Southampton
Local
Safeguarding
Children Board

Annual Report 2018-19

Foreword

This is the fifth year I have served as Independent Chair of Southampton Local Safeguarding Children Board. As I write this, the Board enters a period of significant change following the passing of the Children and Social Work Act 2017 and as such, this will be the last report of its kind to be produced by Southampton LSCB before responsibility for this partnership working transfers to the three Safeguarding Partners in September 2019.

In my time as Chair I have been very impressed by the quality of partnership working in the City, this is second nature to the Board members who offer high level of support and challenge to each other and to our committed workforce and communities who are dedicated to keeping children safe.

Southampton continues to face complex social issues that impact on children's wellbeing and safety. Child poverty rates in the city are high and many families experience deprivation and the number of children in the city that are in need of help and protection is also above national and statistical neighbour averages. The numbers of children and families referred for statutory services is high as a result. This places pressure on the local system that cannot always be matched with resources at a time when investment in public services nationally has reduced. Key frontline services have faced additional challenges this year particularly in the recruitment and retention of qualified and experienced staff. These issues have regularly been reported to the LSCB, where multi-agency action is coordinated to improve and develop services and responses continue to be monitored. However we know that this is a problem that is reported regionally and nationally and continues to be reflected in our LSCB.

This year the LSCB were made aware of tragic circumstances that have led to harm to children and referred to the LSCB for case review to ensure that any learning for our services is identified and actioned to prevent future similar harm. I would like to take this opportunity to pass on condolences to individuals, families and communities affected. Where appropriate, it is our job as an LSCB to coordinate action in response and also to seek assurance that all systems of safeguarding and protection are effective and proportionate to needs of children and families, and this continues to be a focus for the new arrangements and coming year. Our work has drawn out some notable themes for learning and improvement, which will focus our responses and continue our work as champions of children's safeguarding in Southampton. Southampton LSCB is a learning partnership and will continue to ensure that action is taken where learning from our reviews indicates change is needed.

I have been impressed to see the way that Southampton has worked together to plan improvements and respond to key priorities; particularly the Working with Families Project ensuring a citywide approach to ensuring restorative and whole family approaches to safeguarding. The LSCB has modelled both approaches, working closely with our Adults Board colleagues, operating a shared executive group and delivering joint audit work to test this. We have also focussed on preparing for the transition to the new arrangements ensuring that close working with our neighbouring LSCB's provides benefits the residents of Southampton. I write this with knowledge that I will step down as chair once new arrangements for the safeguarding children partnership are in place. I would like to take this opportunity to thank Board Members for their continued and passionate efforts to keep children in Southampton safe. I have hugely valued my time working in the City, in particular the opportunities I have had to engage with children and their families, as well as the times that I have been fortunate to discuss key issues with professionals of the city. Partnership working in Southampton is of a strength not commonly seen and I know that this will continue to improve the safety of children in the city. I hope that you find this annual report of the work of the Board informative and wish the Safeguarding Partners and those leading the Safeguarding Partnership well in their future work.

Keith Makin, Independent Chair of Southampton LSCB

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Who are the LSCB?

Children in Southampton can only be kept safe if all professionals and services work together. Southampton Local Safeguarding Children Board (LSCB) operates to provide a way that this can be done. This is currently called 'the LSCB', but will likely change during the coming year as statutory changes are taking place which mean that in every area, three safeguarding partners (the Local Authority, Police and Clinical Commissioning Group) must come together to make new arrangements to ensure children are safeguarded.

Southampton's safeguarding partners have agreed that the local partnership for safeguarding children in the city will change from the current Southampton Local Safeguarding Children Board (LSCB) to Southampton Safeguarding Children Partnership (SSCP). To complement this local arrangement the safeguarding partners in Southampton have joined forces with our neighbouring authorities to form a Hampshire and Isle of Wight, Portsmouth and Southampton safeguarding children partnership arrangement known as 'HIPS' to enable larger scale strategic development of partnership working beyond the our city boundaries and improve our ability to influence practice and positive outcomes for children across local borders. Alongside the local change of identity the partnership will develop in structure and function to enable a greater focus on influencing practice development and local improvement to outcomes for our children.

During 2018-19, the LSCB operated according to statutory guidance and best practice with a Board of senior representatives from the services that work to safeguard and protect children in Southampton (including social care, health, voluntary sector, the police, probation service and family courts. Southampton LSCB is also fortunate to have Lay Members that offer their time as volunteers to bring a valuable and independent perspective to the meetings and work.

During this year the LSCB continually checked that what is done in Southampton to safeguard children works. For example, ensuring that services are working safely, that the procedures we publish are clear and help staff and volunteers know what to do when they are worried about a child, or that staff and volunteers receive the training they need to undertake their roles. We focus our attention and efforts on a range of agreed priorities taken forward by 'sub groups' and occasionally issues focussed 'task and finish' groups of the main LSCB. A structure chart and explanation of the sub groups can be found in Appendix 4.

Southampton Context and Demographics

The current population of Southampton is 252,800[1], with:

57,600 children and young people aged (0-19 years)[2]
53,000 residents who are not white British (22.3%)
43,000 students.

The city has a young demographic with 20% of the population aged between 15 and 24 years compared to just 12.4% nationally. 33% of school pupils in Southampton from an Ethnic Group other than White British[3] (compared to 26.3% in 2010) and for 25.7% of pupils their first language is other than English.

Using Child Health Profile data for England, the health and wellbeing of children in Southampton is below average. In recent years there have been 6 child deaths (1-17 year olds) each year on average and more information can be found in the CDOP section of this report (page 21).

