiny Panel to ensure that focus is directed at improving outcomes for children and young people in Southampton.
POLICY FRAMEWORK IMPLICATIONS	
9.	None.

KEY DECISION?	**No**	
WARDS/COMMUNITIES AFFECTED:	None	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Southampton Safeguarding Children Partnership Annual Report – 2020/21	

Documents In Members' Rooms

1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?		**No**
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**	
1.	None	

Southampton Safeguarding Children Partnership

Annual Report

2020/2021

Foreword

It is a privilege for me to introduce the Annual Report for the Southampton Safeguarding Children Partnership for 2020/21. It has been a year of unprecedented challenges for all the partners agencies involved in safeguarding the children and young people of the city.

The pandemic has continued to exacerbate vulnerabilities, and this has inevitably led to an increase in demand for services.

We have seen pressures in the system around online abuse, mental health and wellbeing and incidences of neglect, all of which require a partnership response if long-term sustainable solutions are to be found.

The Annual Report provides an overview of these and other issues faced, the outcomes experienced and an assessment as to whether the partnership has made a difference.

There remains more to be done in 2021/22 and beyond, and the immediate future continues to be shaped by the pandemic. Our priorities reflect the need to put children at the heart of what we do, and it is essential we listen and respond to those children and their families.

The safeguarding partnership has responded positively throughout this period demonstrating commitment, flexibility and innovation.

Southampton has a strong partnership at both the strategic and operational levels, and I am confident that we will see further improvement in the services provided for the children of the city.

Derek Benson
Independent Chair

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Introduction

The role of the Safeguarding Children Partnership (SSCP)

Nothing is more important that the welfare of children[1]. The Children Act 2004 (amended by the Children and Social Work Act 2017) placed new duties on police, clinical commissioning groups and local authorities to make arrangements to work together and with wider partners to safeguard and promote the welfare of all children in their area. In Southampton this has created a strong alliance between the three safeguarding partners, working with and wider agencies in the city.

The work of the SSCP is overseen by Derek Benson, Independent Chair, and undertaken by an team hosted within Southampton City Council Children's Services. The three safeguarding partners in Southampton are:

- Southampton City Council Children's Services – Rob Henderson, Executive Director for Children's Services & Learning
- Hampshire Constabulary – Simon Dodds, Superintendent & District Commander
- Southampton City Clinical Commissioning Group – Matthew Richardson, Deputy Director of Quality & Nursing – Southampton

Safeguarding and promoting the welfare of children is defined by *Working Together 2018* as:

• protecting children from maltreatment

• preventing impairment of children's mental and physical health or development

• ensuring that children grow up in circumstances consistent with the provision of safe and effective care

• taking action to enable all children to have the best outcomes

About this Annual Report

This Annual Report captures the work of the SSCP as a result of the safeguarding arrangements in place in Southampton, including learning from reviews, and an analysis of how effective the arrangements have been in improving outcomes for children and families in the city. This report also looks at the impact of the partners' work together.

The impact of Covid-19 on us all, cannot be underestimated, but particularly on children who are vulnerable. This report begins with a section dedicated to the impact of COVID-19 and the response by services working with children and families.

The focus in Southampton is learning and impact, and as such this report follows the Covid Impact and Response with Learning from Reviews and the improvements that this has brought about and closes with background information on the demographics of Southampton and governance arrangements.

[1] *Working Together to Safeguard Children 2018*

COVID-19 - Impact & Response

Following the Prime Minister's "stay at home" in March 2020, processes were put in place to assess children's vulnerabilities/risks, ensuring appropriate levels of contact and service were maintained in partnership with schools, early years and post-16 settings. This included our children known to be most vulnerable and those with emerging vulnerabilities and risks. These processes were further refined during each lockdown, with mechanisms for checking in with families and schools during this time, which were shared between the Children and Learning Service (including our integrated Early Help Service), schools and settings and Hampshire Constabulary. A focused partnership response to ensure the safety and wellbeing of our children safe and ensuring the right children continued to attend school, were contacted, seen and supported.

The early stage of the pandemic saw a reduction in referrals to MASH. As schools opened to more children referral rates returned to more usual levels and have subsequently increased. The HIPS Section 11 'Keeping Children Safe Organisational Self Audits' displayed themes correlating to the pandemic such as recognising the rise of concerns about mental health, child to parent violence, domestic violence and neglect during the pandemic and the resultant pressure on services.

The safeguarding partners and independent chair have met regularly to consider risk factors around COVID-19, including the ways that Government restrictions and lockdown affected the children and families and the settings/services supporting them. This allowed for problem solving, collaboration and the timely sharing of information. The safeguarding partners continue to meet regularly. The flexibility of the agenda in these meetings, focused on safeguarding matters, allows for problem solving in a safe environment and has supported effective partnership working.

The SSCP were able to respond to some of concerns and challenges raised in this meeting, sending information to partners and practitioners about various areas of safeguarding practice, including Neglect, Domestic Abuse, Child Exploitation, Abusive Head Trauma and Safer Sleep.

Across partner agencies there has been much learning regarding virtual working and where this may add value and where it does not. This has resulted in a more flexible offer to children, young people and families. Partnership meetings have moved to being virtual and this has been generally viewed as positive and is likely to remain at least partly virtual.

Training largely moved from face to face to virtual sessions. A few training sessions entirely suited to being face to face were put on hold, but the majority have been reviewed and placed online either through e-learning or a webinar platform. This has meant attendance at safeguarding training events has been maintained and for some services has increase engagement through ease of access.

In June 2020, the SSCP conducted a survey regarding learning points for partners from operating during the early stages of COVID-19. This survey considered the positive aspects of remote working for professionals with regards to certain meetings concerning children:

- Strategy meetings
- Professional meetings
- Discharge planning meetings
- Child Protection Case Conferences
-

Core staff involved with the care of the child can be present at the meeting and share information more easily. It also gives colleagues the opportunity to have access to computer systems and significantly reduce travelling time. This has not been the same experience for children and families as we know face-to-face meetings are generally more appropriate, essential and preferred. This has left a need to develop a hybrid model which can be flexibly used.

The caveat is the clear view that not all multi-agency working should be virtual and there is the benefit of face to face working that can allow for deeper exploration of areas, increased awareness of risk factors and is beneficial in relationship building. We know that work with children and families clearly must have a component of face-to-face work in order to effectively safeguard children.

Services have flexed and reviewed delivery models to ensure vulnerable children and families are supported, this has been seen in relation to all partner and relevant agencies. The multi-agency safeguarding workforce has continued to support children and families, with a recognition from senior managers of the impact on staff of a quick change to often complete remote working, different working practices and the resultant impacts. It is recognised face to face and/or frequent contact and support is important to us all, opportunities for colleagues to step away from their work, reflect together and build relationships with each other remain important for the work we do.

Family feedback during the pandemic

"We couldn't have done so well if it wasn't for our superstar health visitor. I didn't think I'd need as much support as I do but she's been a lifesaver for us! She really went above and beyond what I would think is asked for her and she wasn't even originally my health visitor."
Parent's feedback on Health Visitor during Covid

"I liked the games. I made friends and had a good time."
Child's feedback on Sure Start family day on 17 June.

"Sure Start have been amazing in this lockdown world. That was amazing, funny, original so appreciated."
Parent's feedback following Sure Start family activity and support 'jungle day' on 17 June.

"Having the virtual support has been a lifeline."
Parent's feedback on virtual group(s) for families, co delivered with volunteers, for those impacted by domestic abuse.

Learning from Reviews

Case Reviews and Learning

In line with Working Together 2018 the Southampton Safeguarding Children Partnership commissions Child Safeguarding Practice Reviews. Under transitional arrangements, Serious Case Reviews commissioned by the Local Safeguarding Children Board (LSCB) are being completed. The reviews published during this year were commissioned by the LSCB.

Reviews are a key method of gaining learning from when services could have been better for a child and their family. The recommendations from reviews drive action to address the issues and ensure that services improve in future. Recommendations are monitored by the Serious Incident Learning Group on behalf of the Safeguarding Children Partnership.

Full details can be found here

Freddie (published August 2020)

This Serious Case Review focussed on neglect and harmful sexual behaviours and the review examined the barriers to keeping Freddie safe. Several lessons were highlighted for the partnership, which included the need for child protection planning to have pace and purpose to prevent drift and less effective multi-agency working.

There is now training for the multi-agency workforce in respect of Child Sexual Abuse within the Family Environment, and this will continue in 2021/22.

Clare (published November 2020)

This Serious Case Review was commissioned following Clare's death in 2018. Several themes were identified for the partnership, including parental discord, domestic abuse, impact on children and disguised compliance and hostility towards professionals, male partners in the family environment and the importance of listening to children.

The SSCP now commission Sandstories training to support multi agency practitioners where there are concerns about disguised compliance. An Unidentified Adults Toolkit has been produced to help raise awareness of the need to be curious about the background of male partners. Agencies have demonstrated the training provided to their staff about Domestic Abuse and the impact on children.

The SSCP have updated and refreshed their Learning from Reviews Briefing which can be found here

The Serious Incident and Learning Group on behalf of the safeguarding partners commissioned two Child Safeguarding Practice Reviews in 2020/21.

Effectiveness of Safeguarding Arrangements

Safeguarding Practice Improvement Group

The Safeguarding Partnership Improvement Group (SPIG) works to ensure that that learning from reviews and audits results in practice development and improvements to outcomes for children in Southampton. The group also focusses on priority themes agreed by the SSCP at the start of each financial year. This year the priority theme was Child Sexual Abuse in the Family Environment and Early Help information was reviewed as provided to Ofsted for the focussed visit. Progress against themes for last year (Neglect and Mental Health) were also revisited to ensure progress. The group has oversight of Keeping Children Safe (section 11) audit work and links to Hampshire, Isle of Wight and Portsmouth; drawing out themes to present to the SSCP Board annually. Lastly, the group reviews data on priority themes and quality assures activities on behalf of safeguarding partners to ensure that services work effectively to safeguard children.

Priority Theme: Child Sexual Abuse in a Family Environment (CSAFE)

SPIG auditing activity confirmed that CSAFE remains one of the most hidden, secretive and challenging types of abuse, remaining particularly difficult for children and young people to disclose and for professionals to identify. The subject has been highlighted in the Clare and Freddie reviews this year. A SPIG audit was conducted in October 2020 that identified the following areas for improving practice:

- The voice of the child must be heard throughout investigation (impact of virtual contact) and the child kept at the centre of all work
- The need to link together isolated incidents (increasing the use of chronologies)
- Effective supervision/management oversight specific to CSAFE cases
- Accuracy of recording
- Understanding of Adverse Childhood Experiences (ACES) and parental childhood trauma
- Increased and improved Information sharing between agencies & professionals feeling confident in doing so
- Promoting/ signposting practitioners to online resources
- The need for a comprehensive training offer

Areas of effective practice were also identified:

- Use of Child Protection Online Management System (CPOMS) for storing safeguarding information enables schools to transfer electronically
- Children's medical needs were met
- Positive information sharing between Emergency Department & Children's Services

In response to this (and the Freddie case review which centred around CSAFE):

- A specialised multi-agency training day has been devised by the Child Protection Advisor in partnership with a multi-agency team including the SSCP, SCC Children's Services Training, Police and Health providers. This training is currently run online and helps practitioners identify and respond effectively to CSAFE. It is open for anyone working with children and families to attend. The training has also been reviewed by the Centre for Expertise in Child Sexual Abuse who supported its development.
- In addition, there is now more structured specialist supervision and support to practitioners working with children and families where CSAFE is known or suspected. This includes a focus on the importance of chronologies and genograms in understanding what risks may be

present for a child. This is led by the Child Protection Advisor from the SCC Children and Learning Service.

Priority Theme: Early Help

This theme was assessed using the Early Help position statement produced by colleagues in Children and Learning Services.

Locality based data will be used to improve the understanding of need, particularly in areas of deprivation.

It was noted the Early Help Hub have identified areas which require a stronger Early Help offer to encourage schools to refer in. All Sure Start centres are linked into Early Help and majority of them are based in the most deprived areas in the city.

It was noted there has been an increase in the number of children and families moving to early help from children's social care which is positive.

Early help services supported work with vulnerable children and families during lockdowns and since the Early Help Hub was introduced in July 2019, there has been a 25-30% increase in new referrals and families receiving support.

It was agreed that awareness raising and understanding of the Early Help hub and their offer is required. In addition, a greater understanding of the multi-agency work force of early help activity outside of the Children and Learning Service, such as Sure Start and other services and settings.

The Safeguarding Improvements Practice Group will continue learning from thematic audits in the future. The areas that have been agreed for the deep dive audits in 2021-22 are Domestic Abuse and Neglect, both of which have been highlighted as areas of continued importance for the partnership during the pandemic.

2019/2020 Priority Themes

Last year's priority themes of Child & Adolescent Health and Neglect were also revisited. The i-Thrive model is currently being used to develop a new system-wide approach to the emotional wellbeing and mental health of children and young people in Southampton. This recognises the broad contribution of partners. This work has been impacted by the effects of the COVID-19 pandemic and is planned to continue in autumn 2021.

Neglect was a priority theme for last year and remains a priority for the partnership. It was revisited by SPIG this year through a practitioner survey which showed a continued need to promote the new SSCP Neglect Strategy and Guidance for Practitioners (formerly known as the Neglect Toolkit). The SSCP continue to provide workshops to promote and explain the Strategy and Guidance. A Spotlight on Neglect briefing was also released to partner agencies and published on the SSCP website. In 2021/2022 the SSCP will lead a review and refresh of the Neglect Strategy and Practitioner Guidance.

JTAI Dry Run

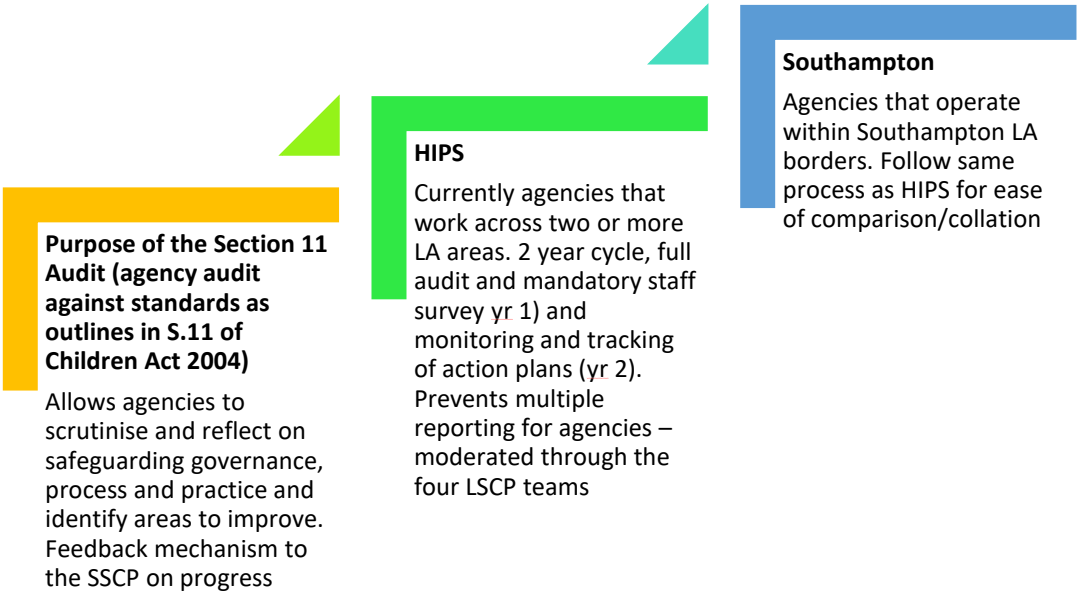
The SPIG also conducted a Joint Targeted Area Inspection (JTAI) dry run on the subject of Child Exploitation in November 2020.

The process and findings of the agreed JTAI dry run in relation to Child Exploitation are detailed below. This allowed the partnership to clarify where strengths and areas for development lie in terms of JTAI readiness.

Colleagues' willingness to engage in this work during the pandemic and related pressure was very much appreciated.

HIPS Keeping Children Safe (Section 11) Audit

In February and March 2021, the Safeguarding Children Partnerships across Hampshire, Isle of Wight, Portsmouth and Southampton co-ordinated the Keeping Children Safe (Section 11) Audit for agencies that work across two or more local authority borders.



Section 11 audits enable agencies to scrutinise their governance arrangements, processes and practice and identify improvements. They also enable agencies to show areas of good practice and provide feedback to Safeguarding Partnerships on progress and barriers to partnership working.

The process was endorsed by the HIPS partnerships and reflects a two-year cycle of self-assessment (year 1) followed by monitoring and tracking of action plans (year 2). The focus for 2020/21 was to re-visit the safeguarding standards through completion of a new self-assessment tool and a mandatory staff survey (year 1).

The audit tool for 2020 was reviewed and slimmed down to ensure that the standards remained relevant and that the process took account of system-wide pressures due to COVID-19. The Tool was sent out on 14 October 2020 with an extended completion date of 4th January 2021. A staff survey was sent out across the HIPS areas during this period. Take up of the staff survey this year was universally very low and though understandable in the context of pressures on the system at this time.

Strengths of the 2020/21 Section 11 Audit process were identified as:

- The process was well planned enabling SCP managers to review all self-assessments from agencies covering two or more HIPS areas in one panel day.
- A standard letter format was used to populate with individualised responses to send to agencies, and this ensured a standardised approach to feedback.

The were some areas highlighted for improvement in future audits:

- There is a need to revisit with agencies the purpose of the Section 11 self-assessment and how it might benefit agencies in better safeguarding children, preparing for inspection and action planning for improvement.
- Revise instructions given out to agencies for completion of the self-assessment to encourage greater self -reflection and evidence in responses.
- Whilst some responses were very detailed and identified further areas for development which were captured in the action plan, some contained no evidence of impact in their answers.
- Some responses had no completed Action Plan, even where there were a number of standards either partly in place or not currently in place. Action Plans are a key part of the Section 11 Audit cycle and are effective when detailed with SMART targets for improvement.

There were some common themes across the HIPS areas:

- A need to improve knowledge and understanding of thresholds/Continuum of Need documents
- A need to increase in practitioners taking a Family Approach to safeguarding
- A need to improve understanding of Early Help across the workforce and for practitioners to take a proactive approach to securing/providing Early Help services
- A need to increase awareness of additional vulnerabilities that children with disabilities and those with English as an additional language may face, that require consideration when seeking to assess their safety and wellbeing

All services reported a rise in needs (such as from increased mental health issues, domestic abuse, child to parent violence and neglect) following COVID-19 and some areas articulated their response to these and showed some innovative practice.

The SSCP will complete the process of our local Keeping Children Safe (Section 11) self-assessment from March 2021.

Schools Safeguarding Audit

In addition, the SSCP received the report of the schools safeguarding self-evaluation. Despite COVID-19, 100% of schools across Southampton successfully returned the self-evaluation in the Spring term, marking the first full return. Many positive discussions follow up meetings, reviews and actions have resulted from the review of the information we have some city-wide education specific actions as a result outlined below.

Some of the aspects for development have been brought to the fore by COVID-19 and remote learning, increased focussed work on safeguarding, and prevalence of incidents requiring response within schools. It has enabled some staff to be diverted at times into safeguarding work. However, this has led to pressures when delivering live lessons as the greater return of pupils has occurred and the incidents remain. The requirement to support pupil well-being alongside staff well-being is high. Some of the benefits of the past year have included remote meetings, which have enabled school staff to attend with less disruption to teaching at times. Schools are indicating that they can support some of these remote meetings continuing into the future, if possible.

The impact of COVID- 19 has meant that schools and education settings have had to shift focus a number of times; firstly, during lockdown 1 to provide care to vulnerable pupils in line with the Department for Education and the school's own definitions. Over time, the focus has gradually shifted back to learning. However, safeguarding has remained a central focus, with schools continuing to work well with professionals and escalate concerns where necessary, amending policy and process where required.

In-school checks were limited by COVID 19 and some have taken place remotely. Checks on training continued during the pandemic, and support around finding resources or training has also been given.

Occupation of virtual learning opportunities during the pandemic, including remote training and e-learning – has remained strong for staff and governors. This is likely to remain a part of practice moving forward, with blended learning approaches becoming more frequent.

Workforce Development

The SSCP adapted to the changes brought about by Covid-19 and shifted to online delivery for almost all its training. This section shows the training that has taken place and includes feedback from attendees and an analysis of areas for improvement next year.

Weekly Wednesday Workshops

This popular format allows busy practitioners to take part in brief lunch time learning sessions on Wednesdays (although days are flexible!) The sessions generally run for 1 hour and cover a wide range of topics. They enable practitioners from a wide variety of agencies to come together and the online format has allowed more practitioners to attend as there is no need to travel. Workshops were run on the following subjects:

- Neglect – including the Strategy and Practitioner's Guide
- The role of LADO
- Private Fostering
- Fabricated and Induced Illness
- Exploitation from the perspective of the Child
- Allegations against Foster Carers
- Online Safety Introduction
- Online Safety – Your Digital Footprint
- Bruising Protocol
- Reducing Parental Conflict
- Hampshire & Isle of Wight Criminal Justice Liaison

"Great. It's useful to meet people more personally and so much easier to have discussions. This could be made more interesting by varying the participants in breakout rooms for different tasks so I can talk to more people."
Practitioner Feedback

"A chance to take time out, reflect on my practice and the online format it so much easier to attend"

"This training was challenging but thoughtfully delivered, with real insight into how CSAFE happens and how to respond if I'm concerned"

Practitioner Feedback

Child Sexual Abuse in a Family Environment (CSAFE)

This training was developed in response to recommendations from the Adam & Anna Serious Case Review (published 2019), the Clare and Freddie Safeguarding Child Practice Reviews (2020) and the SPIG audit work around CSAFE. The training content was developed by a multi-agency team and led and run by the Children's Services Child Protection Advisor in partnership with a consultant expert in CSAFE. Two training days have taken place so far, with more dates planned regularly throughout the year. The second session gained greater traction than the first, with 43 attendees in total and an average evaluation score of 4.7 out of 5.

HIPS Webinars

The SSCP works in partnership with the neighbouring areas of Hampshire, Isle of Wight and Portsmouth and this includes delivering training. In 2020/2021 training took place across the HIPS areas on the following topics:

- Missing, Exploited and Trafficked webinars x 3

- Harmful Cultural Practices - Female Genital Mutilation
- Harmful Cultural Practices - Breast Ironing
- Harmful Cultural Practices - Honour Based Abuse/ Forced Marriage
- Introduction to Child Abuse Linked to Faith and Belief
- The new Child Exploitation Risk Assessment Framework (CERAF)
- Modern Slavery
- Child Exploitation from a Health Perspective

"It was a good introduction but a longer video with more information would have been great".

I had never heard of breast ironing before. The workshop was really well led despite it being virtual"

"XX and XX are very knowledgeable and have a good way of presenting. Pleasant to listen to and very thought provoking"

Half-Day workshops

"The information provided by Dr XX was very informative and thought provoking and everything was explained very clearly."

SSCP run half-day workshops on a regular basis, however a number of these were unfortunately cancelled due to the pandemic. However, half day training took place on the Bruising Protocol in December 2020. This training was devised by Named Doctors across the HIPS areas. This training was well received, with an average evaluation score of 4.8 out of 5.

Safeguarding Level 3

The SSCP also continue to offer Safeguarding Level 3 training via two separate full days' training in either **Identifying Needs – Early Intervention and Making a Referral**, and **The Child Protection Process** with practitioners able to choose which is most relevant for them (or attend both). Refresher half day sessions for both days are also offered. This training is delivered by an external training company, and there was impact by Covid 19 until July 2020, when training recommenced with refresher training for both subjects offered. Virtual full-day training recommenced in October and December 2020, with further refresher training being offered in November and March.

"Very worthwhile for new employees and to confirm CP planning."

The Child Protection Process participant

"Easy to listen to and delivered well."

Identifying Needs & Making a Referral participant

Areas for improvement

The shift to virtual training has brought both positive and negative impacts. Practitioners have praised the ease of attendance, importance of bitesize learning (Weekly Wednesday Workshops), and the eliminated travel time in attending.

There have however been an increased number of 'no shows'. This has been an issue in past years and the SSCP Business Team have considered options to encourage attendance, for example invoicing non-attendees. It was felt that this was not a viable option. Unfortunately, non-attendance prevents other interested participants from attending, and trainers have expressed disappointment at running a session for an unexpectedly small audience.

The shift to online training has meant some upskilling for trainers in using the technology available and engage with their participants over online training. There have also been some issues with technology and a member of the SSCP team has attended sessions to provide support to trainers. Both issues are expected to much improve as trainers become more accustomed to training online.

It has proved more difficult to gather feedback forms after training session.

Looking to the future it is likely that face to face training will resume for some sessions, and while online training continues for the majority of the sessions, a level of expertise will continue to develop to negate the initial issues with running training online. There is also the possibility of developing training with a blended approach so that those who prefer face to face sessions can do so.

The SSCP is keeping a watching brief and gauging feedback regarding duration of training, as some participants express a wish for more information and more time dedicated, whereas others favour shorter learning sessions as they fit in with busy schedules.

Further Work to Improve Safeguarding

The SSCP has also been engaged in project work this year to safeguard and promote the wellbeing of children. This has concentrated on themes that have arisen during the pandemic.

ICON was launched in Southampton in February 2021 and aims to reduce head trauma in young babies. SSCP has worked in conjunction with the other HIPs areas to produce information for parents and professionals in coping with infant crying. An information leaflet is available here and there is a ICONcope website with a wealth of information for parents & professionals here.

Unborn/Newborn Baby Protocol

Revised and updated for 2021, the HIPS Unborn/Newborn baby protocol sets out how to respond to concerns for unborn babies with an emphasis on clear and regular communications between professionals working with the pregnant person and their family where risk is identified. Unlike many safeguarding situations the antenatal period gives a window of opportunity before the baby arrives for practitioners and families to work together to form relationships, identify protective factors as well as risks and vulnerabilities, and agree multi-agency safety planning for the unborn baby.

This multi-agency protocol provides a robust framework for responding to safeguarding concerns and safety planning by practitioners working together, with families, to safeguard the baby before, during and following birth. This protocol applies across Hampshire Isle of Wight, Portsmouth and Southampton.

The latest version of this protocol now includes a number of updates and new tools to assist practitioners in utilising the UBB protocol. The protocol can be found here.

New Child Criminal Exploitation Risk Assessment Framework

Work has taken place in the HIPS Partnership, to create a new Child Exploitation Risk Assessment Tool to replace the Child Sexual Exploitation Risk Assessment Tool, for completion as soon as any form of Child Criminal Exploitation is suspected. The purpose of this is to take a more holistic approach to the various forms of Child Criminal Exploitation, of which Sexual Exploitation is one. Members of the HIPS areas have created new CERAF which is available here and training has been run by the MET Hub in partnership with HIPS colleagues for Southampton practitioners to familiarise them with the new tool. There is also information available on the HIPS Procedures website here.

There is also a video tutorial available for colleagues about how and when to complete a CERAF.

HIPS Child Exploitation Strategy and Delivery Plan

The workload of Southampton Safeguarding Children Partnership is largely focused on tackling the safeguarding issues surrounding child exploitation, both from a criminal and sexual perspective (Child Criminal Exploitation and Child Sexual Exploitation), as detailed below in the HIPS Child Exploitation poster released in April 2020.

During 2020-2021, the HIPS Child Exploitation Group published the HIPS Child Exploitation strategy, which covers Hampshire, Isle of Wight, Portsmouth and Southampton from 2020 until 2023. There are five key objectives that have been identified as part of the HIPS Exploitation Strategy, including the following:

- Scrutiny and Oversight
- Understand and Identify
- Prevention
- Intervene and Support
- Disrupt and Bring to Justice

Local safeguarding partnerships will be responsible for delivery of the new Child Exploitation strategy through local delivery plans. During 2020-21, HIPS Child Exploitation group revised updated and released the new Child Exploitation Risk Assessment Framework, which supports the continuous focus of community partnership information forms (CPIs).

HIPS Child Exploitation Strategic Group continues to receive support from Youth Commission for Hampshire & Isle of Wight. They continue to support the engagement of young people in the area with regards to gaining stronger clarity and understanding of Child Exploitation through The Big Conversation.