[1] Source: LG Inform, 2019
[2] Source: Southampton City Council website (www.southampton.gov.uk)
[3] Based on those with an ethnicity recorded

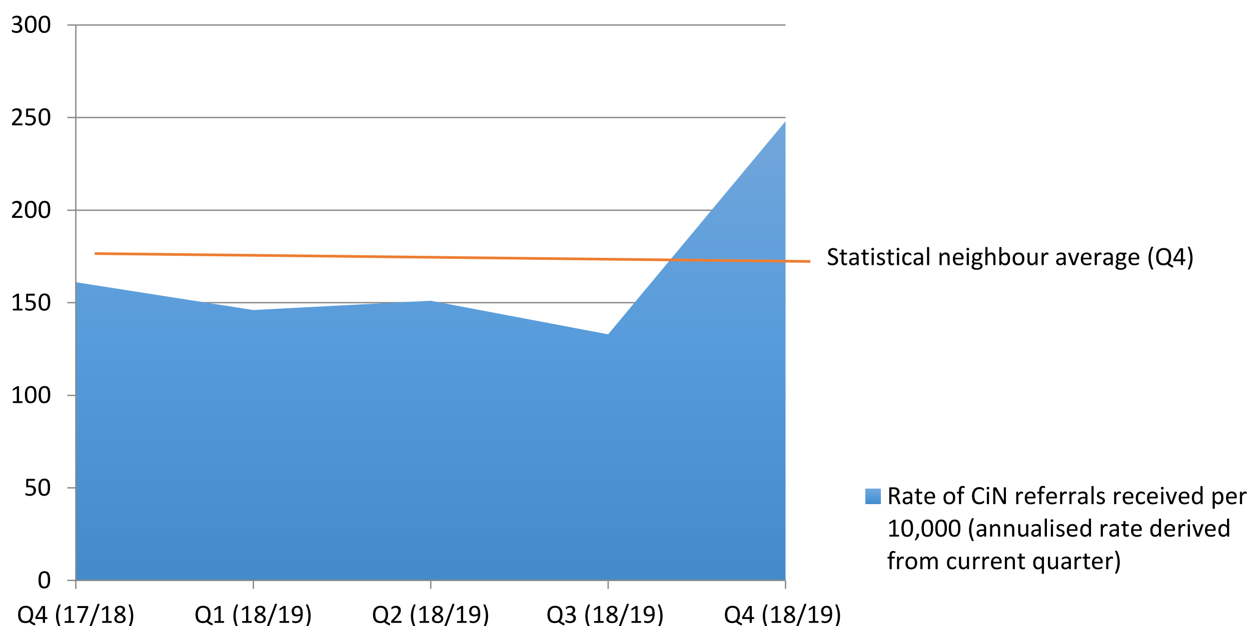
The teenage pregnancy rate in Southampton is higher than the England average with 110 girls becoming pregnant in a year. Levels of child obesity are higher than the England average with 11% of children in reception year and 21.9% of children in Year being classed as obese. The rates of child inpatient admission for mental health are higher than the England average as is the rate for self-harm[4].

20.1% of children in Southampton live in poverty compared to an average of 17% average for England. In 2015 Southampton was ranked 67th out of 326 Local Authorities in England for deprivation, Millbrook ward being amongst the most deprived in the country.

Indicators of Outcomes for Children

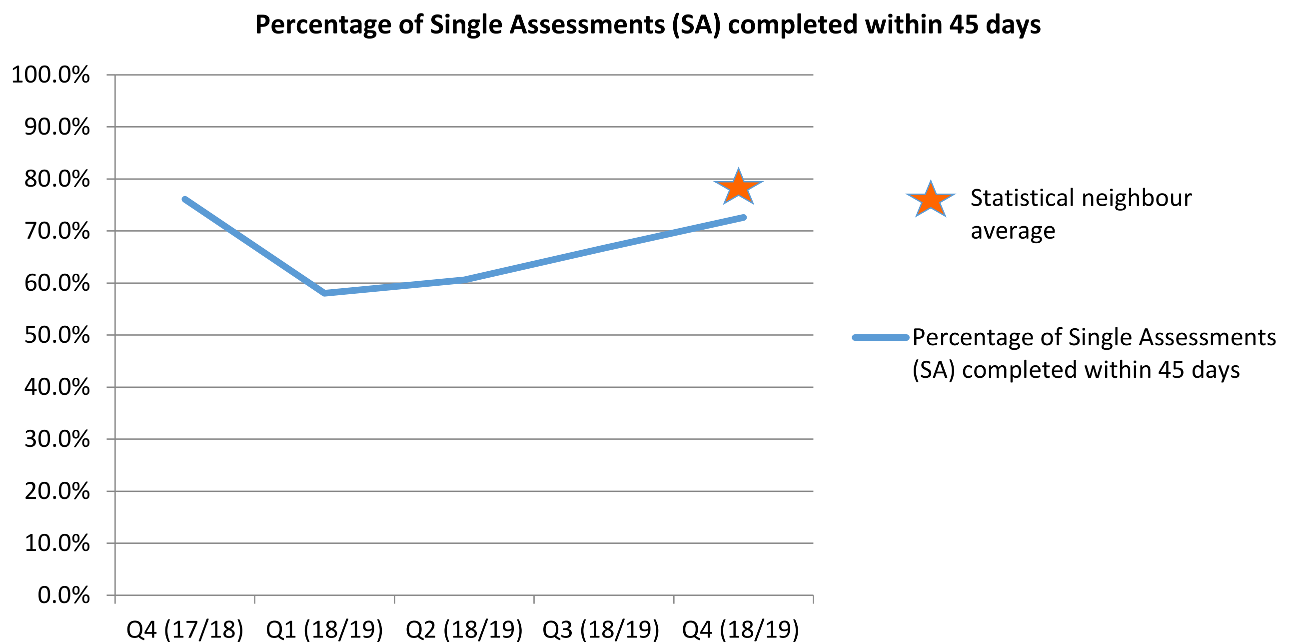
The LSCB regularly analyses a multi-agency dataset containing some key performance indicators for outcomes for children as well as the quality of local provision. It enables the board to understand the impact of its work, and that of services, including changes where transformation projects take place. Tracking and analysing local data provides the Board with key information about areas of concern and changing trends. Data is analysed by the LSCB in its Monitoring and Evaluation sub group (soon to be renamed the Safeguarding Practice Improvement (SPI) Group) at the end of each quarter, key issues are then highlighted to the Local Safeguarding Board Executive. The data reviewed by the LSCB concentrates on tracking the child's journey through the safeguarding system and is linked to the LSCB's priority areas of concern. Below is a summary of annual data for some of these key measures.

Children in Need (CiN) of Help and Protection



[4] Child Health Profile – March 2019, www.gov.uk/phe

The rate of children in need based on 10,000 population (of children under 18) is monitored by the LSCB as a key measure of the needs of Southampton children and therefore the demand placed on the local children's services system. This is also an indicator of the success or otherwise of early help[5] interventions within the local system. As the graph shows, the rate of referrals at this level remained steady throughout the year and below the statistical neighbour average, until the final quarter when numbers rose drastically. This is of concern to the LSCB and will be discussed and monitored closely in 2019-20.

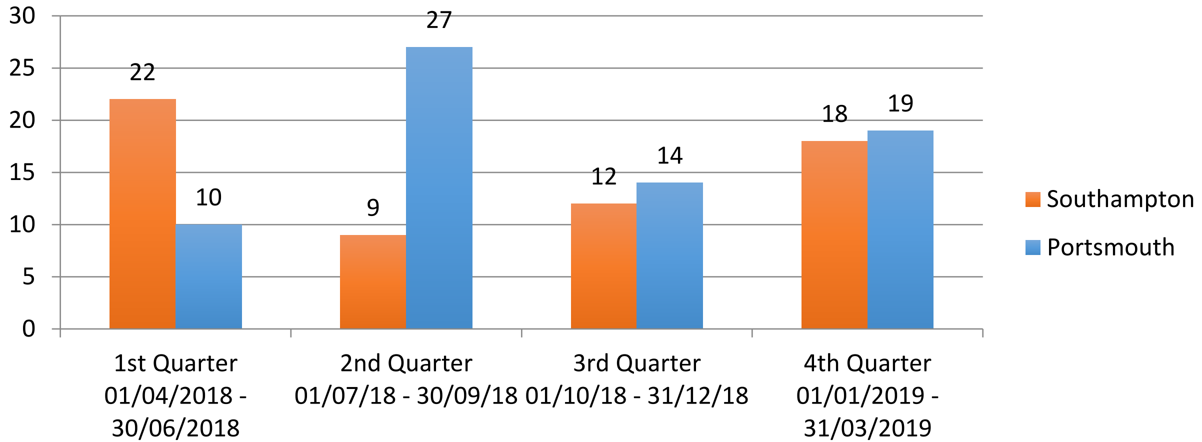


One of the measures that the LSCB uses to monitor the quality of local provision is the percentage of single assessments completed within the statutory timescales of 45 days. As the chart above demonstrates the LSCB has seen variable performance reported during this year with Q1 seeing the lowest number completed. Southampton performance in this area varied between 58% in Q1 and 72.6% in Q4 –the statistical neighbour average of 87.2%. The variable performance in this area is an on-going concern to the LSCB for the following year, although the picture improved in Q4.

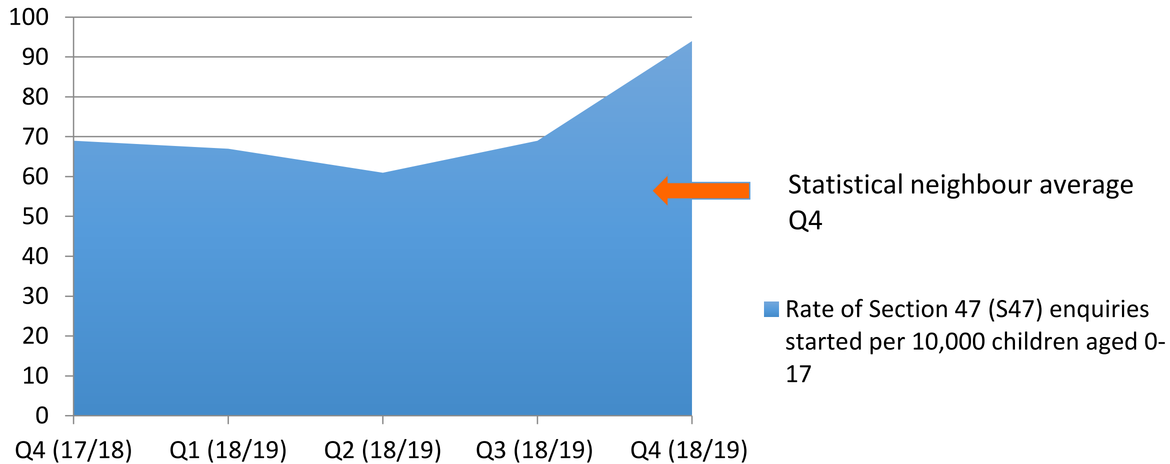
The varying performance and data in this area was explained to the LSCB throughout the year as being due to service pressures relating to high numbers and varying quality of safeguarding and child protection calls and referrals to the 'Front Door' and MASH (Multi-agency Safeguarding Hub) alongside challenges with recruitment and retention of experienced and qualified social work professionals. The LSCB requested and was presented with improvement plans to tackle performance in this area, and continues to monitor this.