Safeguarding in Transitions Framework produced by 4LSAB & HIPS is currently under development and is expected during 2021-22, responding to the gaps in young adults over the age of eighteen and moving into adulthood, who had previously been vulnerable. This will also be inclusive of young adults who have faced risks of sexual and criminal exploitation

HIPS Child Exploitation group works collaboratively with issues such as missing children, modern day slavery, and the use of national referral mechanism. HIPS are also currently developing the Lurking Trolls campaign, a set of resources aiming to keep children safe online, was planned for release this year. Because of the COVID-19 pandemic, this has been pushed back to 2021-22. With regards to the MET section of the Child Exploitation delivery plan, this is featured in a subgroup of the SSCP and has been discussed in an email briefing received by the children's partnership in March 2021.

To conclude, the above areas have been discussed with Southampton Safeguarding Children's Partnership, and the delivery plan has developed alongside the planning for the Young Person's Service which aims to be operational during 2021-22.

For Southampton, the local delivery plan is in place and reports are made to the SSCP on a six-monthly basis on progress. The learning from the Liam Child Safeguarding Practice Review (publication 2021/22) is reflected within this. In addition, the learning from the National Child Safeguarding Practice Review is also incorporated and the local Missing Exploited and Trafficked team led a review of practice against the recommendations in this review. This was shared with both the SSCP and HIP Child Exploitation Strategic Group.

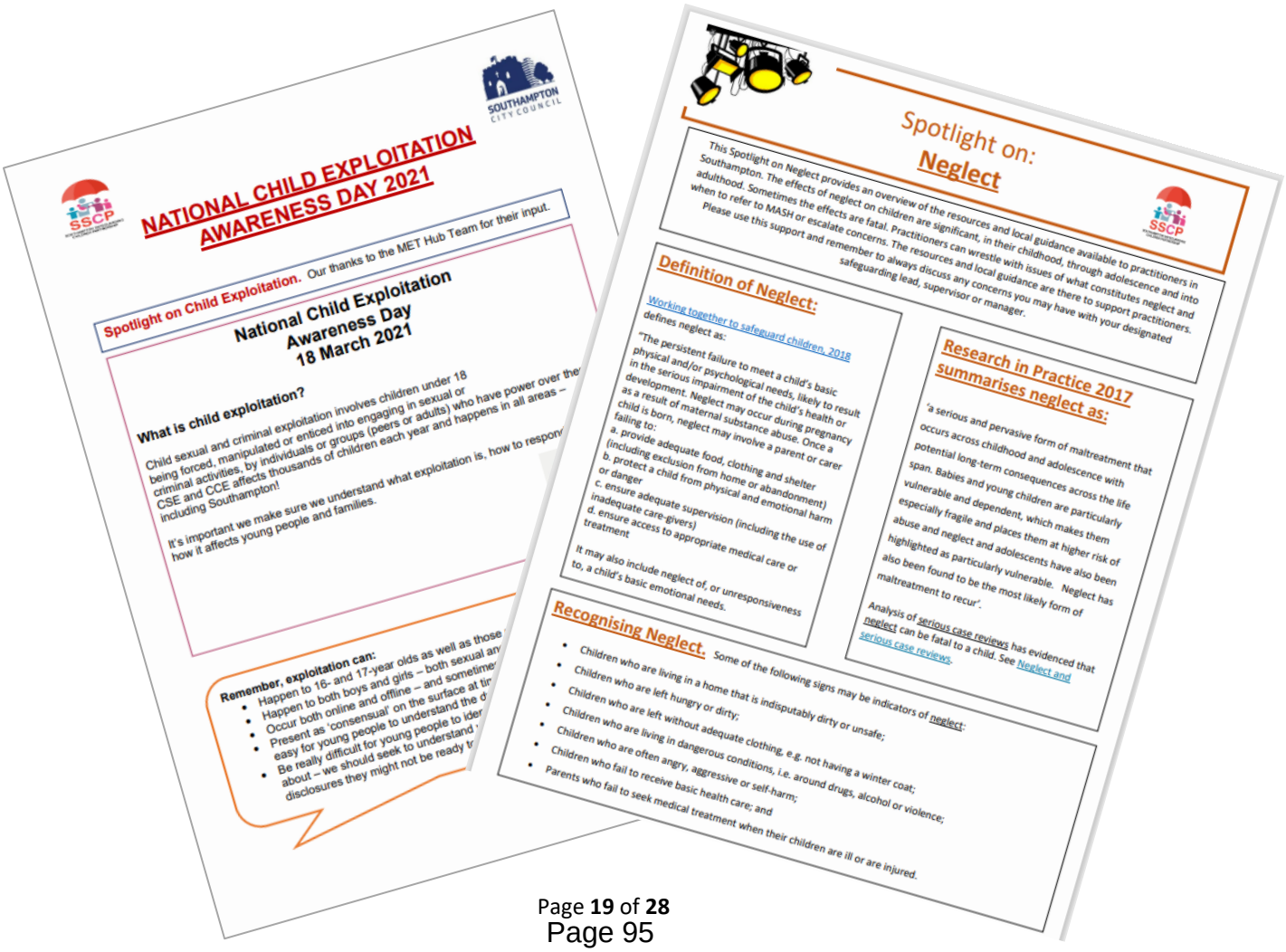
On behalf of HIPS Partnerships, Southampton SSCP produce the HIPS Child Exploitation Newsletter which can be found **here.**

'Spotlight On' briefings

The HIPS Safeguarding Partnerships produce regular briefings to highlight changes and promote awareness and understanding of key policies. The 'Spotlight on' briefings are short summaries of the key points for practitioners and are available on the HIPS website and circulated to teams in each Partnership.

The 'Spotlight On' briefings produced in 2020/2021 are available via the links below.

- Safer Sleep
- Neglect
- ICON
- Child Exploitation (Child Exploitation Awareness Day 2021)



Financial Planning

Funding was provided by SSCP partners as follows for 2020/2021:

Agency	Contribution
Southampton City Council	£101,546
Southampton Clinical Commissioning Group	£42,025
Hampshire Constabulary	£16,600
National Probation Service	£1,522
Community Rehabilitation Company	£1,638
TOTAL	**£163,331**

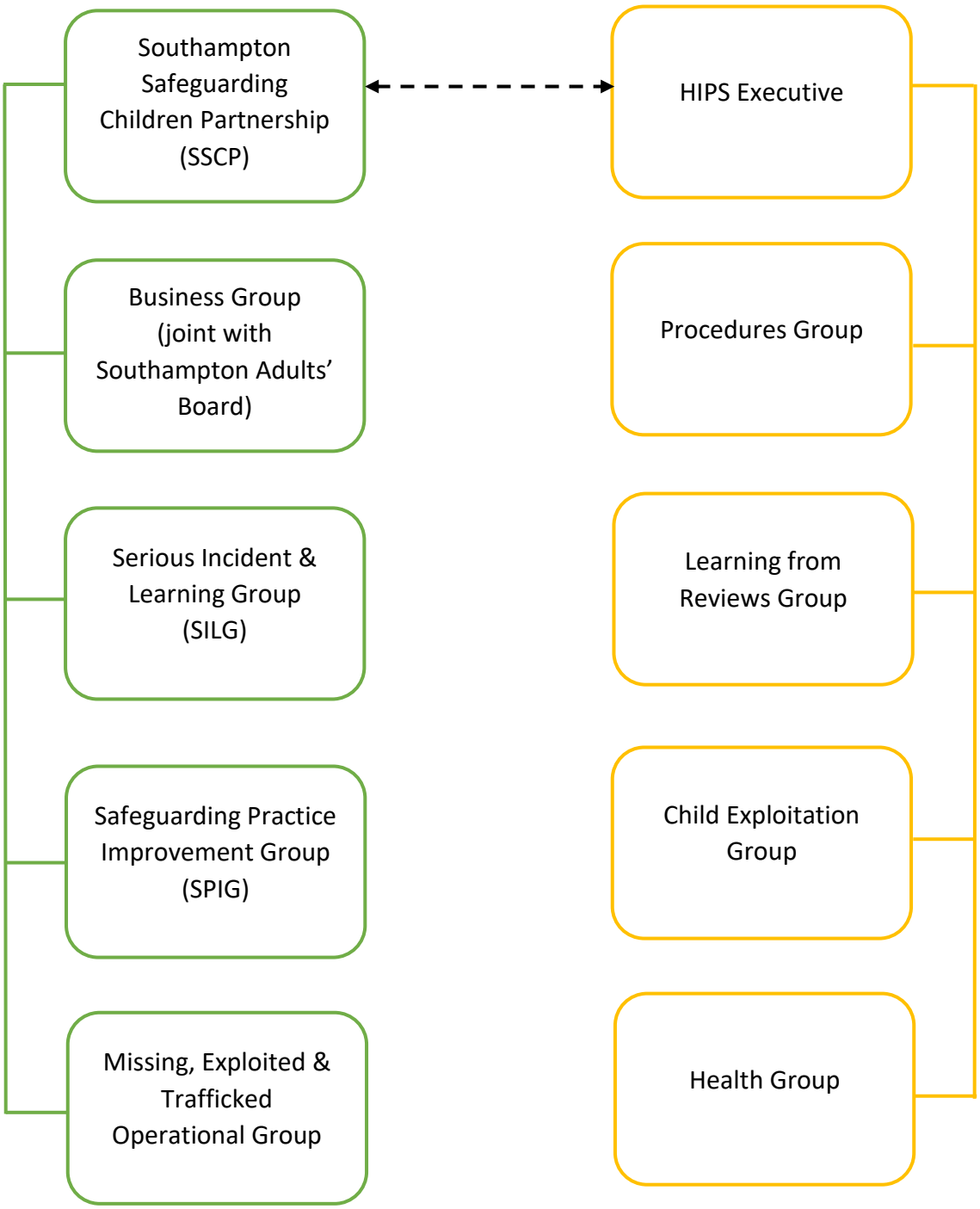
Membership

The SSCP Board is made up of members from the following organisations:

Agency	Position
Independent Chair	Independent Chair
Southampton City Council	Executive Director of Wellbeing (Children & Learning)
Hampshire Constabulary	Superintendent and District Commander
Hampshire Probation	Director of Portsmouth/Southampton LDU
Community Rehabilitation Company	Director of Portsmouth/Southampton
City Clinical Commissioning Group	Director of Quality and Integration/Executive Nurse
NHS England (Wessex)	Director of Nursing
University Hospitals Southampton NHS Foundation Trust	Director of Nursing and Organisational Development
Solent NHS Trust	Operations Director (Children's Services)
Southern Health Foundation Trust	Director of Children and Families Division & Safeguarding Lead
South Central Ambulance Service	Assistant Director of Quality
CAFCASS	Senior Service Manager
Voluntary & Community Sector	SVS – Southampton Voluntary Services
Legal Services	Solicitor (Child Care)
Health providers	Designated Nurse & Designated Doctor
Principal Social Worker	Principal Social Worker
Public Health	Director of Public Health
Cabinet Member for Children's Services	Lead Elected Member
Children & Learning Services	Cross Phase Advisor
SSCP Business Unit	Partnership Manager
SSCP Lay Member	Lay Member

Structure

The structure for the SSCP and its relation to the work across the HIPS areas is as follows:



Context for Southampton - data

Southampton has a total population of 252,900 residents. 20.5% of the population are aged under 18, and 13.4% of the population are aged 65 or over. 14.1% of the population are from a black or minority ethnic (BME) population, and 22.2% of the population described themselves as non-white UK (i.e. not white British, English, Northern Irish, Scottish, or Welsh) at the last Census (2011). This compares to a BME population of 14.6% and a non-white UK population of 20.3% for England as a whole. 2.3% of the population report that they cannot speak English well or at all.

The Indices of Deprivation (IMD, 2015) combine a range of economic, social, and housing indicators to provide a measure of relative deprivation, ie they measure the position of areas against each other within different domains. A rank of 1 indicates highest deprivation. Southampton is ranked 47 out of 152 Local Authorities in England on overall deprivation and is ranked 74 out of 152 local authorities on income deprivation.

26.5% of pupils attending nursery and primary schools and 28.5% of pupils attending secondary school in Southampton are eligible for and claiming free school meals. This compares with 17.8% of pupils attending nursery and primary schools and 18.9% of pupils attending secondary school for England as a whole.

52.2% of children in Southampton achieved 5 or more GCSEs at grades A* to C in 2015/16 (academic) including English and Maths. This compares with 57.7% for England. Among pupils eligible for free school meals, 31.5% achieved 5 or more GCSEs at grades A* to C including English and Maths in 2014/15 (academic), compared to 33.3% nationally. 4.9% of working age people in Southampton are unemployed, compared with 5.2% for England overall. The median gross weekly wage for employees living in Southampton is £602.2. This compares with an England wage of £613.3[2].

Indicators of Outcomes for Children

The SSCP considers a multi-agency dataset containing some key performance indicators for outcomes for children as well as the quality of local provision. It enables the SSCP to understand the impact of its work, and that of services, including changes for example where transformation projects take place. Tracking and analysing local data also allows the SSCP to understand the impact of changes or demand on one part of the safeguarding and child protection system to another. Data is analysed by the Safeguarding Practice Improvement (SPI) Group) through two deep dive thematic audits. In 2020/2021 a thematic audit took place in relation to Child Sexual Abuse within the Family Environment. This allows key data to be brought together with other sources of information including the experience and views of children and young people and practitioner views. This provides a focused analysis of key issues to be highlighted to the SSCP and identifies activity to improve.

To follow is a summary of annual data for some of these key measures.

[2] LG Inform An Overview of Health and Wellbeing in Your Area | LG Inform (local.gov.uk)

Rate and number of Children in Need

	2019/2020				2020/2021			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Rate per 10,000 of Children in Need at end of period (including Child Protection (CP) / Looked after Children (LAC) / care leavers) at end of period	552	565	507	466	460	443	442	425
Number of all Children in Need (CiN) (including Child Protection (CP) / Looked after Children (LAC) / Care Leavers / Children in Need (CiN) in Early Help (EH) teams) at end of period	2778	2874	2577	2367	2339	2250	2247	2159

The rate of children in need based on 10,000 population of children under 18 is a key measure of the needs of children's needs in Southampton and the services and support required. Simply, it can be used as a broad indication of whether children and their families are receiving the right help at the right time and can be indicative of the success or otherwise of early help intervention and support locally. During 2020/2021 it can also be indicative of line of sight to children and young people who may be in need of safeguarding. The impact of COVID pandemic may be apparent in this reduction over time.

Children in Need Referrals

	2019/2020				2020/2021			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Number of new referrals of Children in Need (CiN)	1556	1630	1106	1030	900	1009	1168	976
Rate of new referrals of Children in Need (CiN) per 10,000 (0-17 year olds)	309	321	218	203	177	198	230	192

There has been a reduction from QTR 2 2020/2021 in the number and rate of new referrals of children in need. The OFSTED focussed visit in May 2020 stated that Social Workers in the MASH provide a timely and proportionate response to concerns raised about children. OFSTED pointed to the reduction positively as they noted children had been undergoing unnecessary child protection enquiries, assessment and becoming the subjects of child protection or child in need plans far more than in most other local authorities.

Child Protection

Where there are child protection concerns (reasonable cause to suspect a child is suffering or is likely to suffer significant harm) the local authority social care services must make enquiries to decide if any action must be taken under Section 47 of the Children Act 1989. This is an essential area of the child protection system. 2020/2021 showed a peak in number of enquiries started in quarter 3 this reduced again in quarter 4. To some extent the peaks and troughs mirror the impact of COVID -19 regulations with dips following stay at home advice and increases when more children return to school. It is of note that Southampton remains significantly higher than our statistical neighbours and considerable work is ongoing to focus on this. This is part of the Children and Learning Service Improvement Plan.

Transformational work is underway in relation to Early Help, services for Young People and the roll out of a practice framework for Children and Learning staff.

Rate of Section 47 (S47) enquiries started per 10,000

	2019/2020			2020/2021					
Indicator	Q2	Q3	Q4	Q1	Q2	Q3	Q4	**Statistical Neighbour**	**England**
Number of Section 47 (S47) enquiries started	545	426	362	385	354	463	385	358.3	330.6
Rate of Section 47 (S47) enquiries started per 10,000 children 0-17	107	84	71	76	70	91	76	55.7	41.8

Number and Rate of Children with a Child Protection Plan

	2019/2020				2020/2021					
Indicator	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	**Statistical Neighbour**	**England**
Number of children with a Child Protection Plan (CPP) at the end of the month, excluding temporary registrations	333	419	479	417	407	393	399	313	350.3	338.9
Rate of children with Child Protection Plan (CPP) per 10,000 (0-17 year olds) at period end	66	82	94	82	80	77	78	62	52.6	42.8

2020/2021 has seen a decrease in the number and rate of children with a Child Protection Plan which remains higher than statistical neighbours. The rate can be seen to diminishing significantly from Q3 to Q4. This remains an area of focus for the partnership and the children and Learning Service Improvement Plan. The SSCP continued to receive assurance reports on the progress of child protection work throughout 2020/2021.

Percentage of Initial Child Protection Conferences held within timescale

	2019/2020				2020/2021					
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	**Statistical Neighbour**	**England**
Percentage of Initial Child Protection Conferences (ICPCs) held within timescales (based on count of children)	45.7%	50.3%	61.8%	53.8%	86.0%	69.9%	40.7%	67.5%	81.0%	78.0%

The percentage of Child Protection Conferences held within timescales has remained lower than statistical neighbours and has been impacted by a variety of factors including the COVID-19 Regulations. This is an area of focus for the Children and Learning Service Improvement Plan. The Child Protection Co-ordinators worked hard to move conferences online during the early stages of the COVID -19 pandemic. There has been recognition that while attending conferences virtually is not ideal for most families it can enable effective and regular attendance of some professionals who may otherwise find it hard to attend at times. A hybrid model is being used.

Looked After Children rate (per 10,000 children) and Number of Looked After Children

	2019/2020				2020/2021					
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Statistical Neighbour	England
Number of Looked after Children at end of period	500	516	493	490	488	485	499	495	615.4	80080.0
Rate of Looked after Children (LAC) per 10,000 at period end	99	102	97	96	96	95	98	97	97.2	67.0

Southampton has moved closer to its statistical neighbours in terms of rate of looked after children per 10,000. Children placed more than 20 miles from the local authority boundary are an area of scrutiny for the SSCP. This was highlighted during the Child Safeguarding Practice Review in respect of Liam and the challenges for the multi-agency partnership to support children placed outside of the city in terms of information sharing and physical distance. The move to more virtual working has created opportunities for better contact to be maintained often via a means that children and young people may choose.

Children at risk of going missing

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Looked after Children (LAC) missing for 24 hours or more	14	18	15	16	11	17	13	10
Number of children open to the authority who have been missing at any point in the period (count of children)	243	198	208	221	171	214	200	193

The OFSTED focused visit in May 2021 noted that "most children who go missing participate in informative return-home conversations that assist professionals in understanding their peer associations and the serious risks to which they are exposed."

Percentage of 16-17 year olds Not in Education, Employment or Training (NEET) or whose activity is not known

	2019/2020	2020/2021
Percentage of 16-17 year olds Not in Education, Employment or Training (NEET) or whose activity is not known	6.3%	7.6%

2020/2021 has seen an increase to the highest level since 2018. This is an area of focus within the Children & Learning Services transformation programme and will feature within the Young Person's Services, particularly for young people who have multiple risks and vulnerabilities.

School Absences

This data covers school absences during the Autumn Term 2020 (September 2020 – December 2020). Schools remained open during the second lockdown which occurred during this period.

Primary Phase

- Southampton's Primary Autumn Term 2020 absence is below the Statistical Neighbour average for Authorised Absence and in line with the Statistical Neighbour average for Overall Absence.
- Southampton's Primary Autumn Term Overall Absence rates decreased from 4.3% in 2019, to 4.0% in 2020, a 0.3% decrease.
- Southampton's Primary Autumn Term Persistent Absence rate remained static at 11.5% between 2019 and 2020.

Secondary Phase

- Southampton's Secondary Autumn Term 2020 absence is above the Statistical Neighbour average for Overall (6.8%), Authorised (4.0%), Unauthorised (2.9%) and Persistent Absence (19.2%) by 0.5%, 0.2%, 0.4% and 0.8% respectively.
- Southampton's Secondary Autumn Term 2020 absence (Overall 6.8%, Authorised 4.0%, Unauthorised 2.9% and Persistent Absence 19.2%) have increased by 1.0%, 1.1%, 0.1% and 3.9% respectively when compared to the 2019 Autumn Term absence for Overall (5.8%), Authorised (2.9%), Unauthorised (2.8%) and Persistent Absence (15.3%).

Specialist Schooling

- Southampton's Special School Autumn Term 2020 absence is 0.3% and 0.8% below the Statistical Neighbour average for Overall Absence and Unauthorised Absence.
- Southampton's Special School Autumn Term Overall Absence rates increased from 9.7% in 2019, to 12.2% in 2020, a 2.5% increase.
- Southampton's Primary Autumn Term Persistent Absence rate increased from 27.6% in 2019, to 42.8% in 2020, a 15.2% increase.

Pupil Referral Unit (PRU)

- The PRU overall absence decreased by 9.4% from 51.3% in Autumn 2019, to 41.9% in Autumn 2020. The Statistical Neighbour average for PRU Overall Absence also decreased from 35.2% in 2019 to 27.4% in 2020. The gap between Southampton's PRU Overall Absence and the Statistical Neighbour average for Autumn 2020 is therefore 14.5%.

Year R/4 year olds

- Southampton's 4 Year Old Autumn Term 2020 absence is 4.5%. This is a decrease of 1.5% from 6.0% in 2019. Southampton's 4 Year Old Autumn Term 2020 absence (4.5%) remains 0.2% above the Statistical Neighbour average of 4.3%.

Forward Look

In 2021/2022 the SSCP will continue to operate during the COVID-19 pandemic, although a return to a "new normal" is developing. There has been considerable evidence of creative and flexible responses by partner agencies to ensure children are safeguarded in "lockdown", with many children unable to physically attend school and significant pressures arising for families due to the pandemic.

Priorities 2021/2022 are therefore identified in this context as follows:

1. **Safeguarding practice improvements in priority areas for the SSCP; Neglect, Child Exploitation and Contextual Safeguarding, Child Sexual Abuse**

2. **Ensuring learning, recommendations and actions from Child Safeguarding Practice Reviews, Serious Case Reviews and thematic audits are implemented and embedded.**

3. **Child Sexual Abuse – a new strategy, implementation plan and training for practitioners**

An overview of each priority, how it will be measured and when it is expected to be delivered is as follows:

What	Success measures	When
1. Review and refresh of the SSCP Neglect Strategy and Practitioner Guidance to recognising the Severity of neglect. Implementation plan to be in place	Revised strategy and documentation produced and ratified by SSCP	Dec-21
	Evidence informed tools in place to support the multi-agency workforce in identification and response to children and families where there are concerns regarding neglect	Dec-21
	Delivery of implementation plan include communication plan and training	Mar-22
2. Delivery of SSCP Child Exploitation Delivery Plan aligning with Destination 22 Children and Learning Services Transformation Programme – development of Young Person's Service	Delivery of Safeguarding Adolescents Framework (multi-agency) inclusive of contextual safeguarding.	Mar-22
	Increase in use of Child Exploitation Risk Assessment Framework	QTR 3 21/22
	Safeguarding in Transitions Framework (18 plus) completed and implemented	QTR 4 21/22
3. Child Sexual Abuse strategy, implementation plan and awareness raising/training for practitioners.	HIPS Child Sexual Abuse Strategy ratified by SSCP	QTR 4 21/22
	SSCP implementation plan in place	QTR 4 21/22
	Increase in practitioner confidence and knowledge leading to increase in identification of child sexual abuse	QTR 2 22/23

This Annual Report was produced by the Southampton Safeguarding Partnership and particular thanks go to Shaira Ghoorun, Safeguarding Partnerships Intern and Natalie Johnson, Safeguarding Partnerships Co-ordinator.

Contact the SSCP at safeguarding.partnershipsteam@southampton.gov.uk.

DECISION-MAKER:	CHILDREN AND LEARNING SCRUTINY PANEL
SUBJECT:	QUALITY ASSURANCE BRIEFING
DATE OF DECISION:	27 JANUARY 2022
REPORT OF:	EXECUTIVE DIRECTOR CHILDREN AND LEARNING

CONTACT DETAILS				
Executive Director	**Title**	**Children and Learning**		
	Name:	**Robert Henderson**	Tel:	**023 80 834 899**
	E-mail:	**robert.henderson@southampton.gov.uk**		
Author:	**Title**	**Head of Service – Quality Assurance**		
	Name:	**Stuart Webb**	Tel:	**023 80 834 102**
	E-mail:	**stuart.webb@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
N/A

BRIEF SUMMARY

This report outlines for the Panel how the service's quality assurance processes are informing service improvement and the associated scrutiny arrangements. It summarises the role of the quality assurance unit and then introduces:

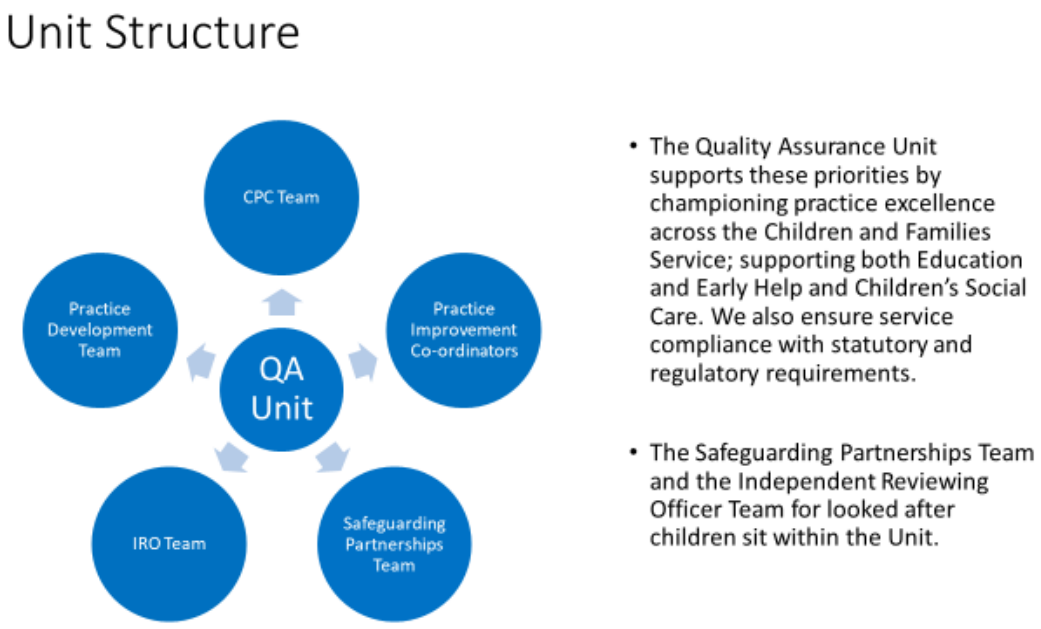
- The Lead Independent Reviewing Officer's (IRO) annual report; presented to the Corporate Parenting Committee in November 2021.
- The Child Protection System report; presented to the Local Safeguarding Children's Partnership (SSCP) in November 2021.
- Analysis of the 'Focus 5' practice priorities.
- The Improvement Report; presented to the Improvement Board in November 2021.
- Report of the Principal Social Worker; content shared with the Chief Executive in January 2022.