[5] 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. Early help can also prevent further problems arising; for example, if it is provided as part of a support plan where a child has returned home to their family from care, or in families where there are emerging parental mental health issues or drug and alcohol misuse. Working Together to Safeguard Children, 2019.

Child Protection

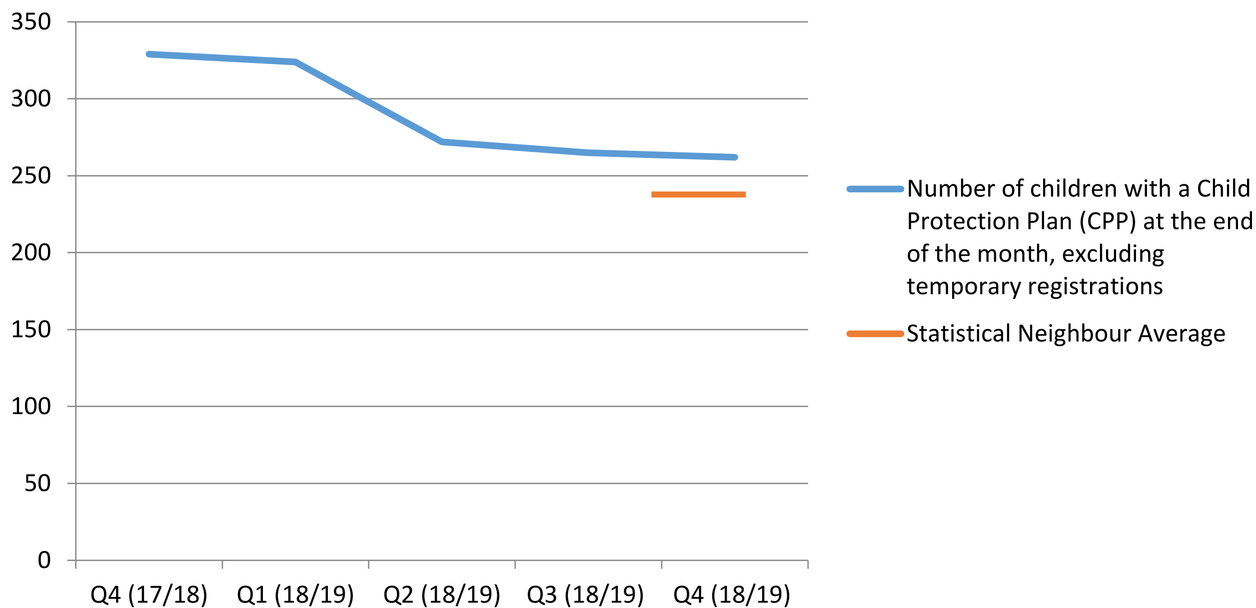


The number of children taken into police protection this year totals 61. Portsmouth city is a comparable authority and a statistical neighbour, and given their proximity and coverage by the same police force as Southampton it can be useful to track comparisons as above. Portsmouth had 70 children subject to police protection during that time.

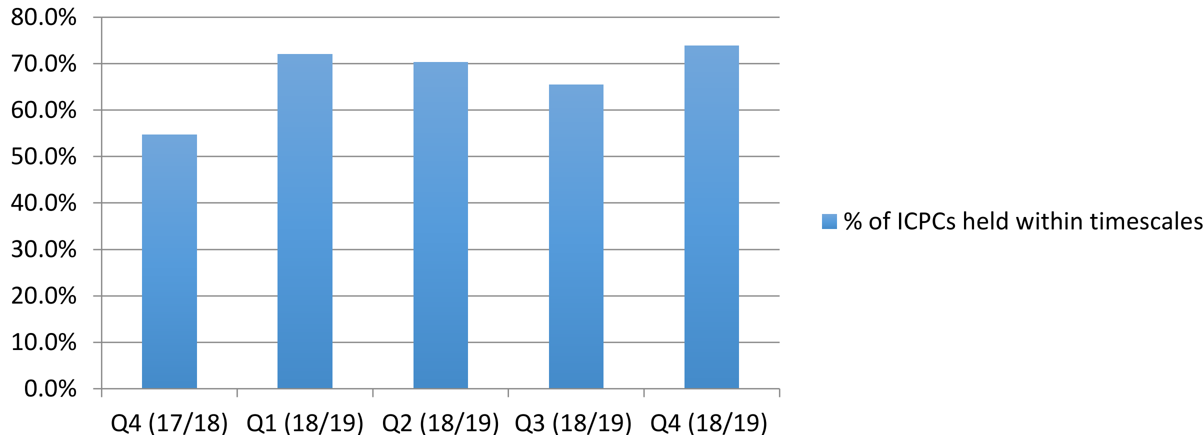


Where there are child protection concerns (reasonable cause to suspect a child is suffering or likely to suffer significant harm) Local Authority social care services must make enquiries and decide if any action must be taken under section 47 of the Children Act 1989. This is an essential area of the safeguarding system that is of interest to the LSCB. The above graph represents the level of activity in Southampton relating to enquiries started during the year. Throughout the year Southampton has continued to have a rate per 10,000 children high above the statistical neighbour average rate of 51 at the end of Q4. The Southampton figure for this at the end of Q4 was 91. This matches a similar upward trend seen in Children in Need (CiN) referral rates and in particular a high rise in numbers at the end of 2018-19. Again, this can be seen as an indicator regarding the impact of early help system, and shows the increasing levels of demand. The LSCB will continue to analyse and investigate the variations in rates shown.

Number of Children with a Child Protection Plan



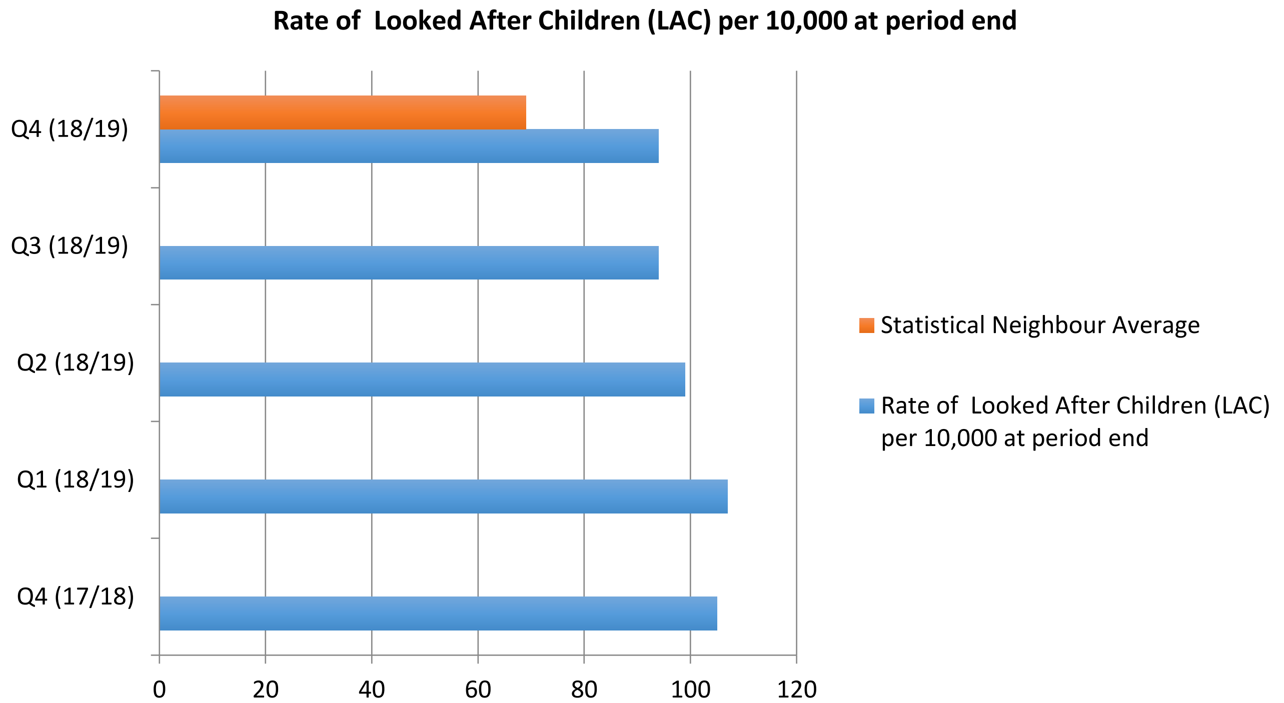
% of ICPCs held within timescales



The number of children with a child protection plan in Southampton (262) has reduced during this year to become closer to statistical neighbour average (236) at the end of Q4. During the year the LSCB has been assured that this reduction is being delivered safely and that multi-agency engagement with this and child protection conferences is maintained despite reducing resources for all services. The Local Authority Quality Assurance Service reports on progress of child protection work to the LSCB throughout the year and raises areas of concern and improvement for multi-agency action. There is a high level of audit activity, engaging families and professionals, which is delivered by the LA in this area and fed in to the LSCB.

The percentage of Initial Child Protection Conferences held within agreed timescales has remained close to the Statistical Neighbour average, at year-end being 73.8% (SN 76%). This is despite increased pressure from higher numbers of referrals.

Looked After Children



In recent years Southampton has had an exceptionally high number and rate of children per 10,000 of the population that are looked after compared to national and statistical neighbour averages. The LSCB has continued to monitor this with the Local Authority. This includes results of investigations into the data as well as evaluating the impact of a number of initiatives that strive to safely tackle this issue.