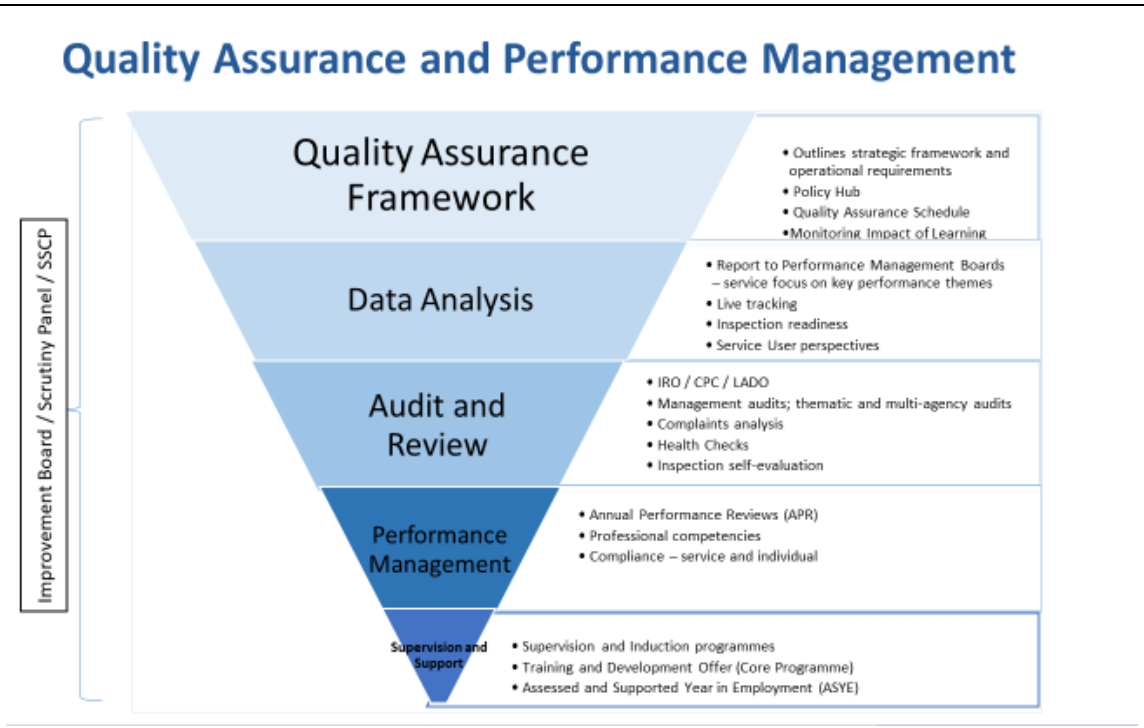
RECOMMENDATIONS:

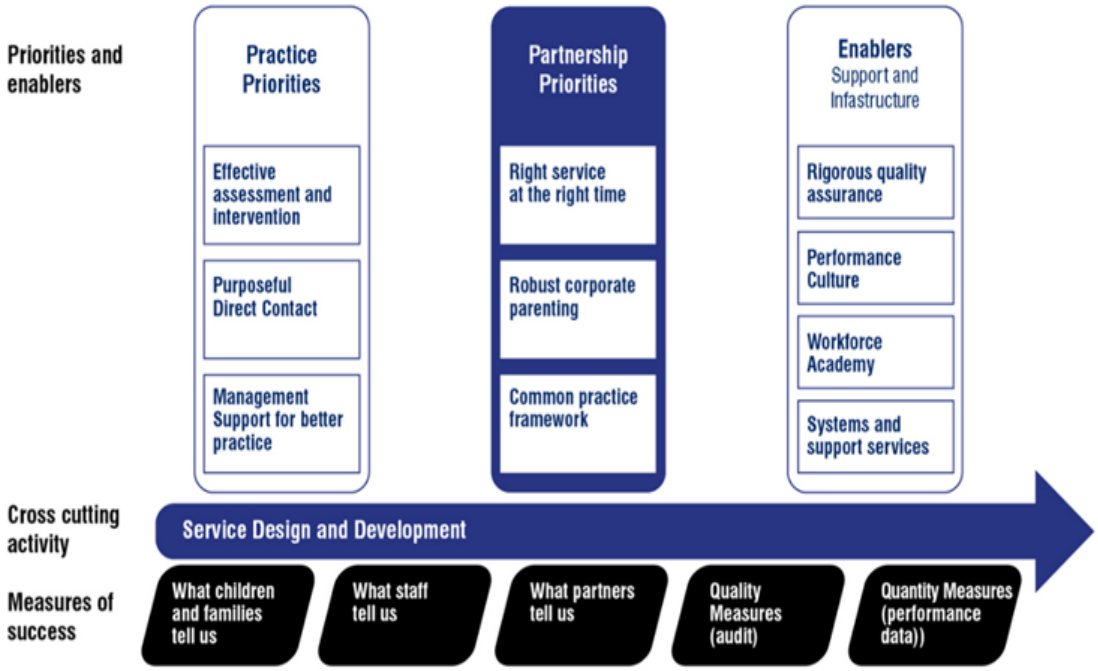
	(i)	That the Panel note the quality assurance arrangements in place for the Southampton Children and Learning Service.
	(ii)	That the Panel considers the next steps in paragraph 10 of the report and requests an update from the service in July 2022.

REASONS FOR REPORT RECOMMENDATIONS

1.	The Scrutiny Panel has oversight of the service improvement plan. The service quality assurance framework should underpin the successful delivery of good social work practice and the discharge of the service's statutory responsibilities.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None
DETAIL (Including consultation carried out)	
3.	**The Quality Assurance Unit** The Quality Assurance Unit is led by the Head of Service for Quality Assurance and comprises of the Practice Development Team (led by the Principal Social Worker), the Child Protection Conference Team, the Independent Reviewing Officer Team, and the Safeguarding Partnerships Team. The service quality assurance framework was last reviewed in December 2020, with oversight from the service's Partner in Practice. An update is programmed for quarter 4, 2021/22, to include the new audit schedule for 2022 / 23.  The service has a number of key responsibilities including co-ordination of the quality assurance framework; data analysis to inform robust self-evaluation and better practice; management of the audit programme; management of performance; oversight of supervision and support for staff.

	
4.	**Service and Partner Scrutiny** The service has worked hard to ensure robust line of sight of practice issues. The service senior leadership team and Cabinet Members are regularly briefed on the service improvement priorities. The areas of focus today have been recently reported to the Corporate Parenting Committee, Safeguarding Children's Partnership, Improvement Board and Chief Executive. There are five documents appended to this report:
5.	**Lead Independent Reviewing Officer's (IRO) Annual report** Presented to the Corporate Parenting Committee in November 2021, the report focuses on: • Highlighting areas of good practice and areas for improvement • Identifying emerging themes and trends • Reporting on work undertaken to date • Outlining service development priorities for the coming 12 months.
6.	**Child Protection Report** Presented to the Local Safeguarding Children's Partnership in November 2021, the report focuses on: • Police / local authority discussion regarding levels of contact • Safeguarding Children's Partnership involvement in Children's Resource Hub and threshold document • Service and multi-agency audits • Implementation of service assurance clinics • Development of the Family Safeguarding Model • Strengthening Families training.

7.	**Analysis of Practice and Improvement Board** 283 audits were completed between January and December 2021. The appended summary identifies findings in respect of the Southampton 'Focus 5' practice priorities: • Chronology • Assessment • Plan • Visiting • Supervision Improvement activity continues to be monitored (last report appended) through the improvement board's priorities: 
8.	**Principal Social Worker Report** The Principal Social Worker last briefed the Chief Executive in January 2022; the briefing focused on: • The Principal Social Work role, the Practice Development Team, The Children and Learning Academy, The Better Together Staff Reference Group. • Staff feeling – PSW engagement and Senior Leadership responsiveness • The Practice Framework & Academy • Recruitment, retention and embedding practice change • Revision of supervision across the service.

9.	**Headline Analysis** **Risk** / **Mitigation** The quality of practice is not yet consistently good across the service; with some areas that still require significant improvement — There is good evidence of senior management oversight and an awareness of where and how things need to improve; informed by quality assurance information and performance data. The level of demand upon the service and capacity within it do not yet support good practice. — There are clear plans in place regarding recruitment and retention; implementing the workforce academy model and delivering against the practice framework. All service areas need to take responsibility for the quality of work in their areas. — There are examples of good ownership (MASH). A comprehensive audit and systemic practice programme has been planned with the service area.
10.	**Next Steps** • The service self-evaluation is being reviewed in January 2022, with a South East Sector Led Improvement Partnership (SESLIP) challenge session to look at quality and accuracy in February 2022. • The audit and systemic practice programme is being rolled out across the service in February and March 2022. • Scrutiny Panel Members are invited to express an interest in attending practice development sessions and to meet with the CPC, IRO, Practice Development and Safeguarding Partnerships teams.
RESOURCE IMPLICATIONS	
Capital/Revenue	
11.	The Quality Assurance Unit has recruited additional staff on a fixed term basis to respond to the current level of demand and to support the service improvement priorities.
Property/Other	
12.	None at this stage
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
13.	S.111 Local Government Act 1972
Other Legal Implications:	
14.	None
RISK MANAGEMENT IMPLICATIONS	
15.	A key role of the Quality Assurance Unit is to reduce the risk of service failure.

POLICY FRAMEWORK IMPLICATIONS	
16.	The service quality assurance framework contributes to achieving the outcomes desired for children in Southampton. The 2021-2025 Corporate Plan sets out the following regarding wellbeing in the city: "We want a city in which people can start well, live well, age well, and live happy and fulfilling lives. We will be a city that prevents and intervenes early, promotes wellbeing, and allows people to live independently for longer, enjoying their lives and all our great city has to offer." Aligned to this, priorities in the Corporate Plan include the following: • Reduce the number of children looked after • Achieve our ambition to become a UNICEF Child Friendly City by 2024/25.

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Lead Independent Reviewing Officer report to Corporate Parenting Committee (November 2021)
2.	Child Protection Report to Safeguarding Children's Partnership (November 2021)
3.	Improvement Report Submitted to Improvement Board (November 2021)
4.	Focus 5 analysis (December 2021)
5.	Principal Social Worker's report (January 2022)

Documents in Members' Rooms

1.	None

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	**No**

Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	**No**

Other Background Documents

Other Background documents available for inspection at:

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	

INDEPENDENT REVIEWING SERVICE

ANNUAL REPORT 2020-2021

An annual report of the Independent Reviewing Service for looked after children is required in accordance with the Children and Young Person's Act 2008 and subsequent statutory guidance.

This report has been produced by the Lead Independent Reviewing Officer and provides both quantative and qualitative evidence in relation to the IRO Service in Southampton.

The report provides an opportunity to:

- highlight areas of good practice and areas for improvement
- identify emerging themes and trends
- report on work undertaken to date
- outline service development priorities for the coming 12 months

1. Purpose of Service and Legal Context

The Independent Reviewing (IRO) service is set within the framework of the updated IRO Handbook, linked to revised Care Planning Regulations and Guidance which were introduced in April 2011. The responsibility of the IRO has changed from the management of the Care Plan Review process to a wider overview of the case including regular monitoring and follow-up between Reviews. The IRO has a key role in relation to the improvement of care planning for children who are looked after and for challenging drift and delay.

The core purpose of the IRO role is to ensure that the care plan for the child fully reflects the child's needs and to ensure that each child's wishes and feelings are given full and due consideration. The appointment by local authorities of an IRO is a legal requirement.

The IRO also has a duty to monitor the local authority's overall performance as a Corporate Parent and to bring any areas of poor practice in the care and planning for children in care to the attention of senior managers.

2. Professional Profile

The IRO team is part of the Quality Assurance Unit and is accountable to the Head of Quality Assurance. Our primary focus is looked after children. There is a separate Child Protection Chair team.

We currently have a team of 12 IROs which consists of 10 IROs for looked after children along with 2 Independent Fostering Reviewing Officers who chair Formal Review Meetings as part of the Foster Carer Review process.

Included in the total of 12 are 2.5 fixed term contracts which add capacity to the team. It has been agreed to continue such posts until September 2022 to ensure the size of caseloads enables each IRO to comply with primary legislation. This additional capacity has also added to a feeling of stability within the team (since September 2020) and avoided changes in IRO allocation for children.

One full time IRO has been seconded part time to the role of the Local Authority Participation Officer to March 2022. We have successfully recruited to cover this vacancy.

We retain strong partnership links with the National IRO Managers Partnership and regularly participate in the Communities of Practice events which aims to bring together IROs and encourage sharing of learning and expertise.

We continue to work collaboratively with Cafcass both at individual case work level and through our joint team meetings.

3. Key messages – Strengths and Challenges

Strengths

- Through working with all children looked after by Southampton Local Authority, IROs have provided strategic oversight and intelligence. This is chiefly evidenced via our analysis of the child's views obtained either during the review process or through written consultation, use of the dispute resolution process and our audit activity e.g. children new into care.
- Through the review process, IROs are well placed to assess the quality and effectiveness of the Local Authority planning and support for children who are looked after.
- IROs have used a balance of positive as well as challenging feedback to the Local Authority to support continuous learning and improvement. Positive feedback has been provided to the Director of Children's Services highlighting good practice e.g. direct work with a child. We have also raised challenges via the Learning & Improvement meetings and analysis of the use of the dispute resolution process.
- The IRO Service has provided a consultative role, sharing expertise and knowledge to support effective care planning. This is evidenced by developing an e-learning training programme and provision of drop-in sessions with the Lead IRO.
- IROs have ensured that the child's wishes, views, and feelings are given full consideration within the care planning and review process. This is evidenced by the child participation data. Despite Covid-19 and subsequent lockdowns, we have encouraged participation of children in Care Plan Reviews and have sought children's ideas to inform continuous improvements to our service design and delivery.
- In 20/21, 77% of children aged 4 and above participated in their Care Plan Review through writing, use of advocacy and meeting with the IRO.
- In 20/21, 84.33% of children have received either a letter or child-friendly review record following the Care Plan Review to inform them of the outcome of the review.
- Our annual data shows that we have achieved improved timeliness in reviews and recording of review decisions and records.
- IROs have routinely reflected on our own performance to address the quality of our practice via quarterly peer audits. Professional Development Days have also been facilitated quarterly to encourage peer to peer learning.

Challenges

- The provision of a quality service to each looked after child requires the IRO to have sufficient time to comply with legislation. Despite additional staffing, IROs have an average caseload of between 65 and 72. This is slightly above the average recommended maximum caseload for an IRO (50-70) and comparable to our colleagues in the regional network however, the practice and outcomes for children in Southampton remain inconsistent which presents a greater challenge to the IRO Service and significant pressures.
- Between April 2020 and March 2021, 528 'mid-way reviews' were recorded and 111 IRO Alerts raised.
- Despite this improved evidence of IRO scrutiny and challenge, Ofsted have raised concerns regarding the impact of our work. An example of this is that despite raising 28% Alerts to address drift and delay in achieving permanence, we are aware of the number of children for whom permanence has not yet been achieved.
- In response to concerns raised by Ofsted, IROs are also involved in additional scrutiny work for key cohorts of children and regularly undertake additional auditing work with operational teams. Examples of this are children new into care, health of children in our care, young people placed in unregistered and unregulated accommodation and children subject to care orders placed with parent(s). We have introduced IRO Case Discussions to evidence our scrutiny in these areas.
- There are many challenges around care planning which we have highlighted to the Senior Management Team and which are being addressed. An example of this is poor preparation for Care Plan Reviews which necessitated the adjournment of 52 Care Plan Reviews in this period.

4. Performance and Quality Assurance

A total number of 1289 Care Plan Reviews were facilitated in the year 2020/21.

Table 1: Key data

MEASURE 20-21	DESCRIPTION
1289	Number of CLA Reviews Held
676	Number of Looked After Children
192	Number of LAC starting to be LAC during year (distinct)
28.40%	Percentage of children starting to be looked after during year (thus requiring more frequent Care Plan Reviews)

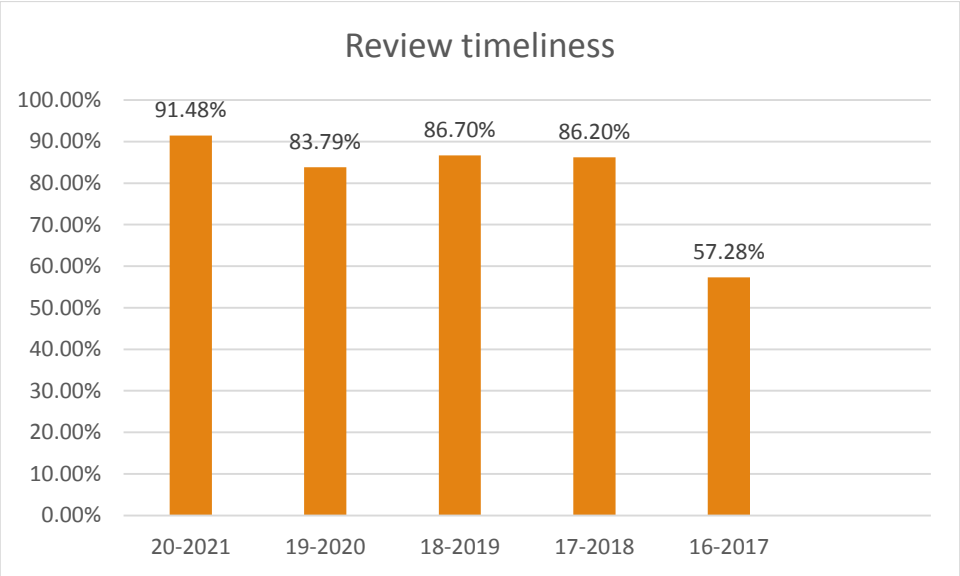
Following the first COVID-19 lockdown in late March 2020, IROs began to facilitate review meetings virtually. We provided clear communication and an organised and flexible approach to ensure participation of children and families.

Performance issues are managed robustly with the IRO team. Regular monitoring of our performance is in place and addressed both at team meetings and within individual supervision meetings. In 2020, we introduced Professional Development Days to support our learning and improvement as well as peer audits which focus on key areas of concern highlighted by Ofsted. Our Service Delivery and Improvement Plan is regularly reviewed at IRO and Quality Assurance team meetings.

We routinely provide an analysis of the use of the dispute resolution process to help identify patterns of concern emerging not just around individual children but also more generally in relation to the collective experience of its looked after children of the services they receive.

Review timeliness

2021-2021: 91.48% of Care Plan Reviews were held within statutory timescale. This shows an improvement in our performance from previous years.



Care Plan Review recordings

In 2019/20, a total of 65.78% of review records were recorded within statutory timescale. In 2020/21, this figure has increased to 85.38%.

Similarly, we have improved our performance in recording review decisions within statutory timescale. At the end of March 2020, 76.69% of review decisions were recorded in timescale. In 2020/21, this increased to 86.37%.

Letters/reports to children and young people

In the period 2019/20, 71.95% (1,003) children received a letter from their IRO following the review. In 2020/21, this increased to 84.39% (1,189)

Table 2: Quarter 1 Performance 2021/22

YEAR/Quarter	Reviews held within timescale	Decisions recorded within timescale	Review records recorded within timescale	Letters/reports sent by the IRO to child/young person following Care Plan Review
Q1 April-June 2021	90.30%	86.29%	90.03%	89.63%
2020-2021	91.48%	86.37%	85.38%	84.39%

Period Q1 2021/22 demonstrates a consistent performance in review timeliness, review recordings and ensuring children receive feedback following the review.

Care Plan Review adjournments

For a review to be productive and sensitive to the needs of each child, time and careful preparation is necessary. The IRO should be provided with or have access to any relevant reports/plans or background information, including the current care plan, the report from the social worker (which should be available at least three working days before the commencement of the review), the current health plan or medical assessment report and the current personal education plan (PEP).

If the IRO is not satisfied that the Local Authority has complied adequately with all the requirements relating to the review, the IRO has the power to adjourn a review. Whilst careful consideration is given to taking such action and any impact this may have on the child, the IRO has to weigh up the relative disadvantages of proceeding with the review on limited information

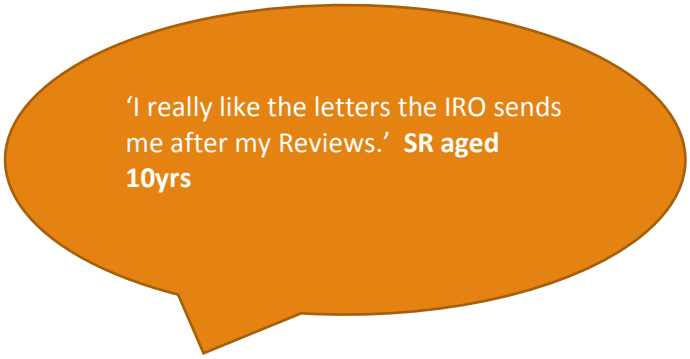
We are often faced with the very basics of care planning not achieved which in turn creates additional work for the IRO whether that is escalating using the dispute resolution process or adjourning Care Plan Reviews.

Between April 2020 and March 2021, the IRO Service found it necessary to adjourn 52 Care Plan Reviews (4%) due to no authorised Care Plan shared with the IRO prior to the review commencing.

Our Service Response

The IRO Service has worked with others to develop processes and training that enables workers to understand the importance of high-quality planning and reviews which focus on permanence. Despite this and use of the dispute resolution process, we have not yet seen an improvement in 2021/22 with 56 Care Plan Reviews adjourned between April and September 2021. This is higher than we would want or expect and has been recognised by the authority as an area that requires improvement. Escalation of concerns around care planning has informed the emergence of quality assurance clinics to be held with managers to improve practice standards, performance and outcomes.

5. Voice of The Child



Learning from children and young people's views

In February 2021, amended Care Plan Review Consultation forms were launched to support children and young people to tell us what was important to them prior to the review commencing and to help us recognise key themes.

We also launched a survey in April 2021 to gain feedback from children and young people about how we had facilitated reviews during the Covid pandemic and subsequent lockdowns.

At the end of September 2021, we have received and analysed a total of 119 completed consultation forms from children and young people.

Key matters

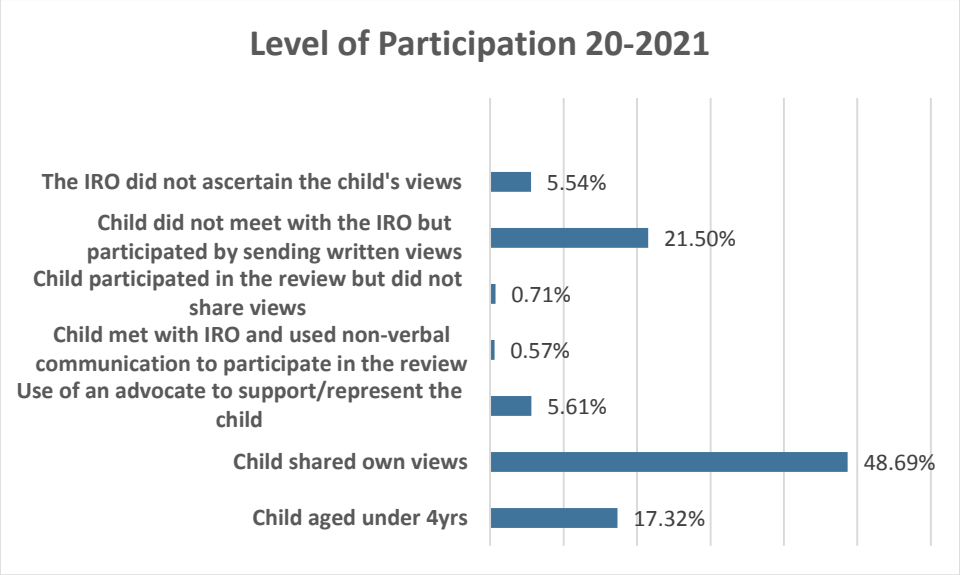
Only 26% of the children and young people who responded had received a written copy of his/her Care Plan.

Less than half i.e. 42% of young people felt involved in the making of his/her Care Plan however, 58% of children/young people responded that they did feel listened to by the Local Authority

At the point of the 2nd Care Plan Review, 87.5% of children and young people responded that they **do not know** what the plan(s) is/are for their present and future care.

Child Participation in the Care Plan Review process

IROs have used a variety of methods to ensure the child's views are known at the time of the Care Plan Review. Despite Covid-19 and subsequent lockdowns, we have achieved an **i**ncreased overall participation figure of 77.14% compared with the previous year's figure of 75.68%.



All looked after children are sent a child friendly leaflet prior to the initial Care Plan Review giving details of their IRO's name, contact number and email address. Children often contact their IRO directly to discuss issues worrying them and the level of contact between Care Plan Reviews is agreed between the child and IRO at every Care Plan Review.

If a child/young person has not participated in the Care Plan Review this is recorded on the child's file. There are various reasons for the 5% of children where the IRO has not ascertained the views of the child. Reasons recorded include decisions made that meeting another professional could be unsettling for the child at that time, young people have chosen not to meet with the IRO, young person have been missing from placement at the time of the Care Plan Review and arrangements have been made to meet with young person at another time.

Foster Carer Reviews

The voice of the child is routinely captured within the Foster Carer Review process. This is a requirement of the Foster Carer Review. As this often provides valuable information to the authority regarding placement stability, we agreed with Fostering Services to collate evidence of feedback obtained from children and record on the child's case-file so that this is evident to the child's social worker and Independent Reviewing Officer.

Advocacy and Independent Visiting

The Advocacy and Independent Visiting provision in Southampton is currently provided by NYAS as a commissioned service.

IROs routinely check that children and young people know about advocacy and how it can support them in having a say in decisions affecting their lives. We have actively promoted to social work teams as well as supporting NYAS to join team meetings to discuss the role of the advocate and Independent Visitor. Leaflets about the service are sent to all looked after children by the 2nd Care Plan Review.

From the end of March 2020 to April 2021, the number of IV matches doubled from 11 to 22.

During the year, the advocacy service has been delivered via a blended approach of both face-to-face and virtual methods. 98 referrals to the Advocacy service were made during the course of the year, in line with the annual service target of 80-100. This was an increase from 2019-2020, when 75 referrals were made.

Appendix 2: NYAS Advocacy and Independent Visitor Services, April 2020-April 2021

6. Qualitative Information – IRO Scrutiny, Challenge and Impact

> *'The case record indicates that in the last six months, there has been regular communication between the IRO and the social care team. These have referenced significant events such as placement changes and missing episodes. The IRO's input on the case can be evidenced e.g. appropriate queries raised in respect of identity work and suggested strategies to mitigate missing episodes. In respect of the child's family time and education, there has been evidence of strong oversight by the IRO'* **SCC Case Audit 2021**

The IRO role is statutory and the work is therefore underpinned by statutory guidance which should be adhered to however, it is not the responsibility of the IRO to manage the case, nor supervise the social worker or devise the care plan.

Once allocated, IROs are expected to provide and maintain continuity and consistency in reviewing a child's care plan whilst they remain looked after. In addition, IROs complete regular case monitoring and liaise with the child's Guardian as well as other professionals as and when required.

Whilst it is the case that monitoring is a function of the IRO role, the demand has significantly increased in terms of case discussions between IROs and social worker following the Ofsted focused visit in May 2021 when it was agreed that IROs would evidence additional scrutiny for key cohorts of children.

IROs maintain regular contact with social workers and monitor progress on permanency and care plans through an IRO Case Discussion conducted either by meeting with the social worker and/or Team Manager or via a telephone call or email with the social worker and/or Team Manager.

These circumstances are often complex and add additional pressure to the work of the IROs e.g.

- 24.30% of looked after children were placed 20 miles + from Southampton as of 31st March 2021.
- There are significant number of children subject of Care Orders and placed with parents, adding complexity, and requiring additional scrutiny.
- There are also significant numbers of children in unregulated and unregistered placements. Similarly, such cases require additional scrutiny and often challenge by the IRO.

This has had a significant impact on our workload and is time intensive most noticeably in work completed between statutory reviews.

Changes in social worker, social worker sickness, re-structuring and changes to systems can all impact on care planning and the delivery of a timely and complete statutory review thus impacting on the child.

Furthermore, the IRO Service is represented in key local authority activities such as:

- Permanence Panel
- Staff Reference Group
- Placement sufficiency/Residential provision
- Health & Social Care Partnership
- Work with the Missing & Exploited children and young people team
- Participation
- Advocacy and Independent Visitors
- Development of Care Director
- Supervision of intern during 2020/21
- Liaison with CAFCASS

Whilst participation in such work may not be part of the IRO core responsibilities, we feel it is necessary to ensure that the IRO Service is consulted and has the opportunity to influence decisions that ultimately impact on the children in our care.

As covered elsewhere in this report, the overall performance of the Service remains very good and has continuously improved over the recent period. However, this will be increasingly difficult to sustain and maintain considering the pressures highlighted unless wider responsibilities can be reduced, or additional resource identified.