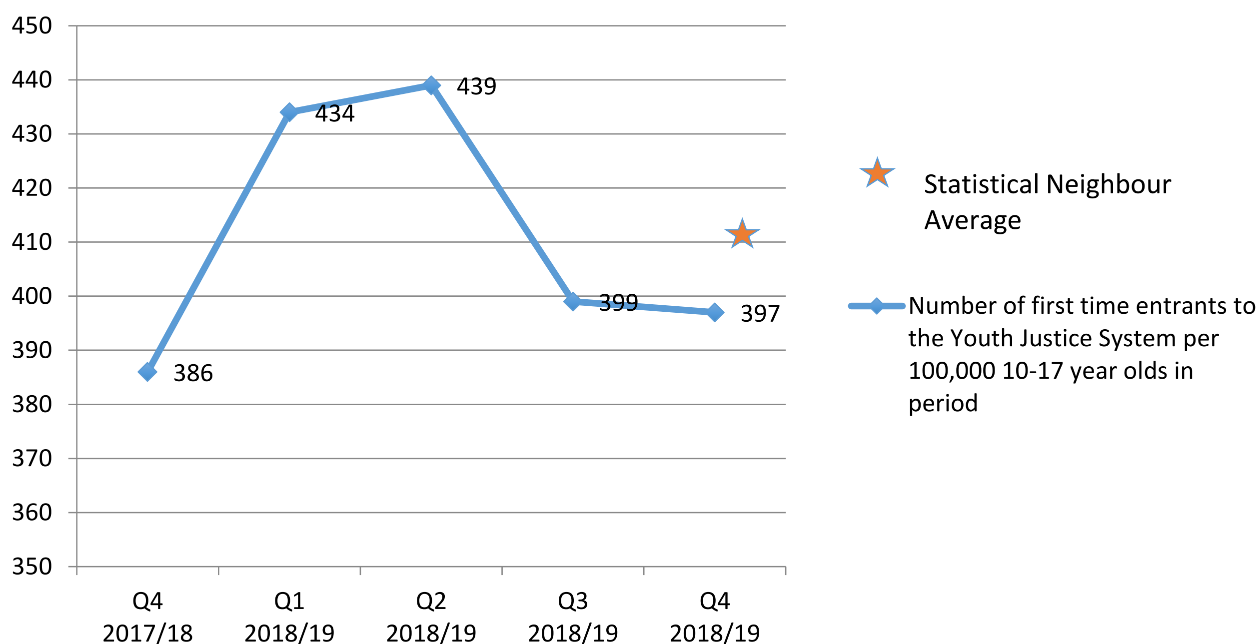
The high number of children that become looked after has also been a focus for the City's Corporate Parenting Board and Children and Families Scrutiny Panel. The LSCB has ensured that links to these strategic bodies are robust to provide a coordinated approach and consistency to this priority issue. The end of year figure was 94 children per 10,000 compared to 69 for our statistical neighbour authorities. The rate still demonstrates high numbers although there has been a reduction from 104 children per 10,000 at the end of the previous financial year.

There were 519 Looked After Children at the end of last financial year and this has reduced to 475 this year. The reducing trend has been reviewed regularly by the LSCB including receiving and evaluating commentary from the Local Authority regarding its work on this.

Children with Special Educational Needs or Disability

The City has an increasing number of children of school age children with a learning disability, which has risen from below the national average in 2013/14 to above the national average in 2017. The demand for specialist SEND provision is increasing. It is predicted that the numbers of children being considered for specialist provision / special school places could increase by up to 50% by 2022. Without additional funding this will put further pressure on the High Needs Block[6] with funding implications across all SEND provisions[7]. Research shows that disabled children are at an increased risk of being abused compared with their non-disabled peers, and that professionals often struggle to identify safeguarding concerns when working with disabled children. The LSCB has focussed on SEND assurance and safeguarding children with a disability to seek assurance of local provision and outcomes for children.

Youth Offending & Criminal Activities



The rate of First Time Entrants to the Criminal Justice System aged 10-17 years old increased in the first 6 months of this year and has now reduced back to a rate below statistical neighbour average. Performance throughout the year has been variable and the LSCB will be seeking assurance that this lower level remains consistent in the coming year from the lead partnership for Youth Offending – the Youth Justice Board and Safe City Partnership.

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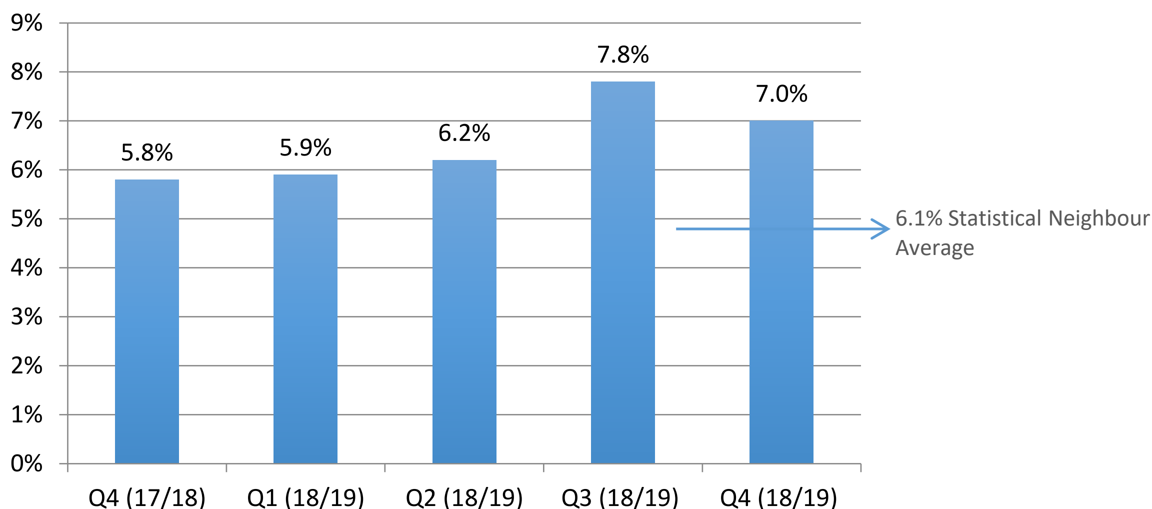
[6] Allocated central government funding for children with disabilities

[7] Southampton SEND Strategic Review 2017-18

Children not in education, employment or training

Percentage of 16-17 year olds NEET or whose activity is not known



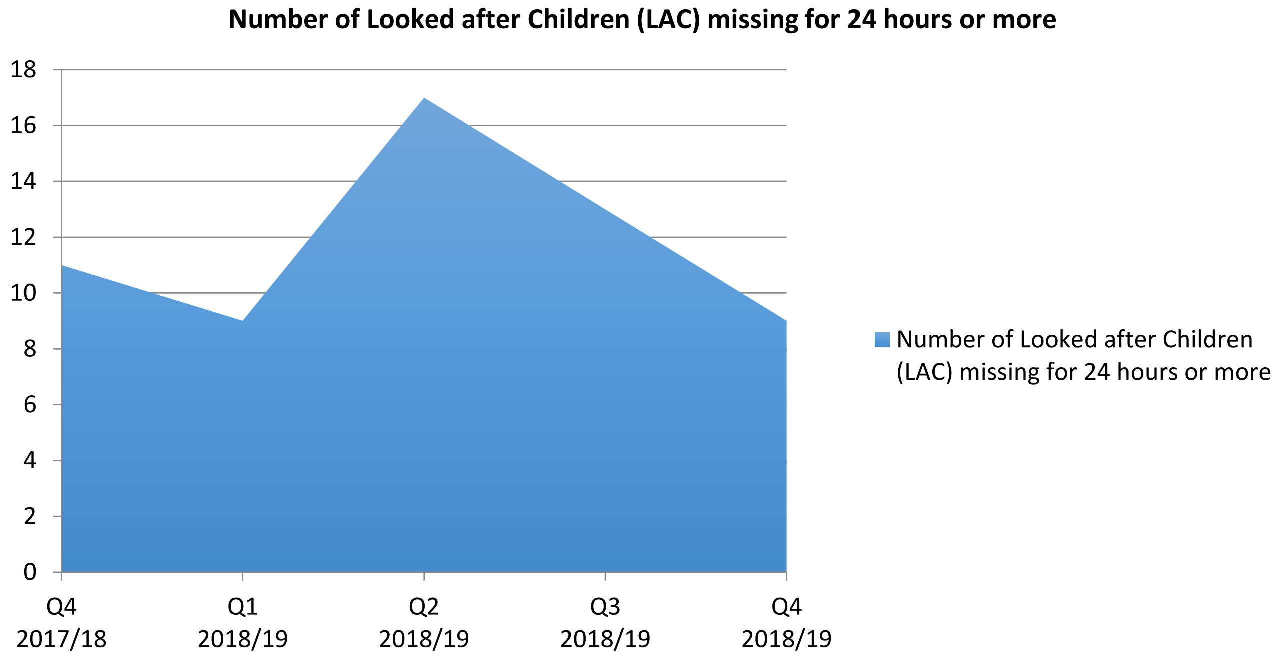
The number of young people (16-18 years) who are not in education, employment or training (NEET) demonstrates a concerning upward trend, peaking in Q3 and remains high in Q4 and above the national average. The picture for care leavers in Southampton is improving slightly compared to the same period last year where 53.7% of care leavers were NEET, reducing to 46% at the end of year this year. This is still a very high number and of concern in terms of positive outcomes for children leaving Local Authority care.

Children missing education

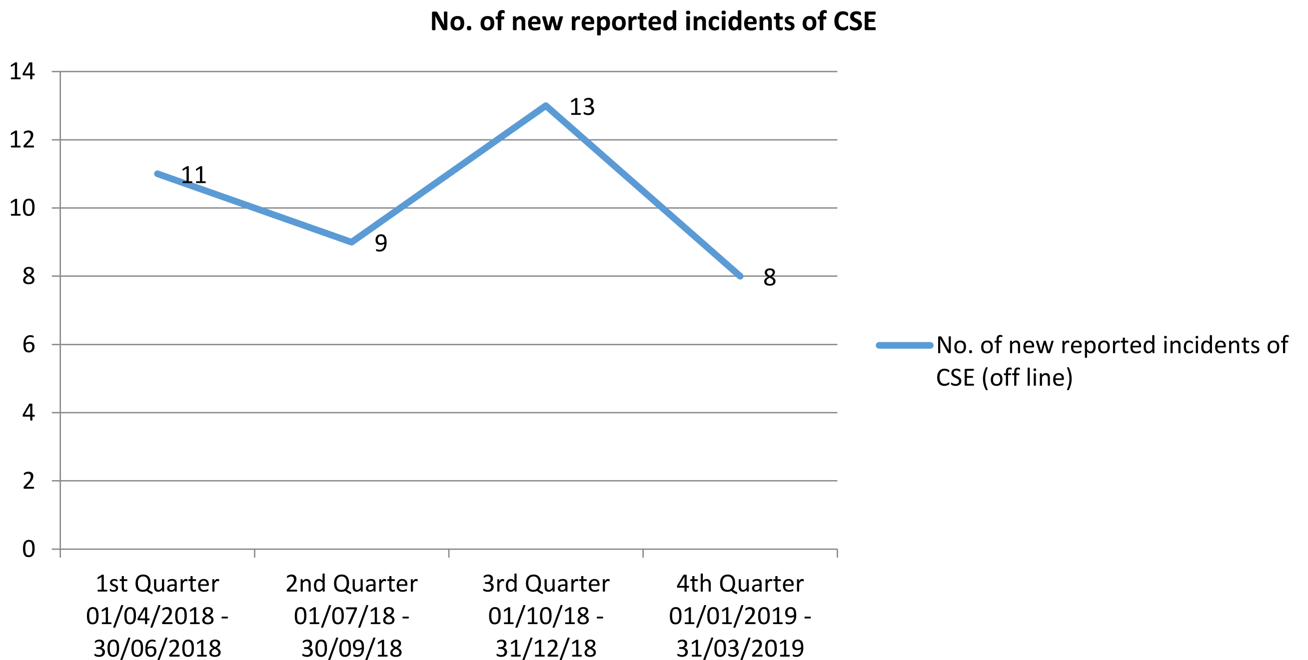
The LSCB reviews and monitors the percentage of pupil absenteeism as a whole; this is an annual measure and is showing an upward and concerning trend. In addition the LSCB requests regular updates regarding Children Missing Education and this information is also fed in to the LSCB via the Missing, Exploited and Trafficked sub group work, given the particular risks in terms of exploitation and missing education.