Use of the Dispute Resolution Process

One of the key functions of the IRO is to resolve problems arising out of the Care Planning process. The Dispute Resolution process (currently known as IRO Alerts) reinforces the authority of the IRO and their accountability for ensuring the needs of the child are appropriately identified and met without delay.

Analysis of use of the dispute resolution process allows us to identify themes, practice issues and timescales for response. Currently a monthly analysis report is submitted to the Senior Managers identifying key issues of concern, how these have been resolved and the impact for the child.

Themes identified have influenced practice thus allowing IRO activity to contribute to the authority's understanding of strengths, weaknesses and plans for improvement

During 2020/21, we have tried to ensure that escalations are child focussed with clarity on the outcome being sought and impact of the resolution.

A key message from the analysis of the use of the dispute resolution process is that the negative perception of IRO Alerts must be addressed to ensure the best outcomes for the child are achieved without delay. We need to ensure that the use of the dispute resolution process is recognised as having influence on outcomes for both the individual and groups of looked after children.

1. Key Matters

(i) Poor preparation for Care Plan Reviews account for the adjournment of 52 Care Plan Reviews in the period April 2020 to March 2021.

30.63% of Alerts raised from 1st April 20 to 31st March 2021 were as a result of no recorded/updated Care Plan and the subsequent adjournment of the Care Plan Review. In 2019/20 this figure was 22.6% (April-March) therefore an increase in 2020/21.

(ii) Timely resolution of concerns

It is positive that most Alerts are resolved at the informal stage of the dispute resolution process I.e. 63.96% however, only 42.35% of Alerts overall were responded to within timescale.
We should be able to demonstrate to children that we are acting on their behalf and be able to evidence how we have resolved any issues of concern in a timely manner.

(iii) Care Planning

Analysis of IRO Alerts raised and audits undertaken by IROs throughout the year evidence inconsistent care planning for children in our care.

Decisions made to adjourn Care Plan Reviews reflect the importance of the child being given the opportunity to contribute to their care plan and to expect that he/she will be given a copy.

IROs routinely check that the care planning process has helped children and young people to have their say about matters important to them and helped them to understand what is happening and why.

As a result of the concerns highlighted above, the Lead IRO has worked with the Workforce Development Team to offer an e-learning training accompanied by a range of resources which offers guidance on the purpose of care planning and review. There is also a strong focus on preparation for the review and the voice of the child. Alongside this training, drop-in sessions have been made available to offer further support to practitioners with the aim of increasing their knowledge and understanding of the care planning and review process.

In response to key themes raised, quality assurance clinics led by the Deputy Director have been implemented to address performance and identify the learning and support needed.

2. Breakdown of all Alerts 1st April 2020-31st March 2021

Table 3: Number of Alerts raised

Reporting period	Number of IRO Alerts
1st April 2020 to 31st March 2021	111
1st April 2019 to 31st March 2020	163
1st April 2018 to 31st March 2019	88
1st April 2017 to 31st March 2018	119

Table 4: Level of Alerts raised

Informal Case Management Discussion	91
Level 1 (Formal) Service Manager	20
Level 2 (Formal) Head of Service/Service Director	10

3. Thematic Issue re Children's Savings

Alerts relating to children's savings have been dealt with separately from the normal escalation process.

From July 2019, several IRO Alerts regarding the savings of looked after children have been escalated to the Director of Children's Services.

An interim response has been received and it is acknowledged that to take this matter forward, additional work is required. This work is now in hand and we hope that the matter will be resolved shortly.

4. Main reason(s) for dispute

Table 5: Main reason for IRO Alerts 2020/21

Reason for Alerts	%
Frequency of statutory visiting	21.62%
Practice issues Unregulated placement Gaps in care planning e.g. family time arrangements, missing HCA, communication with parents, frequency of statutory visits Quality of assessments/planning IRO disagrees with CP	41.44%
Preparation for Care Plan Review	30.63%
Permanence Drift and Delay	27.93%

5. Timescale for resolution for Alerts raised in 2020/2021

63.96% informal Case Management Discussions were resolved without the need to escalate to the formal stage of the resolution process

6. Impact

> *'I would just like to say that I have seen a significant positive improvement in the service that my young people and myself have received with their current IRO. I no longer feel like I am the only one advocating on their behalf and can focus my attention on the day to day stuff rather than the bigger system issues. I know that alerts have been made as I then get csw team on the phone saying 'we have received an alert about ……' I feel confident that I can contact the IRO between reviews which I haven't in the past. As an overview I feel we have received an excellent service from the IRO in the last 12 months'* **SCC Foster Carer 2021**

The outcome and impact of each dispute is recorded on the individual child's file and any agreed action plan is monitored by the IRO.

Examples include:

- Child's views heard and acted upon
- Family time established
- Improved relationships between the child and professionals
- Improved care planning to achieve permanency
- Young Person's needs have been highlighted and are being addressed.

A key learning area for the IRO Service has been to evidence the impact of our work particularly within an authority that continues to be judged as 'requires improvement' by Ofsted. We have focussed on improving our recording of impact and gathering data to evidence impact.

7. Service Development Priorities 2021/22

The plan has been formulated following analysis of the IRO Alerts raised in 20/21, the outcome of IRO Peer Audits undertaken in 20/21 and Ofsted feedback May 2021.

How we will make a difference:

1. IROs will provide independent scrutiny to make sure care plans for children are in their best interests. We will promote high aspirations and seek to ensure the best outcomes for those children and young people.
2. We will ensure that IRO scrutiny and challenge and the impact of this is evident on the child's case record.
3. IROs will ensure best practice in early permanence planning and promote stable care for all children who have entered the care system. This will focus on minimising drift and delay and ensure all options for care have been considered.
4. We will contribute to the local authority permanence panel and other processes to ensure permanency is achieved without delay.
5. IROs will ensure adherence to robust care planning and encourage increased participation of children in the development of their care plans, including consistent and meaningful participation in Care Plan Reviews.
6. IROs will seek children's views, wishes and ideas to inform continuous improvements.
7. We will actively promote children and young people's views about what works in relation to their participation and involvement in reviews.
8. IROs will champion the rights of every child and challenge where appropriate to make sure that these are integrated in policy and practice.
9. We will promote the use of advocacy in a variety of ways
10. Review records will be written in a way that the child can understand their life journey in the future.

11. We will routinely reflect on our own performance to address the quality of our practice.
12. IROs will undertake a quarterly peer audit to inform and support the IRO performance focussing on ensuring that there is clear IRO footprint on the child's case record.
13. Particular attention will be paid to children in the following cohorts: children in unregistered placements, Placement with Parents, children living with a Connected Person where the assessment is not yet complete and children where permanence has not yet been achieved.
14. We will evidence the use of IRO Case Discussions to monitor drift or concerns. Subsequent action plans will be agreed with line managers and recorded on the child's file.
15. We will use data reports to inform us of our progress in our performance and that of the authority.
16. We will use quarterly Professional Development Days an opportunity to reflect on and improve our practice
17. The Lead IRO will ensure that the necessary systems are in place to enable the IRO to carry out his/her statutory support, scrutiny and challenge functions in an efficient manner.

IMPACT ON OUTCOMES FOR LOOKED AFTER CHILDREN

- The child's care plan will be relevant and specifically respond to the full range of the child's needs.
- Through permanence, children will have a sense of security, commitment and identity.
- Permanence will be achieved at the earliest opportunity with a range of options for permanence explored.
- Children will be assured of a high quality of care that best meets his/her needs and supports them to be the best in everything they aim to achieve
- Children and Young People will be supported to have their views and wishes heard and considered thus placing them at the centre of all our decision making.

- Children and young people will be able to raise concerns and make complaints.

SSCP Safeguarding Assurance Report

Southampton Children and Learning Service

November 2021

SSCP Performance Indicators - Summary

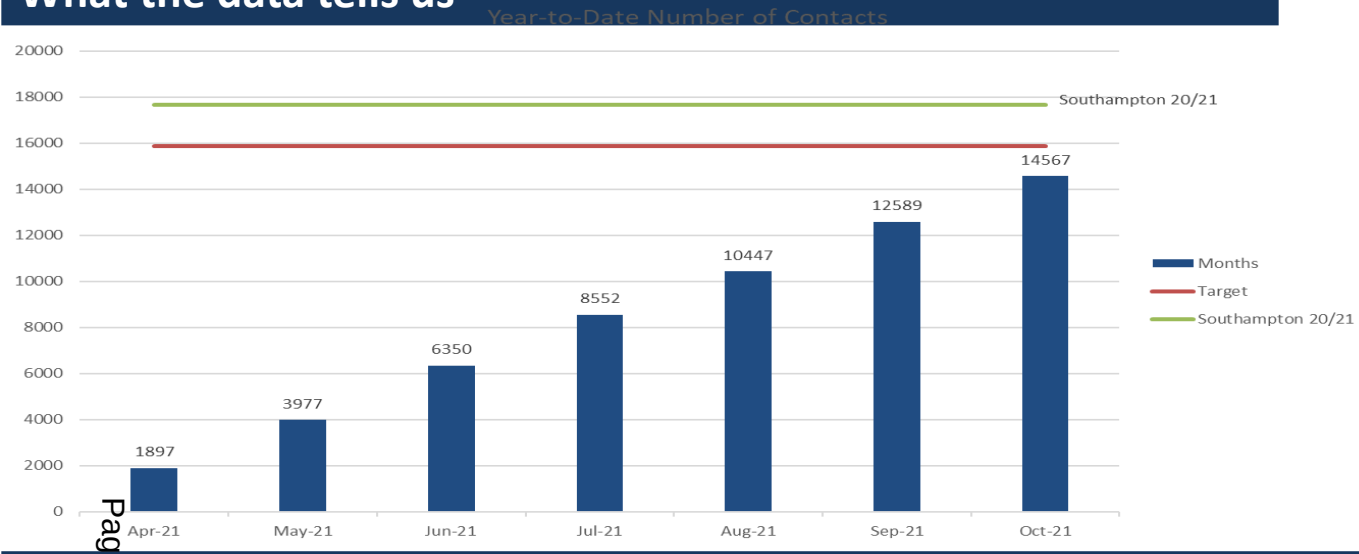
Area	Indicator	Outturn ty	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	Southampton 20/21	South East	England
Front Door	Year-to-date number of contacts	NUMBER	1897	3977	6350	8552	10447	12589	14567	15880	17661	N/A	N/A
Front Door	Rates of referrals per 10,000 of Under 18 Popula	RATE	408	493	559	628	684	766	841	647	790	561	484
Child Protection	Rate of Section 47 enquiries per 10,000	RATE	178	214	237	266	279	309	336	260	320	184	164
Child Protection	Rate of Children subject to an Initial Child Protec	RATE	52	61	72	83	92	98	105	90	103	60	60
Child Protection	Percentage of children for whom ICPC was held	PERCENTA	38	83	61	67	77	73	62	83	72	82	83
Child Protection	Percentage of Initial Child Protection Conferences (ICPCs) resulting in a Child	Number	89%	92%	93%	96%	98%	97%	79%	89	89	87	88
Child Protection	Number of children who are subject of a Child P	NUMBER	339	355	385	387	420	387	388	340	310	N/A	N/A
Child Protection	Rates of children who were the subject of a Chil	RATE	49	58	68	79	89	96	102	N/A	N/A	N/A	N/A
Child Protection	Number of Child Protection Plans ended in the r	NUMBER	19	29	28	50	18	75	23	N/A		N/A	N/A
Child Protection	Percentage of Review Child Protection Plans (CP	PERCENTA	52	41	37	25	35	33	44	N/A	N/A	N/A	N/A

Key discussion points

- Police / local authority discussion regarding levels of contact.
- Safeguarding Children's Partnership involvement in Children's Resource Hub and threshold document.
- Service and multi-agency audits.
- Assurance Clinics.
- Family Safeguarding Model.
- Strengthening Families.

Number of Year to Date Contacts

What the data tells us



Analysis

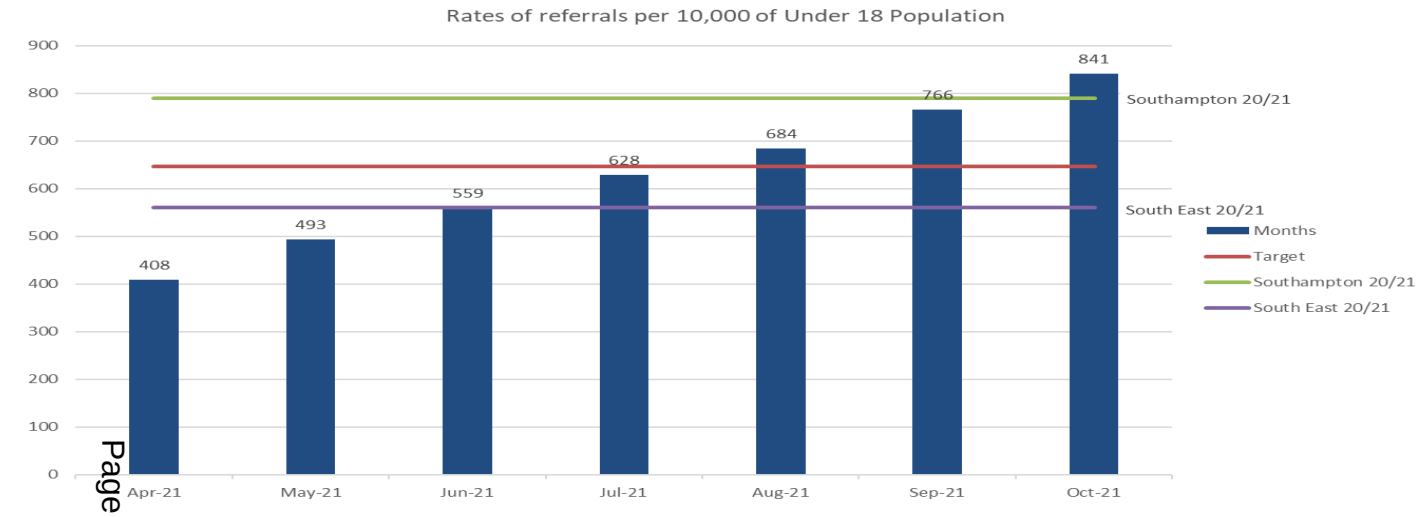
Increasing trend in contacts, with the majority coming from Hampshire Constabulary. This puts pressure on the safeguarding system, notably the MASH.

Action/next steps

Agreement at the Service Improvement Board for there to be a discussion between Children and Learning Service and Hampshire Constabulary before the next Board in January 2022.

Rate of Referrals per 10,000

What the data tells us



Analysis

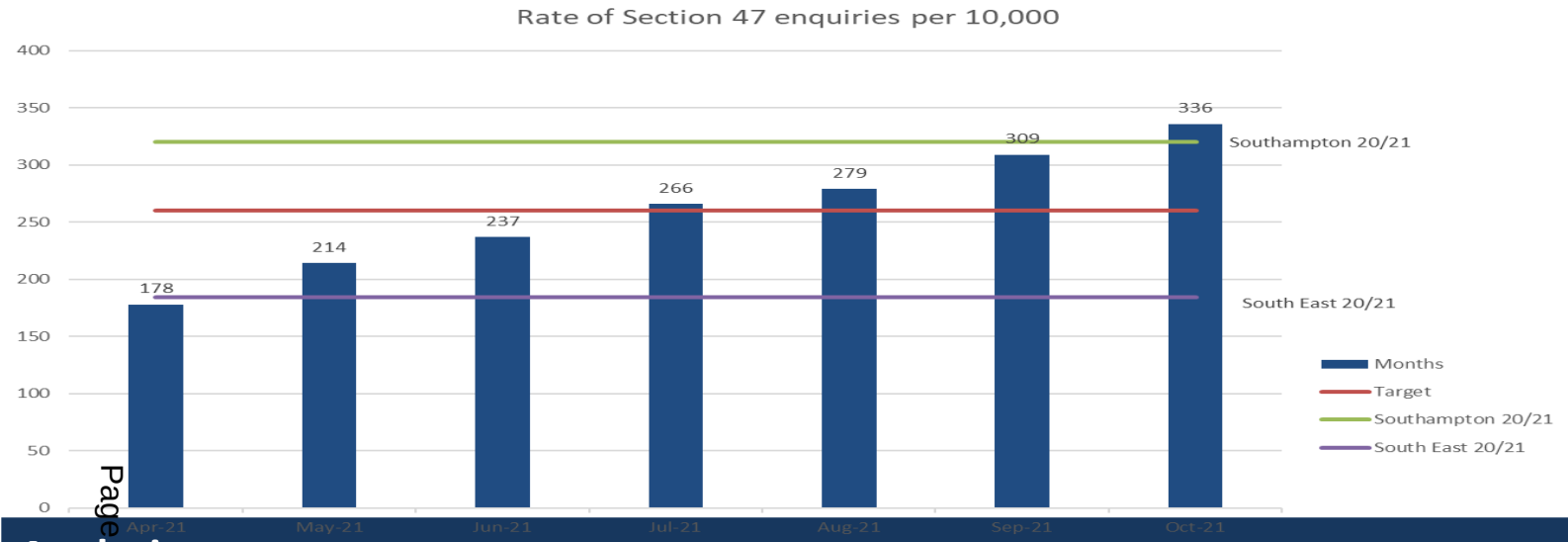
Despite the majority of contacts not converting to referral, the rate of referral is still high. This indicates an approach that risks families receiving a higher tier of intervention than they need.

Action/next steps

Conclusion of Destination 22 staff consultation and then the launch of the new Children's Resource Hub and threshold document. Safeguarding Children's Partnership involvement in this activity from January 2022 will be really critical.

Rate of S47 per 10,000

What the data tells us



Analysis

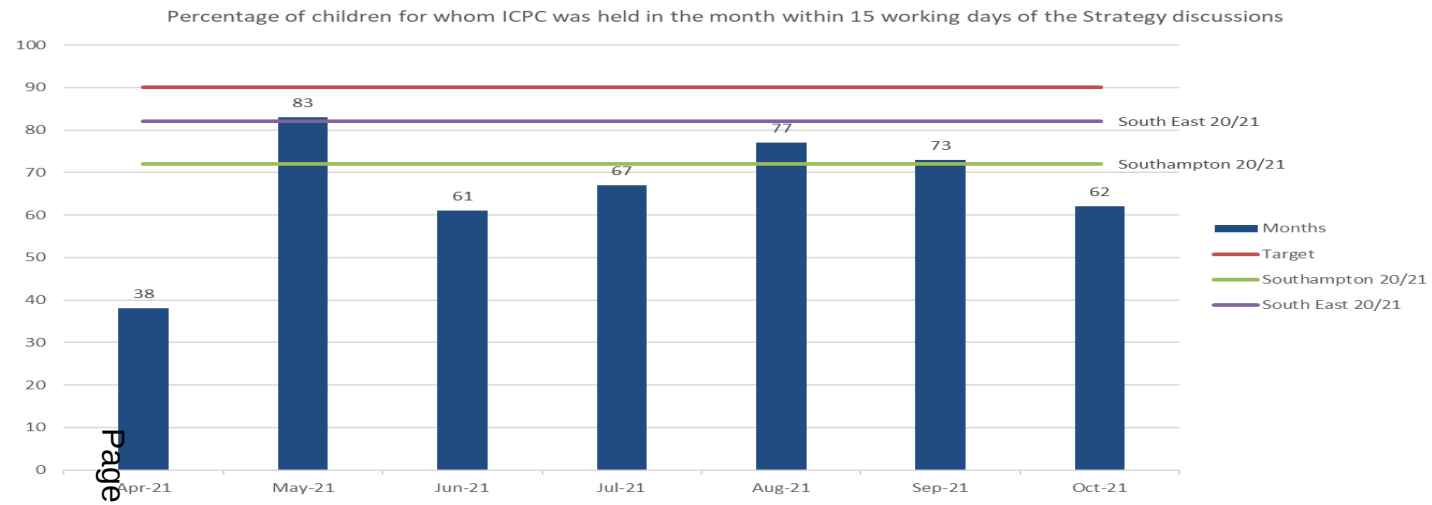
Again, rate of s.47 per 10,000 is high in comparison to statistical neighbour indicators and this suggests local practice that risks families receiving a higher tier of intervention than they need.

Action/next steps

Service and multi-agency audits continue to focus on the quality of referrals and the impact of decision making. Next multi agency audit is end-November 2021.

ICPC's held within 15 days

What the data tells us



Analysis

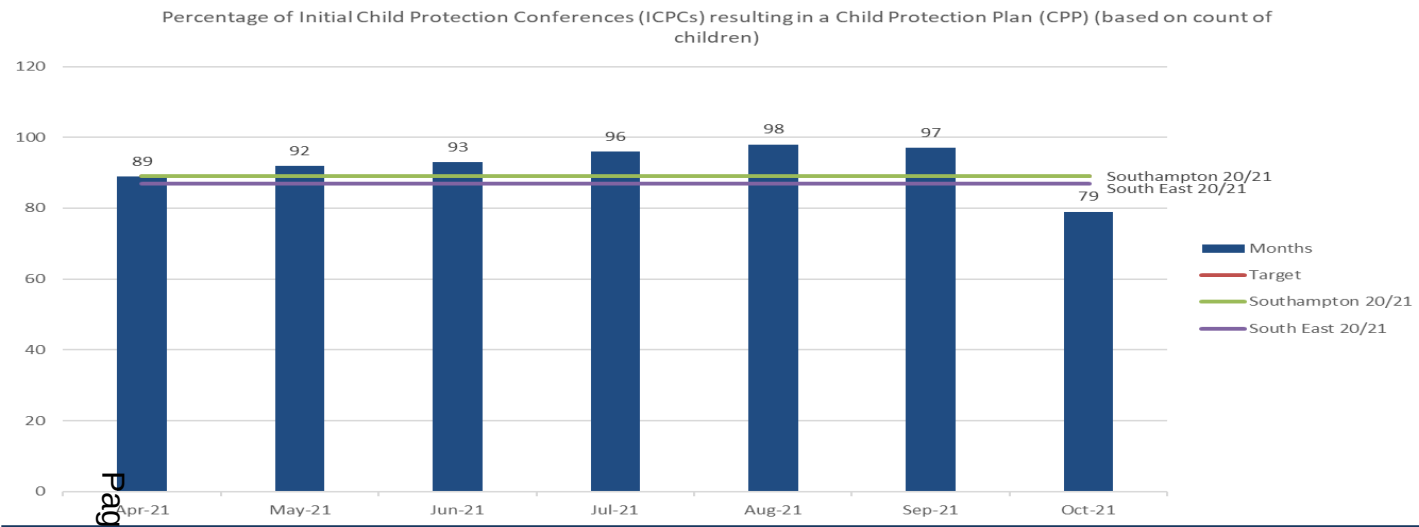
Variable performance, with timeliness around 15 – 20% worse than statistical neighbour average. Delays are often due to lack of timely information from the operational C&L teams.

Action/next steps

Assurance clinics have been launched to ensure a consistent management focus on this area. Recruitment and retention activity is progress to bring social workers in to stabilise this part of the service.

Percentage of ICPC's resulting in CPP

What the data tells us



Analysis

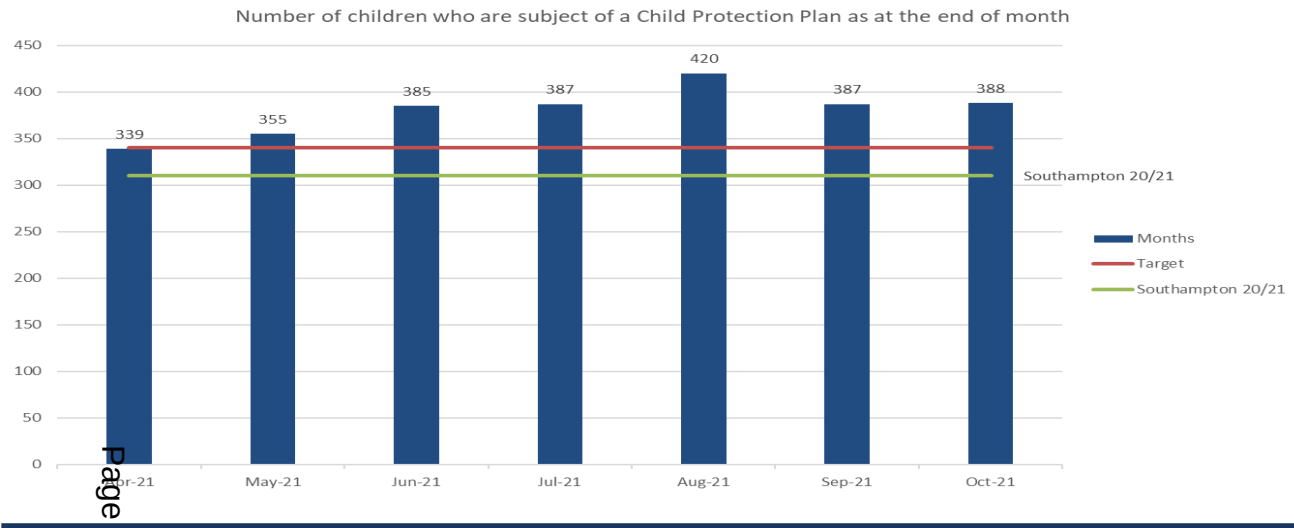
Overall trend for registration is higher than statistical neighbour average; again indicating local practice that risks families receiving a higher tier of intervention than they need.

Action/next steps

Discussions with Partner in Practice and another local authority around how they embedded Family Safeguarding Models. Recommendation that the Safeguarding Children's Partnership is briefed on this learning in January 2022 and safeguarding partners commit in principle to this approach.

Number of CPP at the end of the month

What the data tells us



Analysis

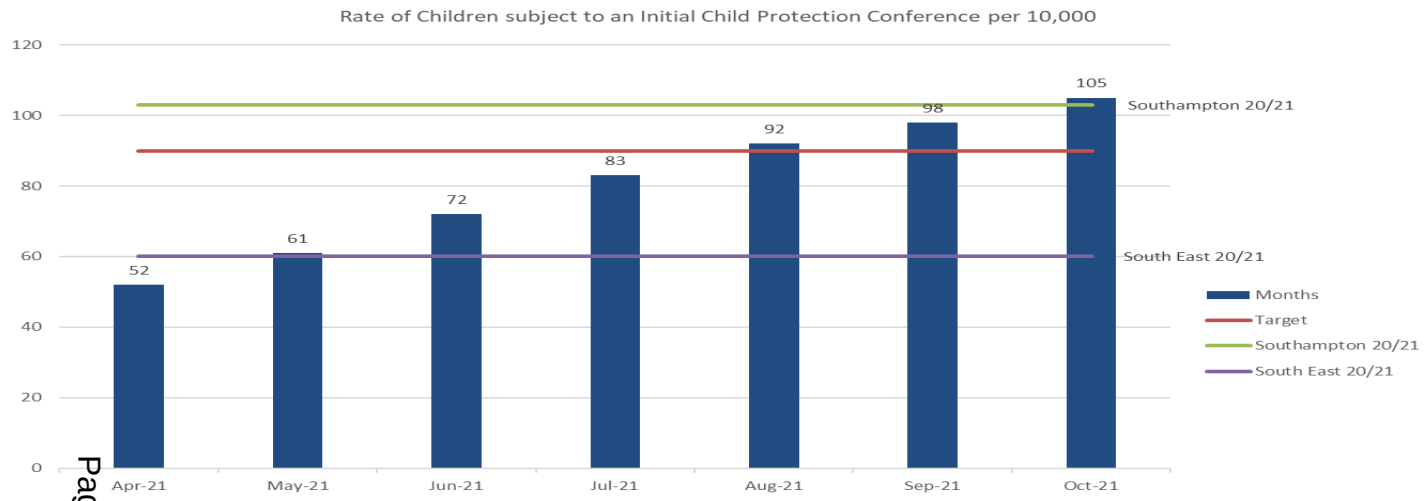
Increasing trend leading into the summer holiday period; with impact of Covid assessed to be a notable factor. Numbers of CPP have remained broadly static for the past two months.

Action/next steps

- Assurance clinics have been launched to ensure a consistent management focus on this area. Recruitment and retention activity is progress to bring social workers in to stabilise this part of the service.

Rate of CPP per 10,000

What the data tells us



Analysis

Increasing trend over the year after local down restrictions were eased. Southampton is a significant outlier in comparison to regional and statistical neighbour comparators.

Action/next steps

Safeguarding partnership has committed to support the Strengthening Families approach as part of the common practice framework. E-learning for partners has been created and will be launched in 2022.

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Improvement Report

Southampton Children and Learning Service Improvement Board
November 2021

Stuart Webb, Head of Quality Assurance
Jo Feeney, Performance Manager

Priority Areas

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Practice and Performance Summary

The last two months have been extremely busy for the service, with many important foundations being set for practice improvement in the new year. The key development has been the approval of the Destination 22 business case, which has enabled us to start the staff consultation around the future service structure, begin to progress the workforce academy development and start recruitment activity in critical areas. The new permanent Heads of Service have swiftly made themselves visible within their service areas and are working extremely well together with a collective commitment to tackling critical service need and supporting the service through this time of turbulence.

We believe that the service is becoming more data-intelligent and, although in some areas improvements in the outcomes for children are frustratingly slow, we are increasingly feeling that we are 'getting a grip' of the challenges along with a more accurate understanding of what we need to do differently. Assurance clinics are proving to be successful in terms of the engagement and buy-in of managers and this model is allowing us to apply a more bespoke approach to interrogating performance. Improvements are slow in some areas, but we are seeing pockets of improvement.

Our work with Hampshire Children's Services has progressed further and we have been pleased to welcome the new DfE performance advisor. The profile of our Principal Social Worker is growing, and her energy and engagement across the service is increasing service and partner awareness of our practice framework and enabling many meaningful conversations about life on the front line.

The principal concern for us continues to be the level of demand in key service areas, exacerbated by staffing instability. This is of particular concern in the Protection and Court and Looked after Children services and we continue to see a negative impact upon the consistency of practice as a result of this. We are actively deploying further staff to these teams, including an additional service manager joining the Protection and Court Team. We have developed a structured, targeted response to the rising numbers of children in care, particularly those who are in residential placements but who could live within a family. We are also stepping up our recruitment and retention activity through improved web design and social media. We are planning to launch a major media campaign in January when we are clearer about where the vacancies are across the service post D22 restructure. Our projects team is now supporting our recruitment and retention activity, including a refresh of our strategies.

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I would recommend that the key considerations for the partnership in November 2021 are:

- The level of contacts that are coming into the service, particularly from the police, and the impact upon service effectiveness as a result.
- Partnership support for the launch of the Children's Resource Hub and new threshold document.
- Continued partnership support for recruitment activity (staff and foster carers).
- A collective commitment to promoting positive working relationships on the ground between practitioners within our teams and services, particularly in relation to professional respect and trust.

Steph Murray
Deputy Director
Children's Social Care

Effective Assessment and Intervention

What the data tells us

Indicator	Outturn type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	Southampton 19/20	Southampton 20/21	Statistical Neighbours	South East	England
Percentage of re-referrals within 12 months	PERCENTAGE	27%	28%	26%	33%	26%	31%	24%	23	28	22	28	23	N/A
Number of Early Help assessments completed	NUMBER	417	319	351	428	338	297	264	250 per month	N/A	N/A	N/A	N/A	N/A
Rates of Single Assessments completed per 10,000	RATE	55	118	182	237	292	333	392	637	898	672	637	554	518
Percentage of C&F assessments completed within 45 working days	PERCENTAGE	91%	87%	89%	94%	86%	90%	85	87	65	86	87	89	88

Analysis

The percentage of re-referrals shows a reducing trend overall, in comparison to the previous year. However, there has been a notable fluctuation in some months. Audit activity identified that step down work is not always robust enough and this can leave outstanding needs for families, which can then translate into escalation of concerns at a later stage. Early help local performance is variable and comparison data is currently limited This will be addressed as the new requirements for the Early Help Service are developed. Single assessment timeliness remains good and aligned with statistical neighbours. We need to have an average of no more than 352 assessments per month if we are to come in line with SN's.

Action/next steps

- Greater focus on Early Help performance as part of Destination 22 programme. KPI's are being drafted for D22 Programme Board.
- Development of exemplars for the 'focus five' practice priorities is almost complete. New chronology communications has been developed – ready to be shared with staff.
- Targeted sessions with Assessment/ BIT regarding systemic approach to purposeful practice, assessment as an intervention and reflecting teams. Planning has commenced. Training will also consider findings from Hampshire Partners in Practice CiN audit.
- Launch of systemic practice training to support reflecting team approach (with the aim being to challenge risk averse practice and to focus on purposeful assessment where assessment is viewed as an intervention in its own right) is being planned and considerable communications efforts to ensure staff continued interest.

Purposeful Direct Contact

What the data tells us

Indicator	Outturn type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	Southampton 19/20	Southampton 20/21	Statistical Neighbours	South East	England
Percentage of children subject to a Child Protection Plan seen in the last 15 working days.	PERCENTAGE	100%	83%	88%	83%	74%	88%	89%	100	N/A	N/A	N/A	N/A	N/A
Percentage of CLA for whom a visit has taken place within statutory timescales (6 weeks or less visits)	PERCENTAGE	82%	84%	85%	80%	72%	74%	60%	100	95	TBC	97	53	67
CIN on a plan visited within 4 weeks	PERCENTAGE	85%	82%	79%	76%	70%	69%	87%	100	N/A	N/A	N/A	N/A	N/A

Analysis

Data shows that we are not consistently meeting our visiting requirements in respect of our children who are either looked after or subject to CiN planning and we have drilled down into service / team / SW performance for these cohorts of children. There is better performance for children subject to child protection planning. However, the quality of direct work across the service remains variable and a recent Care Plan consultation undertaken by the IRO Service demonstrated that at second review 87.5% of children and young people in our care did not know what the plan is for their current or future care.

Action/next steps

- Identifying 'good practice' case exemplars to support staff to know what good looks like. 'Why am I in care?' training is being rolled out for staff.
- PSW-led reflective sessions with teams and managers across the service have commenced. reflective practice and embedding the systemic approach to reflecting teams into daily team practice- these will emphasise perspective of the child. Launch of systemic practice training to support reflecting team approach is being planned, with regular communication to ensure staff continued interest.
- Purchase of direct work toolkits for staff and PDT sessions has been approved.
- Love our Children Practice Week – Presentations from SAR Alice and Lisa Cherry and launch of Narrative training to ensure that practitioners understand the need for direct work/ appropriate visiting patterns/ relationship-based practice/ children understanding their own stories. 160 staff attended SAR Alice presentation. Development of staff induction programme which also underscores the need for the above.

Management Support for better Practice

What the data tells us

Indicator	Outturn type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	Southampton 19/20	Southampton 20/21	Statistical Neighbours	South East	England
Percentage of CIN who have had their supervision and within timescale	PERCENTAGE	85%	65%	55%	59%	53%	55%	67%	90%	N/A	N/A	N/A	N/A	N/A
Percentage of CPP who have had their supervision and within timescale	PERCENTAGE	88%	66%	56%	66%	49%	63%	71%	100%	N/A	N/A	N/A	N/A	N/A
Percentage of CLA who have had their supervision and within timescale	PERCENTAGE	80%	68%	51%	65%	66%	70%	58%	90%	N/A	N/A	N/A	N/A	N/A
Percentage of Care Leaver who have had their supervision and within timescale	PERCENTAGE	81%	64%	48%	72%	83%	69%	82%	90%	N/A	N/A	N/A	N/A	N/A

Analysis

Our data shows us that supervision practice across the board remains inconsistent (although there are pockets of improvement, for example in PACT where timeliness has recently increased from 65 to 81%. Our employee Survey and SWORD (Social Work Organisational Resilience Diagnostic Tool) completed with a focus on wellbeing, supervision frequency and leadership also found that staff thought practice to be inconsistent across the service and staff do not feel that the culture yet fully supports attendance at reflective spaces. To date, staff feeding back in the groups find the supervision policy and tools cumbersome. Managers and staff have volunteered to be part of the redesign.

Action/next steps

- Practice Development Team-led reflective sessions with teams and managers across the service have commenced. PSW has also commenced training some management groups in a) facilitating reflective groups b) facilitating a reflecting team approach to daily practice. This will continue and grow across the service.
- Launch of systemic practice training to support reflecting team approach is being planned and considerable communications efforts to ensure staff continued interest, for example, systemic presentations at the launch of the Making the Difference Practice Development Forum, IFT presentations at the Equality, Diversity and Inclusion Practice Week planned for December.
- Supervision policy rewrite and tool redevelopment and launch to raise the profile of supervision. This will include a review of supervision frequency to 4 weeks in line with newly authored Practice and Management Practice Standards. Audit & Practice learning days scheduled for January 2022 to link audit to systemic reflecting teams activity.
- We will continue to interrogate supervision performance in the assurance clinics (at a service, team and social worker level).

Right Service at the Right Time

What the data tells us

Indicator	Outturn type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	Southampton 19/20	Southampton 20/21	Statistical Neighbours	South East	England
Number of contacts	NUMBER	1897	2080	2373	2202	1895	2143	1978	1400 per month	15657	17661	N/A	N/A	N/A
Number of referrals in the month	NUMBER	336	445	342	355	291	426	387	300 per month	N/A	4092	N/A	N/A	N/A
Rates of referrals per 10,000 of Under 18 Population	RATE	64	152	219	288	345	428	503	647	944	790	647	561	494
Number of CLA at the end of the month	NUMBER	494	498	501	507	507	511	530	456	486	495	615	N/A	N/A
Number of children with an active Child in Need Plan not allocated to CWD (CIN*)	NUMBER	548	549	530	537	512	536	532	475	N/A	N/A	N/A	N/A	N/A
Number of children who are subject of a Child Protection Plan as at the end of month	NUMBER	338	354	384	386	419	385	388	340	396	310	406	N/A	N/A
Number of care leavers	NUMBER	156	154	161	156	163	162	164	150	N/A	N/A	N/A	N/A	N/A
Number of cases in care proceedings	NUMBER	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	N/A	N/A	N/A	N/A	N/A

Right Service Right Time

Analysis

There has been a notable increase in contacts between 19/20 and 20/21 and the trend is continuing. There is a risk that multi agency partnership safeguarding arrangements will not be effective due to the volume of contacts.

The rate of referrals remains high. Audit of sec.47 investigations in summer 2021 concluded that the majority of cases met the threshold for strategy discussion and, following s47 enquiry, for the majority of the families the decision made not to progress to ICPC was proportionate to meeting their needs. However, the service Destination 22 analysis concludes that it can be hard for families to access help easily and this can result in a higher tier of referral and intervention.

The rate of children in need of help and protection and looked after are all higher than Southampton's statistical neighbours; again, suggesting a context where children and families experience statutory intervention too frequently.

Proceedings data was not available for analysis before the Improvement Board. We know that this a key area for improvement and information will be shared with the Board ahead of the January 2022 meeting.

Action/next steps

- The Executive Director is sighted on the high level of contacts and low conversion rate to referrals, alongside police colleagues at a senior level. A plan to address the issue needs to be confirmed. The service is launching We are launching its new Children's Resource Hub after consultation has concluded. This will ensure easier pathways of support for children and families. Aligned with this, the new threshold document will be launched and it will be important for safeguarding partners to support the roll out .

- The conclusion of the Destination 22 service consultation on November 19th will mean that the service can move onto the next stage of its redesign. This will support better service access for children and families through the progression of key workstreams: Early Help, Special Educational Needs and Disabilities, Young People's Service, Safeguarding).

- The service is also engaging with its Partner in Practice and another local authority to draft a business case for a local family safeguarding model.

Robust Corporate Parenting

What the data tells us

Indicator	Outturn type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	Southampton 19/20	Southampton 20/21	Statistical Neighbours	South East	England
Number of CLA at the end of the month	NUMBER	494	498	501	507	507	514	530	456	N/A	N/A	N/A	N/A	N/A
Rate of CLA per 10,000 under 18 population	RATE	95	96	96	97	97	99	104	89	95	TBC	97	53	67
Number of CLA at the end of the month who are UASC	NUMBER	18	15	17	22	25	26	25	35	N/A	N/A	N/A	N/A	N/A
Percentage of CLA children with an up to date review	PERCENTAGE	98%	96%	95%	96%	97%	96%	97%	100%	N/A	N/A	N/A	N/A	N/A
Percentage of children in care for at least 12 months for whom health assessments are up to date.	PERCENTAGE	93%	91%	90%	88%	86%	83%	76%	100%	N/A	N/A	N/A	N/A	N/A
Percentage of initial health assessments delivered within 20 working days of the child became looked after.	PERCENTAGE	TBC	TBC	TBC	TBC	TBC	TBC	TBC	95%	N/A	N/A	N/A	N/A	N/A
Percentage of CLA at end of month with 3 or more placements during the year	PERCENTAGE	16%	16%	16%	16%	15%	15%	12%	8%	N/A	N/A	N/A	N/A	N/A
Number of CLA allocated to CWD	NUMBER	27	27	27	27	27	29	29	N/A	N/A	N/A	N/A	N/A	N/A
Number of Voluntarily Accommodated Section 20s (S20) at period end	NUMBER	39	32	38	39	43	54	60	40	16	TBC	11	13	11
Percentage of Looked after Children (LAC) with a permanence plan in place within 6 months of BLA	PERCENTAGE	TBC	TBC	TBC	TBC	TBC	TBC	TBC	100%	N/A	N/A	N/A	N/A	N/A
Number of Looked after Children placed for adoption at period end	NUMBER	17	16	14	14	12	12	13	N/A	N/A	N/A	N/A	N/A	N/A
Percentage of CLA placed with IFAs at end of period	PERCENTAGE	31%	31%	32%	32%	32%	33%	32%	36	37	N/A	36	38	36

Robust Corporate Parenting

Analysis

The rate per 10,000 for looked after children remains high and has increased because of a higher level of entries in to care, against a stable number of children exiting. The service anticipates that the number of unaccompanied asylum seeking children (UASC) will increase, in line with national requirements upon local authorities. Although review timeliness is generally good, the timeliness of contact has deteriorated, as previously outlined on page 4. Data in respect of children having a plan for permanence by second review is also not available, but will be when the new case management system is implemented.

The service still needs to do much more to ensure that placements for children are stable, as the monthly trend in respect of children who have experienced 3+ placements during the year shows. Completion of health assessments shows a deteriorating picture overall and data for initial health assessments was not available at the time of writing. However, considerable work is being undertaken with health colleagues to obtain accurate data and resolve the performance issues.

Regarding the profile of our looked after children cohort, the number of children with disabilities remains stable. There is a high number of children in the sec.20 voluntarily accommodated cohort. Adoption performance remains generally consistent in Southampton.

Action/next steps

- Extensive auditing of looked after children is underway, which will inform the self evaluation of practice and service delivery plan for that area. This has been coordinated by the Quality Assurance Unit and has involved the management team and Independent Reviewing Officers, with moderation at Panel.

- The Deputy Director is leading a project group from across the service, to deliver on a Placement Action Plan, which has three high level objectives: 1. Prevention of care and return home from care; 2. Substantially reduce the number of children in residential provision, by improving the sufficiency of in-house placements and increasing our access to IFA placements 3. Promote stability and better outcomes for children by reducing placement moves and placement breakdowns. This work is complex and time consuming , but necessary, to ensure the right permanence plan for each child and to ensure that the service is financially sustainable.

- The service has invested in participation activity, bringing additional staffing resources into the service to coordinate and develop the involvement of our looked after children and care leavers in the design of our service, aligned with wider service and corporate participation objectives. The Participation Strategic Plan will be signed of in March 2022, alongside the Corporate Parenting Strategic Plan.

Common Practice Framework

What the data tells us

Training	No. of attendees
Restorative Practice	322
Trauma Informed Practice	309

Partnership training numbers
1st April – 9th November 2021

Analysis

Data is encouraging, but there needs to more structure to the common practice approach; which focused on restorative practice, trauma-informed practice and Strengthening Families. There is evidence of traction being gained: Partners are now invited to the *Making the Difference* Board. The service is represented at the countywide Trauma Informed forums and the Workforce Development Manager chairs the local training delivery group. In September 2021, the service's Principal Social Worker recommended that the Safeguarding Children's Partnership endorse a common practice framework and partners expressed an appetite for a common practice framework. The Child and Adolescent Mental and Emotional Wellbeing Plan cites the core components of the framework. Practice weeks are being used to promote understanding and awareness of the practice framework.

Action/next steps

- Confirmation of training plan with oversight of the Making the Difference Board.
- Launch of Strengthening Families training resources.
- Opening up access to practice weeks for partners.
- Service participation in the Police and Crime Commissioner sponsored Trauma Informed Practice Conference in 2022.
- Plymouth University evaluation of impact in October 2022.

Rigorous Quality Assurance

What the data tells us

Indicator	Outturn type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Number of Cases Audited	NUMBER	12	2	28	105	22	17
Percentage of cases that are Good or Outstanding	PERCENTAGE	33%	0%	36%	66%	41%	65%
Percentage of cases that are RI	PERCENTAGE	42%	50%	57%	30%	54%	29%
Percentage of cases that are Inadequate	PERCENTAGE	25%	50%	7%	4%	5%	6%

Analysis

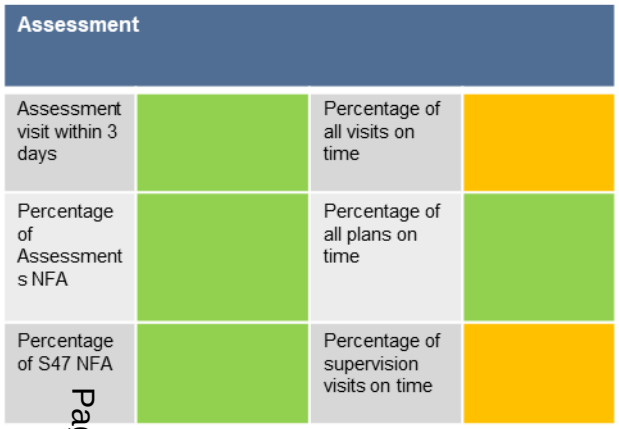
Extensive Looked after Children and Care Leavers audits were completed over the Summer period of 2021 with the inclusion of LAC managers and IROs. These identified inconsistencies in the quality of practice and frequency of visits to this group of children/YP. The Quality Assurance Unit continues to take the lead in most activity and the numbers of audits completed needs to increase. Overall, audit activity shows that the quality of practice remains inconsistent, typically falling below the 70% for case work graded good or outstanding. However, there has been positive engagement by managers in the training run by the Head of Service for Quality Assurance and colleagues from Hampshire Children and Learning Service; to support managers to accurately benchmark the quality of practice, in order to help raise standards. Capacity to undertake audits has been an issue due to staff sickness; but, service continues to flex to audit cases where there are potential concerns. MASH multi-agency audits have continued with good engagement from partners.

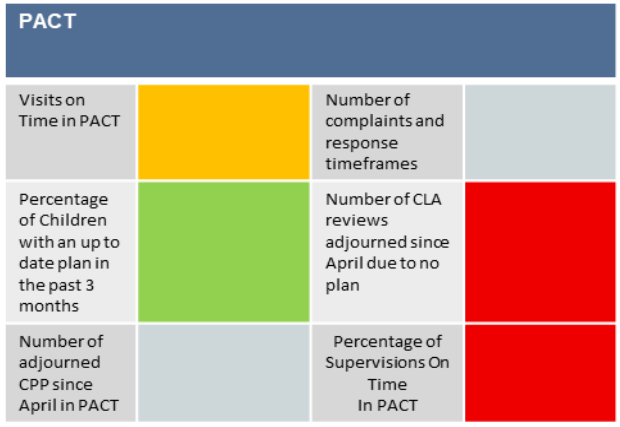
Action/next steps

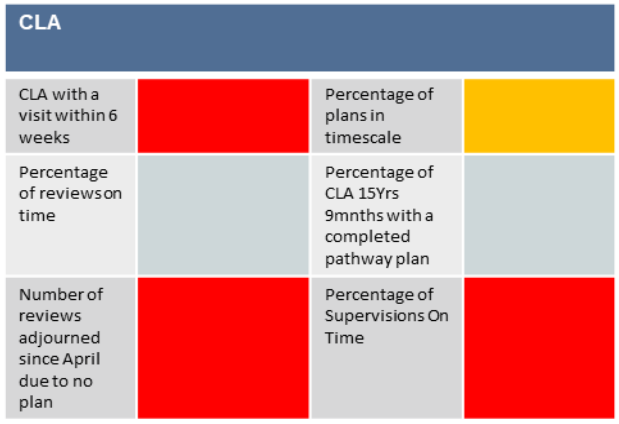
- Case Review discussion/reflection has been introduced at Learning and Improvement Panel to enable learning from audits to be embedded into practice on broader scale within safeguarding teams
- Examples of good/outstanding practice are shared with PSW on monthly basis to encourage practitioners to maintain good standards where this is identified and to encourage other practitioners to emulate this with a view to improving practice within teams
- Team focused audit and reflection days are being launched in January 2021. These will involve managers auditing with practitioners and learning and reflective sessions delivered by the Principal Social Worker.
- We continue to use our Learning and Improvement Panel to review our local CHAT analysis. In this way, we are identifying areas for scrutiny either through audit or dip sample.

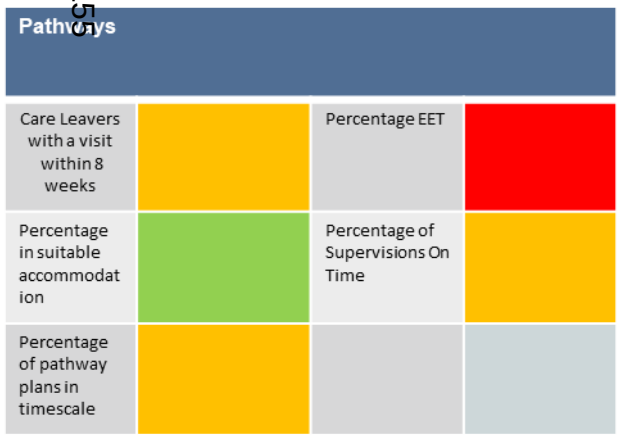
Performance Culture

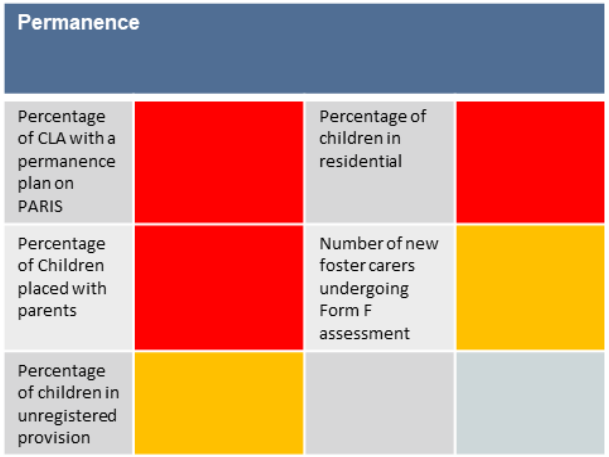
What the data tells us – Assurance Clinic Overview











Early Help
Jigsaw to be convened

Performance Culture

Analysis

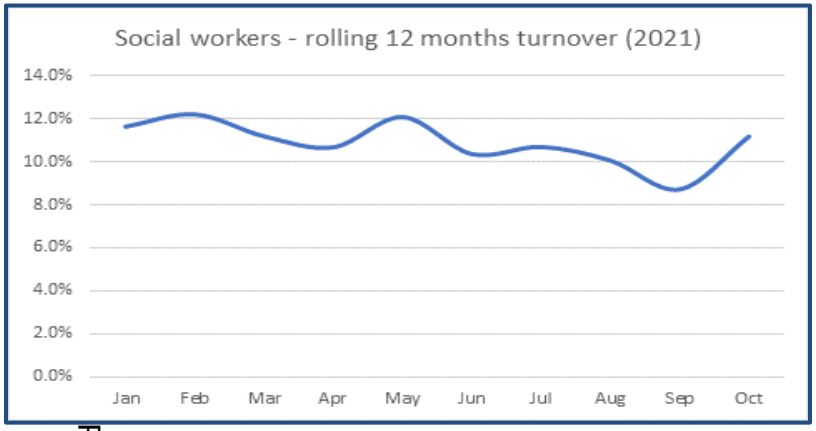
Assurance clinics are running on a rolling weekly schedule. Managers have been engaged in identifying the priority areas for their areas. Data is reported at team and worker manager level and used to track progress (see examples of assessment service and PACT). Assurance clinic discussions are analytical; exploring the service strengths and challenges that sit underneath performance trends.

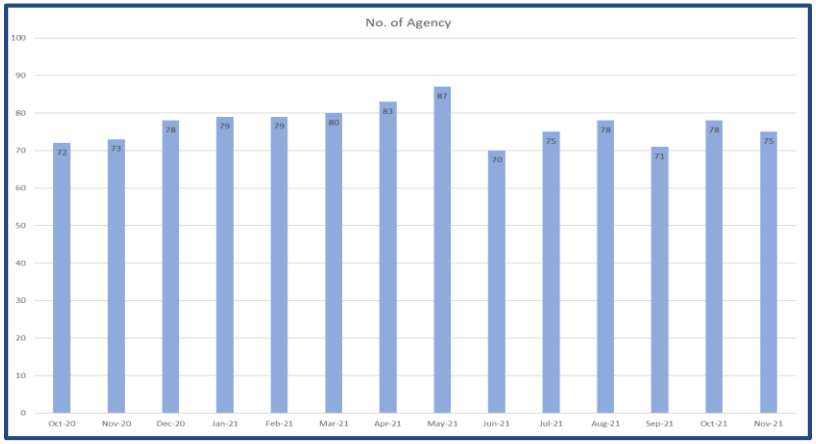
Action/next steps

It is the intention to present the data for the improvement board as 1 dashboard from January 2022 and beyond.
The data set will also be available as a power BI report with additional indicators enabling service areas and TM's to drill down on performance to child level exception data.
The improved set of PI's, many of which we can benchmark against, the functionality of an interactive Power BI dashboard and the assurance clinics will provide a performance structure and PI information which will give Southampton the tools and insight it has long needed to drive good practice as our minimum standard.

Workforce Academy

What the data tells us





Analysis

Recruitment and retention continues to be a significant issue and caseloads will need to reduce if we wish to practice in the relationship based way we aspire to. Turnover shows a recent increasing trend, with Destination 22 having an impact. Agency use remains high, but broadly stable.

We have expanded the number of placements and routes into social work training Work is well underway in commissioning the large scale training that is required to fulfil the ambition of the practice framework. Funding has been secured. PSW is leading change to learning culture and there is evidence that this and senior leadership team engagement is having impact.

Efforts are being made in respect of recruitment, Tripod International recruitment, newly designed adverts and recruitment resources, attendance at recruitment and career fairs, lectures at universities. In order to remain competitive SCC required to develop senior social work post. JDPS completed and evaluated. Progression Panel guidance in draft.

Current position: 20 students with us on placement; 4 students flourishing in our Frontline Hub; 9 social work apprentices across 3 cohorts progressing well; 5 Step Up to Social Work students commence January.

Action/next steps

- Project team supporting the development of a clear recruitment and retention plan as part of Destination 22.
- Recruitment of a second CSW to facilitate an additional Frontline hub next academic year.
- Exit interview analysis to be completed for this quarter.
- ASYE caseload analysis to continue and research underway regarding usefulness of post ASYE year of additional support & review of ASYE policy in line with this .
- Business case in respect of bringing ASYE assessment and support fully in- house.
- Progression panel guidance for Senior Social Work Post to be completed and communications developed.
- Large scale training procurement activity and calendar planning.
- Working with IFT regarding implementation of systemic practice training across the service and ensuring that there is the clinical supervision structure in place.
- Launch of Practice Educator CPD Club – 13 staff have come forward wanting to undertake Practice Educator training .

Systems and Support Services

Care Management System Implementation

- The Care Director implementation has recently had a new Live date approved for the 31st January 2022.
- The project started UAT on Monday the 1st Nov and by 5th and will have completed 20% with HRDA, EDT, MASH, Single Assessment and CIN.
- User Acceptance Testing has commenced.
- Training planning and development underway with training Partner for January delivery.
- Cut over and Live Migration planning ongoing.

Care Director: UAT 1st November – 16th December
Training Jan 3rd – 28th
PARIS Switch off 27th Jan
Live 31st January

Systems and Support Services

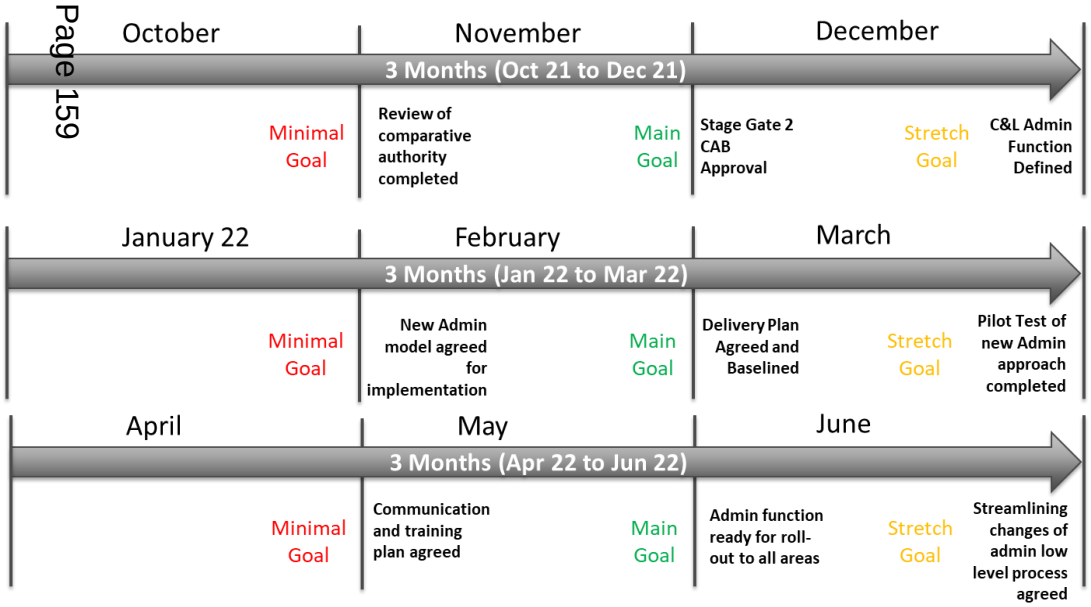
Business Support Review

Status - GREEN

- 2 of 3 Comparative authority interviews completed.
- Analysis of feedback started.
- Preparations for CAB in progress.
- Process mapping stalled awaiting introduction to Admin staff by Managers for priority areas defined in line with D22.

Critical Actions to Dec 2021

1) Complete comparative authority interviews.
2) Produce conclusions and recommendations.
3) Gain CAB Authorisation to continue Project.
4) Agree with QA the admin approach and team structures required.
5) Continue low level admin process mapping.
6) Hold Programme Board meetings prior to CAB for alignment.
7) Exploring a pilot business support project in PACT.



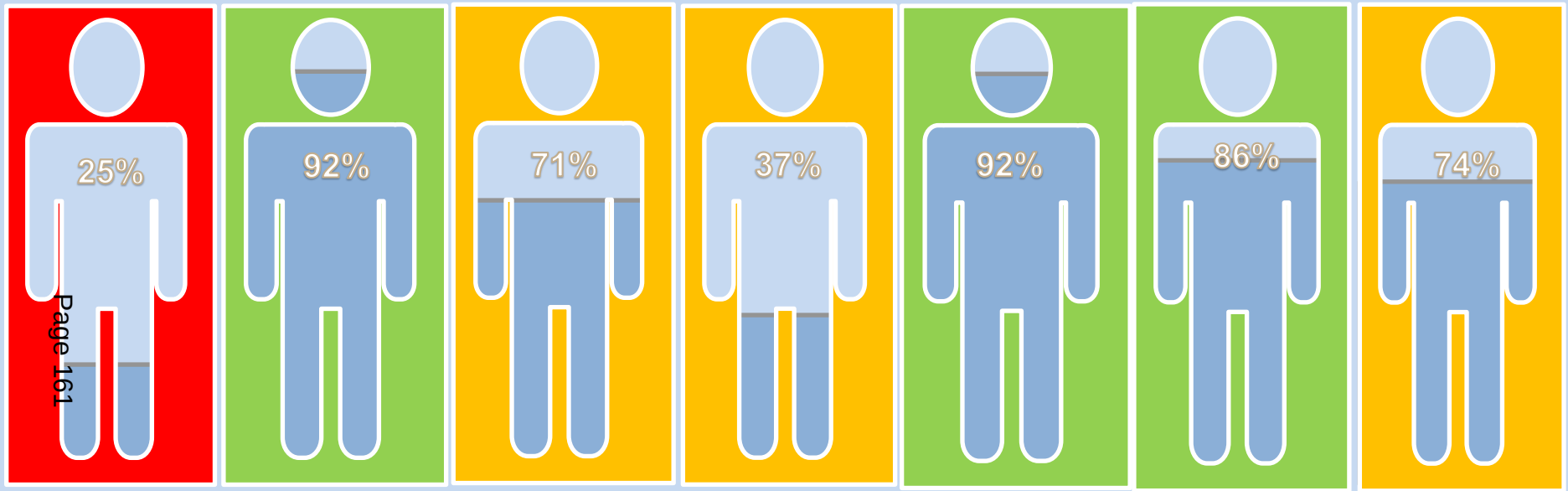
Timeline

Timeline is high level until the Admin Function is defined and the implementation plan can be formed.

The Horizon to December is fixed and baselined.

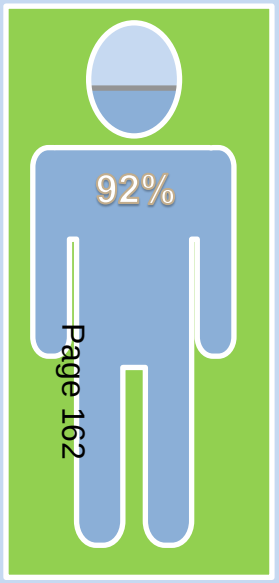
Appendices

Assessment Service

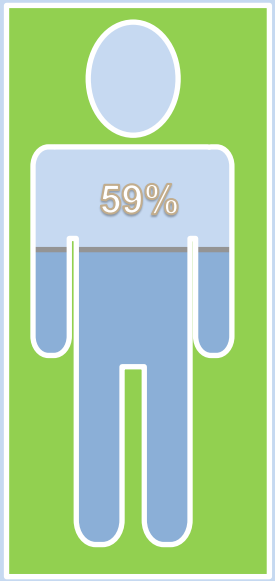


Assessment cases open 3 weeks from date of referral who have had a visit within 3 days of being open	Assessment cases open 4+ Weeks who have had a visit within the last 4 weeks	Percentage of Assessments by the Assessment service that NFA	Percentage of S47 NFA (14/38)	Percentage of Visits On Time	Percentage of Plans On Time	Percentage of Supervisions On Time

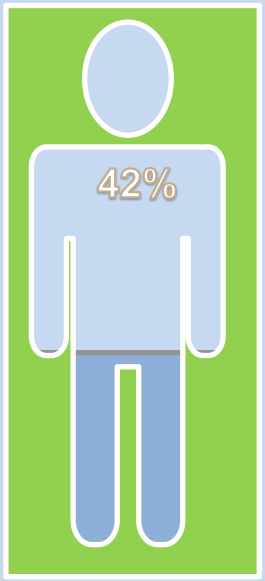
Assessment Service 3/11/21



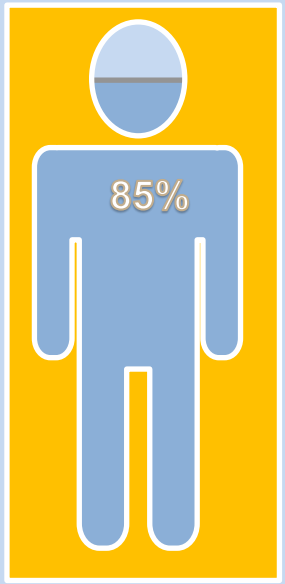
Assessment cases open 4+ Weeks who have had a visit within the last 4 weeks



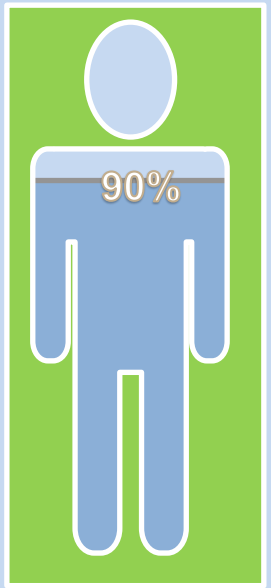
Percentage of Assessments by the Assessment service that NFA



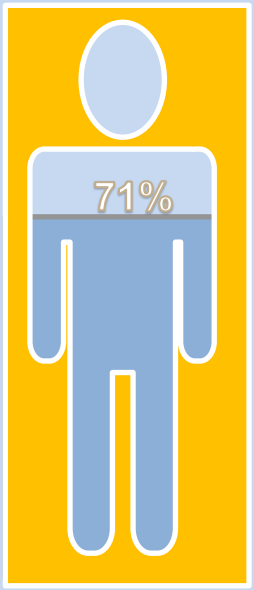
Percentage of S47 NFA (37/89)



Percentage of Visits On Time

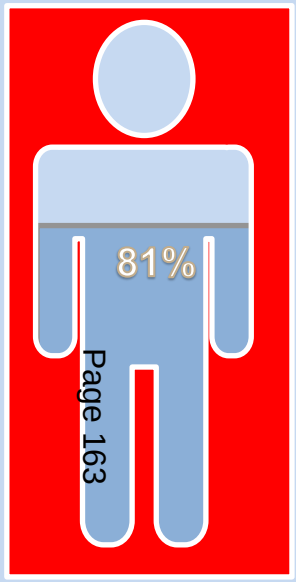


Percentage of Plans On Time

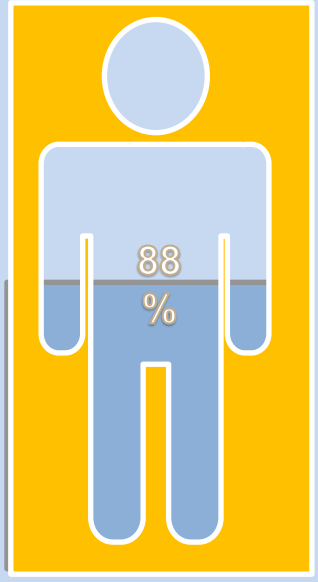


Percentage of Supervisions On Time

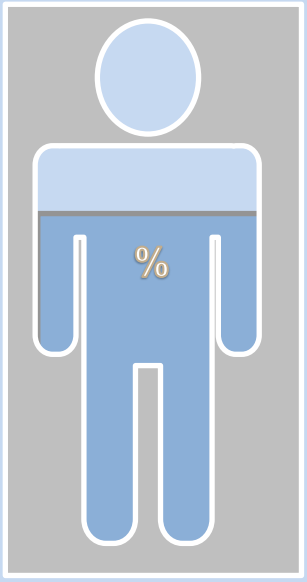
PACT Service 10/11/21



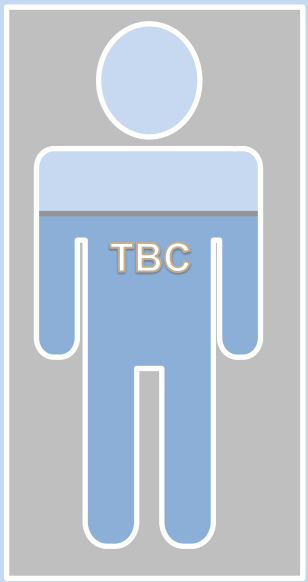
CLA with a visit within 6 weeks
In PACT CLA 85% (121/128)
CPP with a visit within 4 weeks 70% (241/357)
CIN with a visit within 4 weeks 81% (476/547) Combined Total 76% (838/1032)



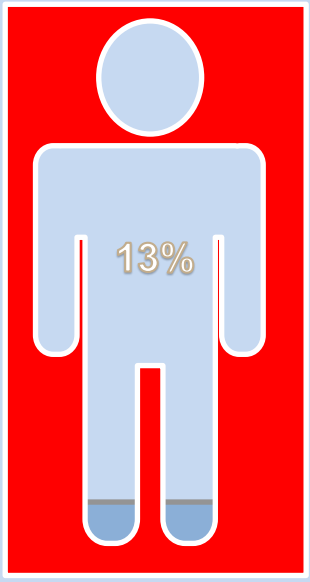
Percentage of Children with an up to date plan in the past 3 months
CLA 94% (118/128)
CPP 99%(337/357)
CIN 80% (341/547)
Combined Total 89% (913/1032)



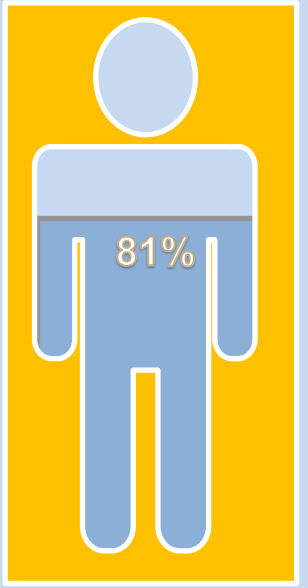
Number of adjourned CPP since April in PACT
ICPC - 8
RCPC – 62



Number of complaints and response timeframes



Number of CLA reviews adjourned since April due to no plan
69
33 in PACT



Percentage of Supervisions On Time In PACT
CLA 81% (104/128)
CPP 79% (281/357)
CIN 82% (449/547)
Combined Total 81%(834/1032)

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FOCUS FIVE – Audit Findings Year 2021

CHRONOLOGY

- Overall, it was identified in the audits completed over the past year that Chronologies were out of date in a majority of cases. Within the cohort of children whose cases were audited as part of 'This Child' programme of Spring/Summer 2021, a total 52% of the audit cohort had chronologies that were out of date by 6 months or more (with 27 months being the highest). Children who were subject to CP Plans were most likely to have chronologies that were a year or more out of date.
- The quality of Chronologies varied considerably across teams, most especially between Early Help and Statutory Teams. Generally, Early Help chronologies were more casework focused (home visit dates, TAF dates, allocation/closure dates) and less focused on significant events in the life of the child/family. As a result, they tended to provide less overview of the child/family's lived experiences and were less likely to be a useful tool for identifying trends/pattern in the family's timeline. The statutory teams performed better in this area, often beginning the chronology from the birth of the child, and also covering key events. However, the main area for improvement is consistency in the quality of recording. In summary, there is a training need in this area. Teams require additional support to improve their competency around creating and maintaining a Chronology Document that provides coherent overview of significant events in the child/family's timeline.

ASSESSMENTS

- It is generally accepted that 'Good' Assessments form the foundation of 'Good' decision making. In this respect, a sample of S.47 Inquiries were audited in Spring of 2021, specifically where the inquiry concluded with NFA. This audit activity highlighted that the decision not to proceed to ICPC was appropriate in almost all cases except one. Another short audit activity was completed in Summer 2021 that examined S.47 cases where the ICPC resulted in CIN plan being developed as opposed to progression to CP Plan. Within this audit cohort, it was found that the decision to present the case to ICPC was mostly evidence based and was justified. Thus, in some respects assessments are supporting good decision making in cases where risk of significant harm is present. However wider scale audit activity is needed to test the consistency of this across all teams.
- Within 'This Child' audit programme, in 60% of cases, the 'Assessment' section of the casework was graded 'Good' or above. The main areas of 'Good Practice' were analysis or risk, identification of needs/strengths, consideration for the child's whole journey, views of the children and their careers being incorporated, consideration for family history and context. In 40% of cases where the grading was 'Requiring Improvement' or below, the main issue identified repeatedly was timeliness; specifically, updated assessments not being initiated within appropriate timescale. The quality of the assessment itself was only identified as a concern in very few cases.

- Within the Fostering Audit activity that was completed over the Summer of 2021, the 'Initial Enquiry, Assessment and Approval' section was graded as 'Good' or above in 73% of cases. Within this cohort, it was identified that assessments were timely, there was evidence of appropriate agency checks being undertaken and there was evidence of assessments being completed at different stages of the carers' career to evidence their continued suitability for the role. The main areas of improvement for the cases that were rated less than 'Good' were timeliness of the assessments and delay in ADM ratification.
- A selection of cases were audited for the Safeguarding Practice Improvement Group in September 2021 where domestic abuse was identified as a primary area of concern. Within this audit activity, it was identified that male perpetrators were routinely engaged in DA assessments. This is especially positive as it places the Service in a better position to engage this group in meaningful interventions and also supports the Service's focus on shifting from placing excessive responsibility on the victim to effect change.
- With regards to the Thematic and Individual audits completed between January and October 2021, where an audit grade was provided for the 'Assessment' Section of the casework specifically, 62% were rated as Good or above. Within this group, there was significantly more 'Good' or 'Outstanding' assessments identified in the Jigsaw and SAT teams. There was less consistency in the quality of assessments in other teams (AST, YOT, LAC, PACT).

PLANS

- Within the Thematic and Individual audits completed where Core Audit Tool was used, 43% were graded as 'Good' or above for the Planning section of the casework. Early Help and Pathway Teams were rated highly within this cohort. It seems that services whose work centred more on management of risk (such as PACT and YOS) struggled more in this area, with greater percentages being graded as Requiring Improvement. Evidence of good practice that were identified within this audit cohort were, Plans being led by young people and permanency being achieved in a timely way. For Early Help cases, it was identified that Goals within Plans were SMART, there was Joint Agency input in the Plans and the Plans corresponded well to the areas of need identified. The areas of improvement within the PACT service in particular was greater consistency in the quality of Plans, more timely reviews of Plans, avoidance of delays where cases require escalation and avoidance of delay in the implementation of actions on Plans. More generally, it was identified that greater focus was required on achieving SMART plans across all teams.
- Within 'This Child' audit cohort, it was identified that in a majority of cases, Plans were child focused and were inclusive of the childs'/parents' views. Some of the areas of improvement that were identified were large gaps between the completion of assessments and the development of CIN Plans. It was identified that this left room for drift. It was also identified that Plans needed to be more 'SMART' and Reviews of Plans needed to be timelier. This outcome is reflective of the findings of the above audit activity also. Within 'This Child' audit cohort, 52% of the audits were graded as 'Good' or above for the Planning section and 48% were graded as Requiring Improvement or below.

- With regards to the LAC/Care Leavers audits of Summer/Autumn 2021, the 3rd audit cohort that offered in-depth reviews, concluded with 55% of cases being graded as 'Good' for the Planning section of the casework and 45% as 'Requiring Improvement'. The areas of good practice were child centredness of Plans, incorporation of children's/YP's wishes, recognition of growth and difficulties and good recognition of needs. The areas of improvement were Plans not being updated in a timely way, Plans not being sufficiently SMART, and actions not being progressed in a timely way. Within the 1st and 2nd audit Cohorts, it was identified that Care Plans needed to include analysis of the outcome of statutory visits. Overall however, the majority of the CLA and Pathways plans were identified as being of good quality and being child centred.

VISITING

- The LAC/Care Leavers audits of Summer/Autumn of 2021 focused extensively on the quality and frequency of visiting. Out of the first and second audit cohorts that comprised of 123 cases, it was identified that 44% of children were not seen within agreed timescales. In a significant number of cases, the reasons for the visit being out of timescale was not clear/not recorded. In a few cases, SW sickness or absence was cited as the cause. Slow improvement is however being noted in this area. For example, during the third audit cohort, cases found where the manager explicitly clarified the cause of delayed visits. However, more concerted effort is still required to embed this practice across all teams. On a positive note, 56% of children from the 1st and 2nd Audit cohorts were seen withing the agreed visit frequency. Additionally, in 87% of cases, it was found that the frequency and quality of the visits was meeting the child's needs.
- The impact of Covid restrictions was explored at length within the 1st and 2nd Audit Cohorts. Overall, it was identified that visits for most children in this cohorts changed to 'virtual' during the initial Covid lockdown period. Some good practice was still maintained nonetheless during this time. For example, it was found that conversations with children were still meaningful and in-depth, difficult issues were still addressed virtually, children were still spoken to alone and children coped well with video calls. However, there were areas where the change was less positive; for instance, where children had communication difficulties and or where they were hospitalised.
- Within the LAC service overall, there is a greater proportion of practitioners who routinely write visit records to and for the child. This practice is less consistent in the other statutory teams that hold LAC cases (i.e. PACT).
- Within 'This Child' audit cohort, 86% of children were seen in accordance with agreed visit frequency. It was additionally noted that visits were linked to the Plans for the child, there was evidence of trust bond being created between children and practitioners, in some cases the practitioner made more frequent visits than agreed in order to build a relationship with the child and the voice of the child was evidenced well in the visit records. The areas of improvement noted were that the use of 'visit recording template' was not consistent. This also correlated to the lack of consistency in the quality of visit records. Additionally, it was noted that the voice of the child needed to be evident

consistently, the progress of the child's plan needed to be more explicit, and more reflection/analysis was required of the information gathered during visits.

- Within the thematic and individual audits, 'visiting' was explored within the 'Intervention' section of the audit framework. In 70 cases where a grade was given for this section specifically, 36 cases were graded as Good or higher; 23 cases were graded as 'Requiring Improvement'; and 11 cases were graded as inadequate. Within the inadequate group, visits were significantly out of timescale, or not recorded or were of poor quality. Also, there was limited evidence as to how the visits were linked to the Plans, there was limited evidence as to how they were progressing Plans and there was no evidence that children were spoken to alone or that direct work was completed with them.

SUPERVISION

- Within the thematic and individual case audits, where a grade was offered for Supervision specifically, 46% were graded as RI, 43% were graded as Good or above, 11% were graded as Inadequate. Interestingly, cases where 'Inadequate' was given for Supervision, were more likely to receive similar grading for the Intervention section of the audit (i.e. 75%). The same trend was observed for cases where 'Good' was given for the Supervision (i.e. 89%). This highlights direct correlation between the quality of management input and the quality of service offered to families.
- In 'This Child' audits, 40% of the Supervision section was graded as good or above and 60% was graded as requiring improvement or lower. The areas of good practice identified were; focus on the referral concerns, clear plan around next steps, supervision tool being used with clear notes of discussion that had taken place, supervision notes providing clear plan of how to move the case forward, evidence of the needs of the child being reviewed and the ongoing changes being implemented. In the majority of cases where 'Requiring improvement' was given, supervision template was not used consistently, supervisions were out of timescale, some of the content of the supervision was the same with minimal variant, some of the supervision notes were hard to follow and there was no evidence of reflection (i.e. on children's wishes/views or the family's history).
- Within the Fostering Audits, 45% of cases were graded as Good or above for Supervision and 55% as Requiring Improvement or below. Within the latter group, it was identified that in some cases management oversight was significantly poor with limited recording of supervision, supervision was outside of SCC Policy of bi- monthly and aspects of the supervision form were not completed (including reflective analysis). The areas of good practice were provision of analysis of the child's progress/contact/plan for the future, analysis of placement stability, reflective case discussion pertaining to the individual children's needs and detailed handover supervision from one manager to another.
- Consistency in management structure within services/teams has had significant bearing on the quality of supervision overall. Typically, the PACT/LAC teams who have seen high management turnover and have seen many cases being supervised by a succession of managers have performed less well in the audits, in comparison to Jigsaw and AST for instance, where there has been greater level of stability.

Principal Social Worker Report
January 2022

Agenda

- The Principal Social Work role, the Practice Development Team, The Children and Learning Academy, The Better Together Staff Reference Group
- Staff feeling – PSW engagement and Senior Leadership responsiveness
- The Practice Framework & Academy
- Recruitment, retention and embedding practice change
- Revision of supervision across the service

The Principal Social Worker, Practice Development Team and Children and Learning Academy

The Principal Social Worker has the lead responsibility for practice in a local authority and can report the views and experience of the frontline to all levels of management.

The Principal Social Worker should:

- Champion good practice – to inspire and challenge to improve
- Fulfil a quality assurance role – beyond auditing
- Bring reflective practice into supervision
- Promote evidence informed practice
- Promote the importance of Continuous Professional Development

The Children and Learning Workforce Development Academy

The Academy was launched in May 2021.
It provides development opportunities to embed Our Practice Framework: Making the Difference, ensuring that training on the core components Systemic Practice, Restorative Practice, Trauma Informed Approach, Motivational Interviewing and Strengthening Families are embedded and mandated within our large scale training programme.

It will invest in our early help, education & social care staff and support them to have the right knowledge and skills to safeguard children, young people and their families and meet our practice and management standards.

- Build and sustain a learning culture which supports our workforce to have the right tools and the practice conditions for early help, support and social work to flourish.
- Promote evidence-based practice,
- Support staff to develop and maintain professional practice standards
- Build adaptive and systemic leadership skills
- Support career progression pathways
- Support retaining a workforce of proud, competent and motivated practitioners.
- Facilitate staff conferences 3 times a year, quarterly Practice Weeks and regular Practice Hub bulletins.
- Develop group and individual reflective supervision

Staff Reference Group (SRG) Report – Better Together

- Better Together was established in response to a recommendation from an investigation reporting in 2020 which identified the need for senior managers to consult with relevant staff to build an opportunity for free flowing feedback between operational and strategic workstreams and managers.

- All teams in Children and Learning volunteered a representative, with 35 members making up the Better Together group.

- The aim of the group is to shift the culture within parts of the service and enable an open dialogue between decision makers and front line staff.

- All areas of the directorate can contribute to service improvement and hold accountability for the collective vision to best meet the needs of children and young people.

- The group meets monthly and reports to the Improvement Board. The Co-Chairs of Better Together act as a conduit between the two. The Principal Social Worker also attends. The Chief Executive and Deputy Director have both attended the group in recent months.

Staff feeling – PSW observations

- High levels of engagement with staff – professional forums, team meetings, facilitating learning events, induction, ASYE, apprentices, co-producing supervision policy and model with groups of staff and managers, task and finish group for Practice Week. 13 1:1s in last month.
- Positive strides forward re cultural and reputational change work including Senior leadership and Staff engagement, the Better Together Group and the development and launch of the leadership pledge.
- Pockets of resistance to change still exist in the context of a national shortage of social workers.
- Enormous efforts into grow our own, recruitment and retention and embedding practice change.

Staff feeling

Main matters raised in 1:1s/ team meetings with PSW

- The death of Arthur Labinjo-Hughes
- Wishing to register an interest in systemic practice training
- Advice around career development
- Queries around Destination 22 – where will I be? Staff needing reassurance and support.
- Advice regarding SWE re-registration
- Workloads – as blockers to relationship-based social work practice, supervision, reflective supervision, training and wellbeing – exit inteviews
- No concerns being raised in respect of decision making or thresholds – my observation of SLT decision making – child centred.
- In the main SLT are responsive to concerns raised by the PSW.

Making the Difference Practice Framework

Systemic Practice
Restorative Practice
Trauma-informed Practice
Motivational Interviewing
Strengthening Families

- Revision of Practice Framework and associated documents.
- Large scale training plans - areas of core training already in place, providers identified for others and commissioning in progress.
- Work ongoing to commission the Institute of Family Therapy who will assist us in development of systemic practice and the creating of a grow our own systemic psychotherapist pathway. Launch for Spring 2022. Very positive response from PSW led staff sessions.

Recruitment and Retention & Embedding Practice Change

- 4 new apprentices have joined our other two cohorts. PSW led reflective groups for 3 cohorts have commenced. Additional sessions requested.
- 5 Step Up To Social Work candidates start January 2022. Induction programme complete and first placements being sought.
- 4 Frontline candidates completed their first CLE. 3 candidates have commenced as Family Engagement Workers with a plan to commence their social work training in 2022. Plan to have two hubs next year. Recruitment for second CSW post to commence.
- Providing 20 student placements from Solent and Winchester Universities. Training for Placement Supervisors delivered, support drop in sessions and student induction delivered.
- Practice Educator (PE) CPD launched 21st October with Thank You event and reflective resources. First session led by Siobhan McLean received positive feedback. Staff wishing to undertake their PE training now.
- PDT are currently supporting 18 Newly Qualified Social Workers (NQSWs). In December 3 NQSWs passed their ASYE.

Recruitment and Retention & Embedding Practice Change

- Staff induction written, launched and delivered to 3 cohorts. Roll outs planned for January and February 2022.
- Career pathway development work concluded including development of Senior Social Worker post. JDPS and progression policy authored.
- Revision of ASYE policy to include external moderation panel, and post ASYE support programme.
- Recruitment fairs and university career workshops being attended and Solent and Chichester Universities in the New Year.
- New recruitment resources developed with comms and the design team - stands, banners and logo products.
- International Recruitment via Tripod has progressed.
- Sponsorship of Social Worker of the Year Awards.
- Launch of the Making the Difference Staff Awards.

Recruitment and Retention & Embedding Practice Change

- Love our Diversity Practice Week in December 2021. Launch of the systemic training pathway is drawing particular attention. PSW visiting teams and managers to inspire.
- Successful launch of the Making the Difference Practice Development Forum - November session focussed on the NAI Thematic Review. Learning shared with service.
- SWE re-registration session with Kate Metcalf, Regional Lead, SWE.
- PSW 1:1s and PSW tracker under development for SLT attendance. PSW has undertaken 13 1:1 sessions with staff across the service in last four working weeks.
- Making the Difference Practice Development Days planned for January 2022.

Supervision, reflective supervision & reflecting teams model

The way that staff supervision is delivered across the service is being reviewed. This is in light of the:

- Staff Survey
- Social Work Health Check
- Feedback from the Better Together Working Group
- Supervision Survey conducted by the Practice Development Team
- PSW engagement sessions with teams and managers.

Likely outcomes given data received:

- Policy and tool rewrite
- Restructure of how reflective supervision is delivered across the service –wellbeing and systemic reflecting teams model
- Research in Practice SWORD tools will utilised and Action Learning
- Professional Development Supervisor training and leadership training

Principal Social Worker Report

Karen Biddle

January 2022

For further details contact :
Karen Biddle, Principal Social Worker, Southampton Children & Learning Service
02380 83 3372 or karen.biddle@southampton.gov.uk

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DECISION-MAKER:	CHILDREN AND FAMILIES SCRUTINY PANEL
SUBJECT:	CHILDREN AND LEARNING - PERFORMANCE
DATE OF DECISION:	27 JANUARY 2022
REPORT OF:	SERVICE DIRECTOR – LEGAL AND BUSINESS OPERATIONS

CONTACT DETAILS				
Executive Director	**Title**	**Deputy Chief Executive**		
	Name:	**Mike Harris**	Tel:	**023 8083 2882**
	E-mail	**Mike.harris@southampton.gov.uk**		
Author:	**Title**	**Scrutiny Manager**		
	Name:	**Mark Pirnie**	Tel:	**023 8083 3886**
	E-mail	**Mark.pirnie@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
Attached as Appendix 1 is a summary of performance for Children's Services up to the end of December 2021. At the meeting the Cabinet Member and senior managers from Children's Services and Learning will be providing the Panel with an overview of performance across the division.		
RECOMMENDATIONS:		
	(i)	That the Panel consider and challenge the performance of Children's Services and Learning in Southampton.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To enable effective scrutiny of Children's Services and Learning in Southampton.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
3.	To enable the Panel to undertake their role effectively members will be provided with monthly performance information and an explanation of the measures.	
4.	Performance information up to 31 December 2021 is attached as Appendix 1. An explanation of the significant variations in performance has been included.	
5.	The Cabinet Member for Children's Social Care, and representatives from the Children's Services and Learning Senior Management Team, have been invited to attend the meeting to provide the performance overview.	
RESOURCE IMPLICATIONS		
Capital/Revenue/Property/Other		

6.	None directly as a result of this report.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
8.	None
RISK MANAGEMENT IMPLICATIONS	
9.	None
POLICY FRAMEWORK IMPLICATIONS	
10.	The 2021-2025 Corporate Plan sets out the following regarding wellbeing in the city*: "We want a city in which people can start well, live well, age well, and live happy and fulfilling lives. We will be a city that prevents and intervenes early, promotes wellbeing, and allows people to live independently for longer, enjoying their lives and all our great city has to offer."* Aligned to this, priorities in the Corporate Plan include the following: • Reduce the number of children looked after • Achieve our ambition to become a UNICEF Child Friendly City by 2024/25.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	None

SUPPORTING DOCUMENTATION

Appendices	
1.	Summary of performance and commentary – December 2021
2.	Glossary of terms

Documents In Members' Rooms

1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	No
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	No
Other Background Documents **Other Background documents available for inspection at:**	

Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1. None	

Scrutiny Report

Southampton Children and Learning Service Improvement Board
January 2022

Stuart Webb, Head of Quality Assurance
Jo Feeney, Performance Manager

Agenda Item 10

Appendix 1

Practice and Performance Summary

This month's performance report highlights a dip in performance in some key areas, in particular visits to children in care and frequency of case supervision. The Improvement Board will rightly have concerns about the quality of support for children and how well social workers are being supported. Some parts of the service have been negatively affected by staff leaving (mostly linked to Destination 22) and by pressures associated with the pandemic. For some teams there is still a problem with recording and general compliance.

I am frustrated about slow progress, and even decline, in some parts of the service. But I also have a sense of optimism that the foundations for a sustainable service are in place and we are now starting to build. Our senior leadership and management team, from Deputy Director to Service Leads, is now complete, with all twenty posts recruited to, with permanent staff. Almost all are in post, with the 20th starting mid-March. The 12 Service Leads who have joined our leadership team will need support to excel in their roles and to establish themselves as a team, but we are seeing some early signs of management grip. We have strengthened our quality assurance function (in response to unexpected absence) and we continue to improve accountability, oversight and openness about performance through monthly service assurance clinics. We are taking steps to develop and procure training to support the implementation of our practice framework.

In the context of the pandemic we have maintained firm expectations about face-to-face visiting and encouraging staff to collaborate and support each other, safely, in the office. We know that our social workers are finding their profession tough right now. Rob and I, together with our Principal Social Worker, ran a very well-attended webinar for all staff to acknowledge the huge impact of the tragic death of little Arthur. The message of care, compassion and 'if not us then who?' was well received.

My huge focus at the moment is staff stability. We launch a major recruitment campaign on 17 January and we hope to complete out management team by recruiting to our remaining practice manager posts. This will, I believe, be a tipping point. We also desperately need good social workers to join us. We envisage that all 29 of our South African social workers will be with us by mid-April and we are busy preparing a warm welcome and solid induction for them.

The areas of collective focus I would like to share with the board are similar to those for November:

- I remain worried about the number of contacts that are coming into the service, particularly from the police, and the impact of this on the service
- We need ongoing partnership support to manage what is now very high demand by making sure that only families who really need our support are referred to us
- Continued partnership support for recruitment activity (staff and foster carers).
- We need an ongoing collective commitment to promoting positive working relationships on the ground between practitioners within our teams and services, particularly in relation to professional respect and trust.

I would like to the board to support our staff and fostering recruitment campaigns in any way that they can. I also I have a request that partners commit to including a short corporate parenting video in their induction of all their new recruits. We think this would be a concrete way to demonstrate tour shared commitment to the City's looked after children. We need to work together to make sure that families are supported in the right way at the right time, and that we reduce demand our specialist services. If we work together we will be able to give children a better service and embed our practice framework across the new service.

Steph Murray
Deputy Director
Children's Social Care

Scrutiny CSC Performance Indicators 17/01/22

What's Going Well

- Assessments completed in 45 days
- Children on a CPP
- CLA reviews in timescale
- Care Leavers with an up to date Pathway Plan

Ones to Watch

- Rate of Re-referrals
- Visits to Children in Need in timescales
- Visits to CLA in timescale
- Reduce the number open on a Child in Need plan

What We Need to Do Better

- Reduce number of contacts submitted from across the partnership
- Reduce the number of Children on a Child Protection Plan
- Visits to children on a CP plan
- Visits to Children Looked After
- Reduce CLA numbers
- Supervisions within timescale

What the Data tells us

Area	Indicator	Outturn type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target 21/22	Southampton 19/20	Southampton 20/21	Statistical	South East	England
Early Help	Number of cases (children) open to Early Help at the end of the month	NUMBER	1069	1194	1236	1248	1296	1305	1208	1159	1047	1000	N/A	N/A	N/A	N/A	N/A
Front Door	Number of contacts	NUMBER	1828	2016	2294	2093	1781	2038	1895	1843	1653	1400 per month	15657	17661	N/A	N/A	N/A
Front Door	Year-to-date number of contacts	NUMBER	1828	3844	6137	8229	10009	12046	13938	15779	17431	15880	15657	17661	N/A	N/A	N/A
Front Door	Rate of Contacts per 10,000	RATE	366	401	458	425	365	413	381	360	322	805	974	902	805	610	602
Front Door	Percentage of contacts that lead to No Further Action where the reason for contact was request to children's social care	PERCENTAGE	87%	86%	89%	89%	90%	88%	90%	88%	88%	70%	N/A	N/A	N/A	N/A	N/A
Front Door	Number of referrals in the month	NUMBER	336	444	342	349	283	414	372	374	347	300 per month	N/A	N/A	N/A	N/A	N/A
Front Door	Rates of referrals per 10,000 of Under 18 Population	RATE	64	150	216	283	338	418	490	562	629	647	944	790	647	561	484
Front Door	Percentage of re-referrals within 12 months	PERCENTAGE	21%	27%	26%	33%	26%	31%	24%	24%	27%	23%	23	28	22	28	23
Assessments	Percentage of C&F assessments completed within 45 working days	PERCENTAGE	90%	86%	88%	94%	86%	89%	85%	92%	88%	87%	N/A	86	87	89	88
Child In Need	Number of all Children in Need (CiN) (including Child Protection (CP) / Children Looked After (CLA) / Care Leavers / Children in Need (CiN) in Early Help (EH) teams) at end of period	NUMBER	548	549	530	537	512	536	532	523	515	N/A	N/A		N/A	N/A	N/A
Child In Need	CIN on a plan visited within 4 weeks	PERCENTAGE	73%	66%	79%	76%	70%	69%	87%	73%	66%	90%	N/A	N/A	N/A	N/A	N/A
Child Protection	Number of children who are subject of a Child Protection Plan as at the end of month	NUMBER	339	355	385	387	420	387	388	413	453	340	396	310	430	N/A	N/A
Child Protection	Rates of children who were the subject of a Child Protection Plan per 10,000 of Under 18 Population	RATE	65	68	74	74	81	74	74	79	87	N/A	N/A	N/A	N/A	N/A	N/A
Child Protection	Number of CP with a visit within 10 days	NUMBER	277	177	258	228	171	279	219	246	290	100	N/A	N/A	N/A	N/A	N/A
Child Protection	Percentage of CP with a visit within 10 days	Percentage	82%	50%	67%	59%	41%	72%	56%	60%	64%	100%	N/A	N/A	N/A	N/A	N/A
Child Protection	Percentage of Child Protection plans reviewed within required timescales who had been subject of a plan for 3 or more months	PERCENTAGE	97%	97%	97%	99%	97%	99%	94%	95%	97%	100%	65	63	91	93	93
CLA	Number of CLA at the end of the month	NUMBER	494	498	501	508	508	517	530	540	544	456	N/A	N/A	N/A	N/A	N/A
CLA	Rate of CLA per 10,000 under 18 population	RATE	95	96	96	98	98	99	102	104	105	89	95	TBC	97	53	67
CLA	Percentage of CLA for whom a visit has taken place within statutory timescales (6 weeks or less visits)	PERCENTAGE	65%	79%	80%	77%	74%	75%	75%	90%	73%	100%	95	N/A	N/A	N/A	N/A
CLA	Percentage of CLA children with an up to date review	PERCENTAGE	98%	96%	95%	96%	97%	96%	97%	96%	96%	100%	N/A	N/A	N/A	N/A	N/A
Care Leavers	Care Leavers - LOCAL (non-UASC)	NUMBER	217	221	229	234	244	257	279	245	208	TBC	N/A	N/A	N/A	N/A	N/A
Care Leavers	Care Leavers - UASC (non-LOCAL)	NUMBER	30	30	33	34	36	40	42	38	23	TBC	N/A	N/A	N/A	N/A	N/A
Care Leavers	Percentage not in employment, education, or training (NEET) on their 17th and 18th Birthday	PERCENTAGE	55%	58%	53%	61%	51%	52%	48%	46%	45%	20%	31	TBC	31	28	31
Care Leavers	Percentage not in employment, education, or training (NEET) on their 19th to 21st Birthday	PERCENTAGE	72%	77%	72%	76%	79%	76%	77%	74%	49%	20%	65	TBC	87	N/A	N/A
Audit	Average Caseload per Worker - All Teams	NUMBER	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	21.5	N/A	N/A	N/A	N/A	N/A	N/A
Audit	Percentage of CIN who have had their supervision and within timescale	PERCENTAGE	85%	65%	55%	59%	53%	55%	67%	66%	66%	90%	N/A	N/A	N/A	N/A	N/A
Audit	Percentage of CPP who have had their supervision and within timescale	PERCENTAGE	88%	66%	56%	66%	49%	63%	71%	63%	59%	100%	N/A	N/A	N/A	N/A	N/A
Audit	Percentage of CLA who have had their supervision and within timescale	PERCENTAGE	80%	68%	51%	65%	66%	70%	58%	70%	45%	90%	N/A	N/A	N/A	N/A	N/A
Audit	Percentage of Care Leaver who have had their supervision and within timescale	PERCENTAGE	81%	64%	48%	72%	83%	69%	82%	70%	24%	90%	N/A	N/A	N/A	N/A	N/A
Audit	Number of Cases Audited	NUMBER	12	2	28	105	22	17	3	0	1	TBC	N/A	N/A	N/A	N/A	N/A
Audit	Percentage of cases that are Good or Outstanding	PERCENTAGE	33%	0%	36%	66%	41%	65%	33%	0%	0%	TBC	N/A	N/A	N/A	N/A	N/A

Effective Assessment and Intervention

What the data tells us

Analysis

The service continues to respond to a high level of demand for statutory intervention across the piece. Contacts remain very high, with the majority coming from the police. The level of contacts (the majority of which do not progress to referral) impacts upon the capacity of the MASH to triage cases effectively, which is evidenced through our audit activity.

Feedback from partners indicates that there are general concerns about moving to a less risk adverse response to children and families needs and this will impact upon the effectiveness of the service improvement plans moving forward. Support from senior strategic leaders is necessary to ensure performance that is more in line with cities like Southampton.

The rate of re-referrals over the year to date show a higher level trend than during the previous year, more in line with 19/20 performance. The implication is that families are not getting their needs met effectively and are then subject to re-referral. The additional capacity across Early help and social care will help respond to this trend. Heads of Service are undertaking deep-dives to assure themselves on the social worker contact with children with children who have fallen out of timescale.

Action/next steps

- The Executive Director is involved in discussions, with police colleagues, at a HIPS level regarding the level of contacts received by the service.
- A plan to address the issue needs to be confirmed. The service is launching We are launching its new Children's Resource Hub after consultation has concluded. This will ensure easier pathways of support for children and families. Aligned with this, the new threshold document will be launched and it will be important for safeguarding partners to support the roll out .
- Targeted sessions with Assessment/ BIT regarding systemic approach. Launch of programme February to March 2022.
- Development of the Family Safeguarding Model business case is progressing, with support from Walsall LA and our PIP.
- Deployment of newly recruited social workers across the all teams starting from January 2022. Recruitment into practice manager posts.
- Engagement with new heads of service on performance and practice standards through assurance clinics. Focus on team and individual performance; robust service response to service underperformance.
- PSW-led reflective sessions with teams and managers across the service have commenced and will continue over February / March 2022. Launch of systemic practice training to support reflecting team approach is being planned, with regular communication to ensure staff continued interest.
- Purchase of direct work toolkits for staff and PDT sessions to be progressed.

Management Support for better Practice

What the data tells us

Analysis

Performance has deteriorated since the last Scrutiny meeting, except in regards to children subject to child protection planning. The services have stated this is due to a range of issues. The impact of management changes within the Destination 22 programme were expected and performance improvement is anticipated now that service leads have been recruited and recruitment of practice managers is in train. There is reportedly a backlog of statutory activity that has taken place but has yet to be uploaded onto PARIS this in particular is said of CPP and CLA visits which require improvement. CLA performance has been affected by staffing issues across PACT and CLA. However, additional business support has been secured to help with recording issues.

Action/next steps

- Practice Development Team-led reflective sessions with teams and managers across the service have commenced. PSW has also commenced training some management groups in a) facilitating reflective groups b) facilitating a reflecting team approach to daily practice. This will continue and grow across the service. Launch of systemic practice training to support reflecting team approach has been planned and considerable communications efforts to ensure staff continued interest, for example, systemic presentations at the launch of the Making the Difference Practice Development Forum, IFT presentations at the Equality, Diversity and Inclusion Practice Week in December 2022.
- Supervision policy rewrite and tool redevelopment and launch to raise the profile of supervision. This will include a review of supervision frequency to 4 weeks in line with newly authored Practice and Management Practice Standards. Audit & Practice learning days scheduled for February / March 2022 to link audit to systemic reflecting teams activity.
- We will continue to interrogate supervision performance in the assurance clinics (at a service, team and social worker level).
- The conclusion of the Destination 22 service consultation on November 19th has enabled the service to move onto the next stage of its redesign. This will support better service access for children and families through the progression of key workstreams: Early Help, Special Educational Needs and Disabilities, Young People's Service, Safeguarding).
- The service is launching its alternatives to care panel in January 2022 to better meet the needs of children at risk of coming into care and to support reunification with families.

Robust Corporate Parenting

Analysis

The number and rate of looked after children remain stable in Southampton, at a level that is notably higher than statistical neighbours. Principal areas of concern for the service are: the level of recorded direct contact with children; placement stability and health outcomes. Regarding the final area of focus: our performance manager is liaising with Solent NHS to make sure that we get a better picture.

As a senior leadership team we are not yet confident that the service has sufficient grip on improvements for our looked after children and care leavers. The appointment of new managers into this area is positive and we are undertaking internal quality assurance activity regarding quality of practice, however, we are also requesting a review of practice to maintain focus in this area (see below).

Positive developments since the last Scrutiny meeting include increased engagement of elected members, ongoing development of our Children in Care Council and significant progress against key documents and strategies.

Action/next steps

- Building on the audit activity carried out by the Quality Assurance Unit, the service is requesting an independent review of Care Leavers and In Care to check on progress, identify any barriers to improvement and to support greater service accountability.

- Completing the management team by recruiting additional practice managers in January 2022, as part of the wider service recruitment campaign.

- The Deputy Director is leading a project group from across the service, to deliver on a Placement Action Plan, which has three high level objectives: 1. Prevention of care and return home from care; 2. Substantially reduce the number of children in residential provision, by improving the sufficiency of in-house placements and increasing our access to IFA placements 3. Promote stability and better outcomes for children by reducing placement moves and placement breakdowns. This work is complex and time consuming , but necessary, to ensure the right permanence plan for each child and to ensure that the service is financially sustainable.

- The service has invested in participation activity, bringing additional staffing resources into the service to coordinate and develop the involvement of our looked after children and care leavers in the design of our service, aligned with wider service and corporate participation objectives. The service improvement activity takes into account feedback from our Children in Care Council, Southampton Voices Unite.

Rigorous Quality Assurance

What the data tells us

Analysis

Reduction in graded audit activity in Quarter 3 due to reduced practice development team capacity as a result of staff sickness absence. The remaining staff member prioritised thematic learning reviews (15 audits), MASH audit liaison (65 audits completed Oct – Dec), YOS thematic audit (10 audits – not yet moderated), Social Work England activity and the review of the service self evaluation.

Permission was granted to secure additional support, but this took time to find good candidates. An additional auditor has been secured. Audits across service areas are scheduled to begin in February 2022, after launch of Care Director. All management teams have now benefitted from the audit training developed with our Partner in Practice.

Review of child safeguarding practice / serious case review action plan has been undertaken with DfE advisor oversight. Next areas for review are: review of SSCP and C&L training plans; partnership workshop; ongoing scrutiny.

Action/next steps

- 2022 / 23 audit schedule has been drafted and will be signed off by the senior leadership team in February 2022.
- Case Review discussion/reflection has been introduced at Learning and Improvement Panel to enable learning from audits to be embedded into practice on broader scale within safeguarding teams. We also use our Learning and Improvement Panel to review our local CHAT analysis. In this way, we are identifying areas for scrutiny either through audit or dip sample.
- Examples of good/outstanding practice are shared with PSW on monthly basis to encourage practitioners to maintain good standards where this is identified and to encourage other practitioners to emulate this with a view to improving practice within teams
- Team focused audit and reflection days are being launched in February 2022. These will involve managers auditing with practitioners and learning and reflective sessions delivered by the Principal Social Worker.

Performance Culture

RAG: Red – High Risk

What the data tells us – Assurance Clinic Overview

Assessment			
Assessment cases open 4+ Weeks who have had a visit within the last 4 weeks		Percentage of Plans On Time	
Percentage of Assessments by the Assessment service that		Percentage of Plans On Time	
Percentage of S47 NFA (37/38)		Percentage of Supervisions On Time	

SWwF			
SWwF visits on Time		Number of complaints into SwWF	
Percentage of Children with an up to date plan in the last 3 months		Number of reviews adjourned with CLA due to no plan	
Number of adjourned CPP reviews due to no SW report in SwWF		Percentage of Supervisions on time	

CLA			
CLA with a visit within 6 weeks		Percentage of plans in timescale	
Percentage of reviews on time		Percentage of CLA with 3+ placements	
Number of reviews adjourned with CLA due to no plan		Percentage of Supervisions On Time	

Care Leavers			
Care Leavers with a visit within 8 weeks		Percentage of EET	
Percentage of care leavers in suitable accomodation		Percentaage of Supervisions on time	
Percentage of Pathway Plans in Timescale			

Permanence			
Children in IFA		Percentage of Children in Residential	
Percentage of Children placed with parents		Number of Equiries from new foster carers	
Percentage of Children in unregistered provision			

Performance Culture

Analysis

Assurance clinics are running on a rolling weekly schedule. Managers have been engaged in identifying the priority areas for their areas. Data is reported at team and worker manager level and used to track progress (see examples of assessment service and PACT). Assurance clinic discussions are analytical; exploring the service strengths and challenges that sit underneath performance trends.

Action/next steps

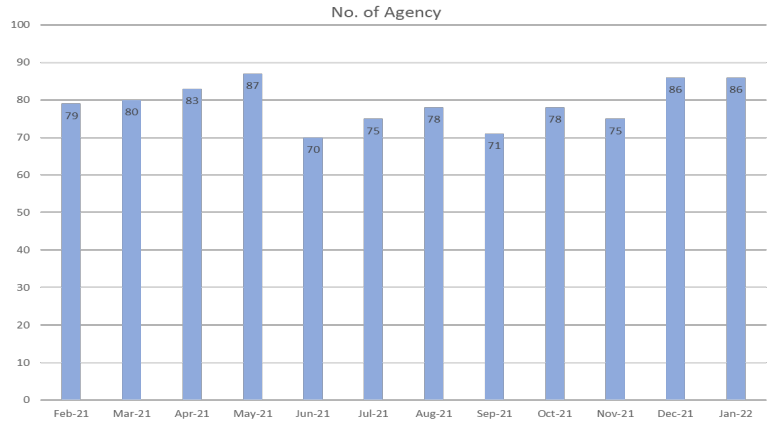
It is the intention to present the data for the improvement board as 1 dashboard from January 2022 and beyond. Now that the data set has progressed we will set targets against each indicator. These will be SN average where bench marking is possible. Where it isn't, we will analysis the local performance trends and also consider the available SESLIP data.

The data set will also be available as a power BI report with additional indicators enabling service areas and TM's to drill down on performance to child level exception data.

The improved set of PI's, many of which we can benchmark against, the functionality of an interactive Power BI dashboard and the assurance clinics will provide a performance structure and PI information which will give Southampton the tools and insight it has long needed to drive good practice as our minimum standard.

Workforce Academy

What the data tells us



Analysis

As predicted, the Destination 22 has created a period of change within the service as some managers and practitioners have chosen to leave. Frontline social work stability will begin to improve from the end of January 2022 as our new South African social workers start. We have 29 new recruits starting over three cohorts.

Increase in agency takes into account temporary business support officers to help with demand and staff changes. More detailed reporting has started with HoS required to provide oversight of agency staff in their areas.

We have expanded the number of placements and routes into social work training
Work is well underway in commissioning the large scale training that is required to fulfil the ambition of the practice framework. Funding has been secured. PSW is leading change to learning culture and there is evidence that this and senior leadership team engagement is having impact.

Concerted efforts are being made in respect of recruitment: major new recruitment campaign, newly designed adverts and recruitment resources, attendance at recruitment and career fairs, lectures at universities. In order to remain competitive SCC required to develop senior social work post. JDPS completed and evaluated. Progression Panel guidance in draft.

Current position: 20 students with us on placement; 4 students flourishing in our Frontline Hub; 9 social work apprentices across 3 cohorts progressing well; 5 Step Up to Social Work students commence January 2022.

Action/next steps

- Project team has supported the development of a clear recruitment and retention plan as part of Destination 22.
- Recruitment of a second CSW to facilitate an additional Frontline hub next academic year (recruitment day February 2022).
- Exit interview analysis completed and with PSW for review.
- ASYE caseload analysis continues and the position has moved from routinely being over limit in some areas of the service, to now rarely being over the limit. Managers have been congratulated for this improvement.
- Business case in respect of bringing ASYE assessment and support fully in- house.
- Progression panel guidance for Senior Social Work Post has been completed and communications launched.
- Large scale training procurement activity – approval by CLCMC scheduled for January 2022.
- Working with IFT regarding implementation of systemic practice training across the service and ensuring that there is the clinical supervision structure in place.
- Launch of Practice Educator CPD Club – 13 staff have come forward wanting to undertake Practice Educator training .

Systems and Support Services

Care Director Case Management System

- The new case management system, Care Director will go live on 31st January 2022.
- Comprehensive User Acceptance Testing is well underway. Staff have begun to use the test environment. Service champions identified
- Training programme has been designed with project team and training partner. Management briefing arranged for 13th January 2021.
- Cut over and Live Migration planning ongoing.

- **Timeline:**

- **Training Jan 3rd – 28th**
- **PARIS Switch off 27th Jan**
- **Live 31st January**

CHILDREN AND FAMILIES GLOSSARY

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Abuse

Abuse is the act of violation of an individual's human or civil rights. Any or all types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance. Different types of abuse include: Physical abuse, Neglect/acts of omission, Financial/material abuse, Psychological abuse, Sexual abuse, Institutional abuse, Discriminatory abuse, or any combination of these.

Advocacy

Advocacy helps to safeguard children and young people, and protect them from harm and neglect. It is about speaking up for children and young people and ensuring their views and wishes are heard and acted upon by decision-makers. LAs have a duty under The Children Act to ensure that advocacy services are provided for children, young people and care leavers making or intending to make a complaint. It should also cover representations which are not complaints. Independent Reviewing Officers (IRO) should also provide a child/young person with information about advocacy services and offer help in obtaining an advocate.

Agency Decision Maker

The Agency Decision Maker (ADM) is the person within a fostering service and an adoption agency who makes decisions on the basis of recommendations made by the Fostering Panel (in relation to a fostering service) and the Adoption Panel (in relation to an adoption agency). The Agency Decision Maker will take account of the Panel's recommendation before proceeding to make a decision. The Agency Decision Maker can choose to make a different decision.

The National Minimum Standards for Fostering 2011 provide that the Agency Decision Maker for a fostering service should be a senior person within the fostering service, who is a social worker with at least 3 years post-qualifying experience in childcare social work and has knowledge of childcare law and practice (Standard 23).

The National Minimum Standards for Adoption 2011 provide that the Agency Decision Maker for an adoption agency should be a senior person within the adoption agency, who is a social worker with at least 3 years post-qualifying experience in childcare social work and has knowledge of permanency planning for children, adoption and childcare law and practice. Where the adoption agency provides an inter country adoption service, the Agency Decision Maker should also have specialist knowledge of this area of law and practice. When determining the disclosure of Protected Information about adults, the Agency Decision Maker should also understand the legislation surrounding access to and disclosure of information and the impact of reunion on all parties (Standard 23).

Assessment

Assessments are undertaken to determine the needs of individual children; what services to provide and action to take. They may be carried out:

- To gather important information about a child and family;
- To analyse their needs and/or the nature and level of any risk and harm being suffered by the child;
- To decide whether the child is a Child in Need (Section 17) and/or is suffering or likely to suffer Significant Harm (Section 47); and
- To provide support to address those needs to improve the child's outcomes to make them safe.

With effect from 15 April 2013, Working Together 2013 removes the requirement for separate **Initial Assessments** and **Core Assessments**. One Assessment – often called Single Assessment - may be undertaken instead.

CAFCASS

Children and Family Court Advisory and Support Service (CAFCASS) is the Government agency responsible for Reporting Officers, Children's Guardians and other Court officers appointed by the Court in Court Proceedings involving children. Also appoints an officer to witness when a parent wishes to consent to a child's placement for adoption.

Care Order

A Care Order can be made in Care Proceedings brought under section 31 of the Children Act if the Threshold Criteria are met. The Order grants Parental Responsibility for the child to the local authority specified in the Order, to be shared with the parents.

A **Care Order** lasts until the child is 18 unless discharged earlier. An **Adoption Order** automatically discharges the Care Order. A **Placement Order** automatically suspends the Care Order, but it will be reinstated if the Placement Order is subsequently revoked.

All children who are the subject of a Care Order come within the definition of Looked After and have to have a Care Plan. When making a Care Order, the Court must be satisfied that the Care Plan is suitable.

Categories of Abuse or Neglect

Where a decision is made that a child requires a Child Protection Plan, the category of abuse or neglect must be specified by the Child Protection Conference Chair.

Child in Need and Child in Need Plan

Under Section 17 (10) of the Children Act 1989, a child is a Child in Need (CiN) if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is disabled.

A **Child in Need Plan** should be drawn up for children who are not Looked After but are identified as Children in Need who requiring services to meet their needs. It should be completed following an Assessment where services are identified as necessary.

Under the Integrated Children's System, if a Child is subject to a Child Protection Plan, it is recorded as part of the Child in Need Plan.

The Child in Need Plan may also be used with children receiving short break care in conjunction with Part One of the Care Plan.

Child Protection

The following definition is taken from Working Together to Safeguard Children 2010, paragraph 1.23.:

Child protection is a part of Safeguarding and Promoting the Welfare of Children. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, Significant Harm.

Child Protection Conference

Child Protection Conferences (Initial – **ICPC** and review – **RCPC**) are convened where children are considered to be at risk of Significant Harm.

Children's Centres

The government is establishing a network of children's centres, providing good quality childcare integrated with early learning, family support, health services, and support for parents wanting to return to work or training.

Child Sexual Exploitation

Child sexual exploitation (CSE) 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.

Corporate Parenting

In broad terms, as the corporate parent of looked after children, a local authority has a legal and moral duty to provide the kind of loyal support that any good parent would provide for their own children.

Criteria for Child Protection Plans

Where a decision is made that a child requires a Child Protection Plan, the Conference Chair must ensure that the criteria for the decision are met, i.e. that the child is at continuing risk of Significant Harm.

Director of Children's Services (DCS)

Every top tier local authority in England must appoint a Director of Children's Services under section 18 of the Children Act 2004. Directors are responsible for discharging local authority functions that relate to children in respect of education, social services and children leaving care. They are also responsible for discharging functions delegated to the local authority by any NHS body that relate to children, as well as some new functions conferred on authorities by the Act, such as the duty to safeguard and protect children, the Children and Young People's Plan, and the duty to co-operate to promote well-being.

Designated Teacher

Schools should all appoint a Designated Teacher. This person's role is to co-ordinate policies, procedures and roles in relation to Child Protection and in relation to Looked After Children.

Discretionary Leave to Remain

This is a limited permission granted to an Asylum Seeker, to stay in the UK for 3 years - it can then be extended or permission can then be sought to settle permanently.

Duty of Care

In relation to workers in the social care sector, their duty of care is defined by the Social Care Institute for Excellence (SCIE) as a legal obligation to:

- Always act in the best interest of individuals and others;

- Not act or fail to act in a way that results in harm;
- Act within your competence and not take on anything you do not believe you can safely do.

Early Help

Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.

Effective early help relies upon local agencies working together to:

- Identify children and families who would benefit from early help;
- Undertake an assessment of the need for early help;
- Provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to significantly improve the outcomes for the child.

Local authorities, under section 10 of the Children Act 2004, have a responsibility to promote inter-agency cooperation to improve the welfare of children.

Every Child Matters

Every Child Matters is the approach to the well-being of children and young people from birth to age 19, which is incorporated into the Children Act 2004. The aim is for every child, whatever their background or their circumstances, to have the support they need to:

- Be healthy;
- Stay safe;
- Enjoy and achieve;
- Make a positive contribution and;
- Achieve economic well-being.

This means that the organisations involved with providing services to children are teaming up, sharing information and working together, to protect children and young people from harm and help them achieve what they want in life.

Health Assessment

Every Looked After Child (LAC or CLA) must have a Health Assessment soon after becoming Looked After, then at specified intervals, depending on the child's age.

Indefinite Leave to Remain (ILR)

When an Asylum Seeker is granted ILR, they have permission to settle in the UK permanently and can access mainstream services and benefits.

Independent Reviewing Officer

If a Local Authority is looking after a child (whether or not the child is in their care), it must appoint an Independent Reviewing Officer (IRO) for that child's case.

From 1 April 2011, the role of the IRO is extended, and there are two separate aspects: chairing a child's Looked After Review, and monitoring a child's case on an ongoing basis. As part of the monitoring function, the IRO also has a duty to identify any areas of poor practice, including general concerns around service delivery (not just around individual children).

IROs must be qualified social workers and, whilst they can be employees of the local authority, they must not have line management responsibility for the child's case. Independent Reviewing Officers who chair Adoption Reviews must have relevant experience of adoption work.

Independent Domestic Violence Advisor

Independent Domestic Violence Advisers (IDVA) are specialist caseworkers who focus on working predominantly with high risk victims (usually but not exclusively with female victims). They generally are involved from the point of crisis and offer intensive short to medium term support. They work in partnership with statutory and voluntary agencies and mobilise multiple resources on behalf of victims by coordinating the response of a wide range of agencies, including those working with perpetrators or children. There may be differences about how the IDVA service is delivered in local areas.

Initial Child Protection Conference

An Initial Child Protection Conference (ICPC) is normally convened at the end of a Section 47 Enquiry when the child is assessed as either having suffered Significant Harm or to be at risk of suffering ongoing significant harm.

The Initial Child Protection Conference must be held within 15 working days of the Strategy Discussion, or the last strategy discussion if more than one has been held.

Local Authority Designated Officer (LADO)

A designated officer (or sometimes a team of officers), who is involved in the management and oversight of allegations against people that work with children.

Their role is to give advice and guidance to employers and voluntary organisations; liaise with the Police and other agencies, and monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process. The Police should also identify an officer to fill a similar role.

Local Safeguarding Children's Board (LSCB)

LSCBs have to be established by every local authority as detailed in Section 13 of The Children Act 2004. They are made up of representatives from a range of public agencies with a common interest and with duties and responsibilities to children in their area. LSCBs have a responsibility for ensuring effective inter-agency working together to safeguard and protect children in the area. The Boards have to ensure that clear local procedures are in place to inform and assist anyone interested or as part of their professional role where they have concerns about a child.

The functions of the LSCB are set out in chapter 3 of Working Together to Safeguard Children.

See http://southamptonlscb.co.uk/ for Southampton LSCB.

Looked After Child

A Looked After Child is a child who is accommodated by the local authority, a child who is the subject to an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation.

In addition where a child is placed for Adoption or the local authority is authorised to place a child for adoption - either through the making of a Placement Order or the giving of Parental Consent to Adoptive Placement - the child is a Looked After child.

Looked After Children may be placed with family members, foster carers (including relatives and friends), in Children's Homes, in Secure Accommodation or with prospective adopters.

With effect from 3 December 2012, the Legal Aid, Sentencing and Punishment of Offenders Act 2012 amended the Local Authority Social Services Act 1970 to bring children who are remanded by a court to local authority accommodation or youth detention accommodation into the definition of a Looked After Child for the purposes of the Children Act 1989.

Neglect

Neglect is a form of Significant Harm which involves the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect can occur during pregnancy, or once a child is born.

Parental Consent to Adoptive Placement

Parental consent to a child's placement for adoption under section 19 of the Adoption and Children Act 2002 must be given before a child can be placed for adoption by an adoption agency, unless a Placement Order has been made or unless the child is a baby less than 6 weeks old and the parents have signed a written agreement with the local authority. Section 19 requires that the consent must be witnessed by a CAFCASS Officer. Where a baby of less than 6 weeks old is placed on the basis of a written agreement with the parents, steps must be taken to request CAFCASS to witness parental consent as soon as the child is 6 weeks old. At the same time as consent to an adoptive placement is given, a parent may also consent in advance to the child's adoption under section 20 of the Adoption and Children Act 2002 either with any approved prospective adopters or with specific adopters identified in the Consent Form.

When giving advanced consent to adoption, the parents can also state that they do not wish to be informed when an adoption application is made in relation to the child.

Parental Responsibility

Parental Responsibility means all the duties, powers, responsibilities and authority which a parent has by law in relation to a child. Parental Responsibility diminishes as the child acquires sufficient understanding to make his or her own decisions.

A child's mother always holds Parental Responsibility, as does the father if married to the mother.

Unmarried fathers who are registered on the child's birth certificate as the child's father on or after 1 December 2003 also automatically acquire Parental Responsibility. Otherwise, they can acquire Parental Responsibility through a formal agreement with the child's mother or through obtaining a Parental Responsibility Order under Section 4 of the Children Act 1989.

Pathway Plan

The Pathway Plan sets out the route to the future for young people leaving the Looked After service and will state how their needs will be met in their path to independence. The plan will continue to be implemented and reviewed after they leave the looked after service at least until they are 21; and up to 25 if in education.

Permanence Plan

Permanence for a Looked After child means achieving, within a timescale which meets the child's needs, a permanent outcome which provides security and stability to the child throughout his or her childhood. It is, therefore, the best preparation for adulthood.

Wherever possible, permanence will be achieved through a return to the parents' care or a placement within the wider family but where this cannot be achieved within a time-scale appropriate to the child's needs, plans may be made for a permanent alternative family placement, which may include Adoption or by way of a Special Guardianship Order.

By the time of the second Looked After Review, the Care Plan for each Looked After Child must contain a plan for achieving permanence for the child within a timescale that is realistic, achievable and meets the child's needs.

Personal Education Plan

All Looked After Children must have a Personal Education Plan (PEP) which summarises the child's developmental and educational needs, short term targets, long term plans and aspirations and which contains or refers to the child's record of achievement. The child's social worker is responsible for coordinating and compiling the PEP, which should be incorporated into the child's Care Plan.

Person Posing a Risk to Children (PPRC)

This term replaced the term of 'Schedule One Offender', previously used to describe a person who had been convicted of an offence against a child listed in Schedule One of the Children and Young Persons Act 1933.

'Person Posing a Risk to Children' takes a wider view. Home Office Circular 16/2005 included a consolidated list of offences which agencies can use to identify those who may present a risk to children. The list includes both current and repealed offences, is for guidance only and is not exhaustive - subsequent legislation will also need to be taken into account when forming an assessment of whether a person poses a risk to children. The list of offences should operate as a trigger to further assessment/review to determine if an offender should be regarded as presenting a continued risk of harm to children. There will also be cases where individuals without a conviction or caution for one of these offences may pose a risk to children.

Placement at a Distance

Placement of a Looked After child outside the area of the responsible authority looking after the child and not within the area of any adjoining local authority.

This term was introduced with effect from 27 January 2014 by the Children's Homes and Looked after Children (Miscellaneous Amendments) (England) Regulations 2013.

Principal Social Worker - Children and Families

This role was borne out of Professor Munro's recommendations from the Munro Review of Child Protection (2011) to ensure that a senior manager in each local authority is directly involved in frontline services, advocate higher practice standards and develop organisational learning cultures, and to bridge the divide between management and the front line. It is typically held by a senior manager who also carries caseloads to ensure the authentic voice of practice is heard at decision-making tables.

Private Fostering

A privately fostered child is a child under 16 (or 18 if disabled) who is cared for by an adult who is not a parent or close relative where the child is to be cared for in that home for 28 days or more. Close relative is defined as "a grandparent, brother, sister, uncle or aunt (whether of the full blood or half blood or by marriage or civil partnership) or step-parent". A child who is Looked After by a local authority or placed in a children's home, hospital or school is excluded from the definition. In a private

fostering arrangement, the parent still holds Parental Responsibility and agrees the arrangement with the private foster carer.

A child in relation to whom the local authority receives notification from the prospective adopters that they intend to apply to the Court to adopt may have the status of a privately fostered child. The requirement to notify the local authority relates only to children who have not been placed for adoption by an adoption agency. On receiving the notification, the local authority for the area where the prospective adopters live becomes responsible for supervising the child's welfare pending the adoption and providing the Court with a report.

Public Law Outline

The Public Law Outline: Guide to Case Management in Public Law Proceedings came into force on the 6th April 2010. An updated Public Law Outline (PLO) came into effect on 22nd April 2014, alongside the statutory 26-week time-limit for completion of care and supervision proceedings under the Children and Families Act 2014.

The Public Law Outline sets out streamlined case management procedures for dealing with public law children's cases. The aim is to identify and focus on the key issues for the child, with the aim of making the best decisions for the child within the timetable set by the Court, and avoiding the need for unnecessary evidence or hearings.

Referral

The referring of concerns to local authority children's social care services, where the referrer believes or suspects that a child may be a Child in Need, including that he or she may be suffering, or is likely to suffer, Significant Harm. The referral should be made in accordance with the agreed LSCB procedures.

Relevant Young People, Former Relevant, and Eligible

- **Relevant Young People** are those aged 16 or 17 who are no longer Looked After, having previously been in the category of Eligible Young People when Looked After. However, if after leaving the Looked After service, a young person returns home for a period of 6 months or more to be cared for by a parent and the return home has been formally agreed as successful, he or she will no longer be a Relevant Young Person. A young person is also Relevant if, having been looked after for three months or more, he or she is then detained after their 16th birthday either in hospital, remand centre, young offenders' institution or secure training centre. There is a duty to support relevant young people up to the age of 18, wherever they are living.
- **Former Relevant Young People** are aged 18 or above and have left care having been previously either Eligible, Relevant or both. There is a duty to consider the need to support these young people wherever they are living.
- **Eligible Young People** are young people aged 16 or 17 who have been Looked After for a period or periods totaling at least 13 weeks starting after their 14th birthday and ending at least one day after their 16th birthday, and are still Looked After. (This total does not include a series of short-term placements of up to four weeks where the child has returned to the parent.) There is a duty to support these young people up to the age of 18.

Review Child Protection Conference

Child Protection Review Conferences (RCPC) are convened in relation to children who are already subject to a Child Protection Plan. The purpose of the Review Conference is to review the safety, health and development of the child in view of the Child Protection Plan, to ensure that the child continues to

be adequately safeguarded and to consider whether the Child Protection Plan should continue or change or whether it can be discontinued.

Section 20

Under Section 20 of the Children Act 1989, children may be accommodated by the local authority if they have no parent or are lost or abandoned or where their parents are not able to provide them with suitable accommodation and agree to the child being accommodated. A child who is accommodated under Section 20 becomes a Looked After Child.

Section 47 Enquiry

Under Section 47 of the Children Act 1989, if a child is taken into Police Protection, or is the subject of an Emergency Protection Order, or there are reasonable grounds to suspect that a child is suffering or is likely to suffer Significant Harm, a Section 47 Enquiry is initiated. This enables the local authority to decide whether they need to take any further action to safeguard and promote the child's welfare. This normally occurs after a Strategy Discussion.

Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect are all categories of Significant Harm.

Section 47 Enquiries are usually conducted by a social worker, jointly with the Police, and must be completed within 15 days of a Strategy Discussion. Where concerns are substantiated and the child is judged to be at continued risk of Significant Harm, a Child Protection Conference should be convened.

Separated Children

Separated Children are children and young people aged under 18 who are outside their country of origin and separated from both parents, or their previous legal/customary primary caregiver. Some will be totally alone (**unaccompanied**), while others may be accompanied into the UK e.g. by an escort; or will present as staying with a person who may identify themselves as a stranger, a member of the family or a friend of the family.

Special Guardianship Order

Special Guardianship Order (SGO) is an order set out in the Children Act 1989, available from 30 December 2005. Special Guardianship offers a further option for children needing permanent care outside their birth family. It can offer greater security without absolute severance from the birth family as in adoption.

Special Guardianship will also provide an alternative for achieving permanence in families where adoption, for cultural or religious reasons, is not an option. Special Guardians will have Parental Responsibility for the child. A Special Guardianship Order made in relation to a Looked After Child will replace the Care Order and the Local Authority will no longer have Parental Responsibility.

Strategy Discussion

A Strategy Discussion is normally held following an Assessment which indicates that a child has suffered or is likely to suffer Significant Harm. The purpose of a Strategy Meeting is to determine whether there are grounds for a Section 47 Enquiry.

Statement of Special Education Needs (SEN)

From 1 September 2014, Statements of Special Educational Needs were replaced by Education, Health and Care Plans. (The legal test of when a child or young person requires an Education, Health and Care Plan remains the same as that for a Statement under the Education Act 1996).

Staying Put

A Staying Put arrangement is where a Former Relevant child, after ceasing to be Looked After, remains in the former foster home where they were placed immediately before they ceased to be Looked After, beyond the age of 18. The young person's first Looked After Review following his or her 16th birthday should consider whether a Staying Put arrangement should be an option.

It is the duty of the local authority to monitor the Staying Put arrangement and provide advice, assistance and support to the Former Relevant child and the former foster parent with a view to maintaining the Staying Put arrangement (this must include financial support), until the child reaches the age of 21 (unless the local authority consider that the Staying Put arrangement is not consistent with the child's welfare).

Unaccompanied Asylum Seeker

A child or young person under the age of 18 who has been forced or compelled to leave their home country as a result of major conflict resulting in social breakdown or to escape human rights abuse. They will have no adult in the UK exercising Parental Responsibility.

Virtual School Head

Section 99 of the Children and Families Act 2014 imposes upon local authorities a requirement to appoint an officer to promote the educational achievement of Looked After children - sometimes referred to as a 'Virtual School Head'.

Working Together to Safeguard Children

Working Together to Safeguard Children is a Government publication which sets out detailed guidance about the role, function and composition of Local Safeguarding Children Boards (LSCBs), the roles and responsibilities of their member agencies in safeguarding children within their areas and the actions that should be taken where there are concerns that children have suffered or are at risk of suffering Significant Harm.

Young Offender Institution (YOI)

The Youth Justice Board (YJB) is responsible for the commissioning and purchasing of all secure accommodation for under 18-year-olds ('juveniles'), whether sentenced or on remand. Young offender institutions (YOIs) are run by the Prison Service (except where contracted out) and cater for 15-20 year-olds, but within YOIs the Youth Justice Board has purchased discrete accommodation for juveniles where the regimes are specially designed to meet their needs. Juvenile units in YOIs are for 15-17 year-old boys and 17-year-old girls.

Youth Offending Service or Team

Youth Offending Service or Team (YOS or YOT) is the service which brings together staff from Children's Social care, the Police, Probation, Education and Health Authorities to work together to keep young people aged 10 to 17 out of custody. They are monitored and co-ordinated nationally by the Youth Justice Board (YJB).

Sources

Tri.x live online glossary: **http://trixresources.proceduresonline.com/** - a free resource, available to all which provides up to date keyword definitions and details about national agencies and organisations.

Southampton Local Safeguarding Board **http://southamptonlscb.co.uk/**

DECISION-MAKER:	CHILDREN AND FAMILIES SCRUTINY PANEL
SUBJECT:	MONITORING SCRUTINY RECOMMENDATIONS
DATE OF DECISION:	27 JANUARY 2022
REPORT OF:	SERVICE DIRECTOR – LEGAL AND BUSINESS OPERATIONS

CONTACT DETAILS				
Executive Director	**Title**	**Deputy Chief Executive**		
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STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
This item enables the Children and Families Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.		
RECOMMENDATIONS:		
	(i)	That the Panel considers the responses to recommendations from previous meetings and provides feedback.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To assist the Panel in assessing the impact and consequence of recommendations made at previous meetings.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
3.	Appendix 1 of the report sets out the recommendations made at previous meetings of the Children and Families Scrutiny Panel. It also contains a summary of action taken in response to the recommendations.	
4.	The progress status for each recommendation is indicated and if the Children and Families Scrutiny Panel confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Panel does not accept the matter has been adequately completed, it will be kept on the list and reported back to the next meeting. It will remain on the list until such time as the Panel accepts the recommendation as completed. Rejected recommendations will only be removed from the list after being reported to the Children and Families Scrutiny Panel.	

RESOURCE IMPLICATIONS	
Capital/Revenue/Property/Other	
5.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
6.	The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
7.	None
RISK MANAGEMENT IMPLICATIONS	
8.	None
POLICY FRAMEWORK IMPLICATIONS	
9.	None

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	None
SUPPORTING DOCUMENTATION	
Appendices	
1.	Monitoring Scrutiny Recommendations – 27 January 2022
2.	Fostering inquiries

Documents In Members' Rooms

1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	**No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	**No**
Other Background Documents **Other Background documents available for inspection at:**	

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	

Children and Families Scrutiny Panel

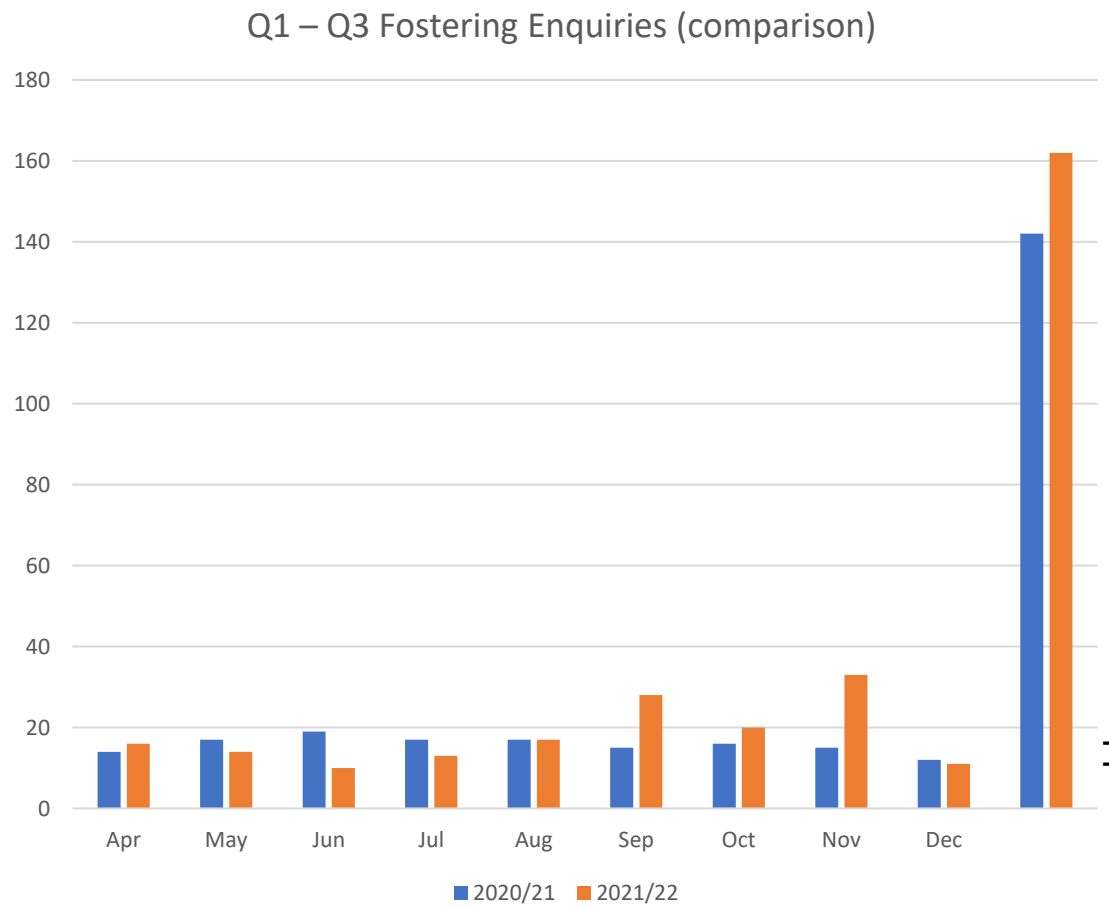
Scrutiny Monitoring – 27 January 2022

Date	Title	Action proposed	Action Taken	Progress Status
17/06/21	Ofsted Focused Letter	1) That the Cabinet Member for Education lobbies the Government, on behalf of the Council, to give local authorities additional powers with regards to the oversight of elected home educated children.	The Cabinet Member has received a briefing from the Head of Education and Early Years on Elected Home Education.	Partially complete
25/11/21	Key performance indicators - SEND	1) That, through the proposed SEND reforms, the service uses this opportunity to engage with the Parent and Carer Forum and SEND Information and Advice Service to encourage a more conciliatory approach to supporting parents of children with SEND, thereby reducing the number of appeals and tribunals.	The service is meeting with the SEND Information, Advice and Support Service in the spring term to establish what other LA's that the service is commissioned by, have in place in terms of their informal mediation/resolution services, with the intention of developing a new model in Southampton. This aims to resolve early any decisions that parents do not agree with/understand which should see a reduction in the number of appeals to the first tier tribunal. As with all service developments, this will be done in collaboration with the Southampton Parent Carer Forum.	Complete
		2) That the self-evaluation being developed in preparation for an Ofsted inspection is considered at a future meeting of the Panel.	The Head of Service for SEND will advise when the timeline for the new inspection framework publication is confirmed by Ofsted and the Care Quality Commission. A date for Scrutiny Panel to be briefed on the service self-evaluation will then be set.	Partially Complete
25/11/21	Children & Learning - Performance	1) That the figure for foster carer inquiries is added to the dataset considered by the Panel.	Foster carer applications is not something we can report on from Care Director. However, the service has provided the most recent performance information (attached as Appendix 2) and can easily update the Panel upon request.	Complete
		2) That, reflecting concerns about performance, clarification is provided on what the NEET indicators are actually measuring and how they are determined.	**NEET – Post 16 Education Team** The NEET data is recorded on our CCIS system CORE+ and is all young people of academic age 16 and 17 (year groups 12 and 13) that reside within Southampton who are not in education, training or employment. The NEET group consists of those that are both available and not available (young parents, illness, carers). The cohort changes each September as the year groups change and we start to track	Complete

Date	Title	Action proposed	Action Taken	Progress Status
			our 4500 young people. The first accurate set of data is from November onwards and is available up until August. The NEET group is approximately 3.5-4% of the cohort around 160-180 young people. **NEET – LAC / Care Leavers** The Virtual School (VS) oversees EET provision post 16 -18 for looked after children wherever they are placed in the country. To ensure tracking of attendance and engagement we use Welfare call, an electronic attendance tool to ensure year 12 and 13 students continue to remain in EET. Early oversight is in place if attendance dips and bespoke interventions can be negotiated – e.g. additional 121 tuition around preparation for exams (especially functional skills/GCSE English and Maths). Individual discussions around bursaries and additional financial support for transport, materials and resources. The VS also promotes high aspiration working in partnership with Solent University – providing workshops and information and guidance around transition to higher education. All opportunities for 16+ are advertised through the weekly designated teacher email distribution in and out of city and through the participation social media outlets. The pathway plan is scrutinised to ensure EET opportunities and support are prioritised to enable transition to independence in adulthood.	
		3) That the Scrutiny Manager works with the Performance Manager to 'fine tune' the presentation of the performance dataset.	Mark Pirnie and Jo Feeney have liaised regarding this action. The presentation of the performance will continue to develop reflecting the views of the Panel.	Complete

How are we doing; generating enquiries

- 162 enquiries to date
- 33 enquiries in Nov 2021 – highest monthly figure since March 2019
- Steady increase since August 2021
- Dip in Dec - impact of holiday season and Omicron?



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