The rate of children missing education is measured as a whole city percentage of pupil absence. In 2017 this rate was 4.7% and in 2018 this rose to 5%. This equates to a high number in comparison of school days lost per year. The Southampton Attendance Action Group (SAAG) is run by the Educational Welfare Service and is working to improve school attendance – joint work with Southampton Football Club has helped to raise this profile and promote good school attendance. There is also a focus on children with Education Health and Care Plans who represent a high proportion of pupils that have a high percentage of absenteeism.

Children at risk of going missing or being exploited



Child Sexual Exploitation



The LSCB continues to develop its coordination and assurance activities relating to child exploitation. The LSCB has coordinated a multi-agency strategic group to develop and deliver its MET (Missing Exploited and Trafficked Children) Action plan, which was refreshed and published during this reporting year. The statistics above show the relatively low, but none the less important numbers of children where crime or concern has

been reported. The above demonstrates an upward trend in Q3. The LSCB seeks assurance from its members that the agreed processes for responding and protecting children at risk of exploitation are implemented and that professionals working within the city are aware of the indicators of risk of exploitation and how to respond.

The future partnership arrangements will develop this work even further, with a 4LSCB Child Exploitation group developing to encompass the wider range of child criminal exploitation issues (particularly County Lines drug supply) cross geographical boundaries. Southampton LSCB will seek assurance locally regarding operational responses and coordination of activities.

Health agencies have undertaken joint work across the 4LSCB (HIPS) footprint to raise awareness of and the identification of child sexual abuse. The Child sexual Risk Questionnaire (CSERQ4) was developed for use by health practitioners who have "time limited" contact with children under the age of 18 to help them quickly identify the risk of sexual exploitation. The form has been shared across all health agencies and is due to be reviewed later this year by the HIPS Health Sub Group.

Priorities, Projects & Activities

For this year the LSCB agreed to continue with its previous priority themes for its partnership work. This was to ensure consistency and embedded action across the multi-agency partnership, and review progress in the light of new arrangements to be implemented during 2019-20:

Priority Themes:

- Developing a Family Approach to safeguarding
- Child Neglect
- Improving safety and outcomes for vulnerable children including Looked After Children and children at risk of going missing, being exploited or trafficked (MET).
- Development of new safeguarding partnership arrangements

Below is a summary of action taken by the LSCB during this year on the above priority areas:

Developing a Family Approach to safeguarding

1. Work with neighbouring LSCBs and LSABs (Adults Boards) on a Family Approach project. This included:
    a. Protocol for working together
    b. Toolkit for professionals
    c. Launch and training events
2. Development of a joint Southampton training programme with the LSAB, which includes topics such as substance misuse, alcohol use and adult mental health training as a regular feature.
3. Joint auditing with the LSAB to ensure whole family / age approach. This year an audit focussed on transition of Looked After Children from child to adult mental health services
4. Regular assurance reporting to the LSCB from adult focussed services to ensure cross over and family approach to safeguarding children – including:
    a. Substance misuse and alcohol
    b. LSAB report
    c. Domestic abuse including the new High Risk Domestic Abuse system linking the MARAC/MASH process
5. Learning from case reviews on family approach to safeguarding developed and disseminated regularly to the local network of professionals.

Child Neglect

1. Published a web page dedicated to raising awareness of child neglect
2. A new Neglect Strategy and Practitioner's Guide to Neglect have been developed by a multi-agency Task and Finish Group and are now published on the LSCB website.
3. Introduction to Neglect training has been run for a multi-agency audience.
4. A multi-agency Action Plan for Neglect has been developed and progress against this will be monitored by the LSCB Monitoring and Evaluation Group.

Looked After Children (LAC) and children experiencing missing, exploited or trafficked (MET) issues

1. County Lines updates reviewed at Southampton LSCB Main Board, providing partners with up-to-date statistics on where the issues are, number of arrests etc.
   The LSCB provide assistance and helped to promote to Police 'intensification weeks' which are a week where a specific issue of concern is tackled by multi agency partners – for example County Lines drug supply, modern slavery.
2. The LSCB arranged workshops in the city to enable staff from all agencies to improve their knowledge of County Lines drug supply (for example how this type of drug supply works and the signs to look out for).
3. The MET Strategic Group met regularly throughout the year, reviewing qualitative and quantitative assurance information, including children missing education, home or care, child sexual exploitation, trafficking and criminal exploitation.
4. The MET action plan was refreshed and aligned with neighbouring authority and Hampshire Constabulary led 4LSCB plan
5. The LSCB delivered audit work for a Joint Targeted Area Inspection (JTAI[8]) into children involved in criminal activity and gangs.
6. Multi-agency training workshops regarding Child Exploitation including MET issues and criminal exploitation delivered
7. Online safety awareness raising work with Designated Safeguarding Lead's in education settings through a workshop and regular feed in to the network
8. Sought assurance and progress updates from the Local Authority regarding plans to safely address the number of Looked After Children.
9. Annual report from the Corporate Parenting Committee with updates on how this work is progressing.
10. Looked After Children data is monitored by the LSCB (including data relating to attainment at school, further and higher education.
11. The Board sought assurance that the Education department have a detailed action plan to address attendance rates and attainment – where information demonstrates 'gap' against national averages and for priority groups including CLA.

Communication

1. Developed further links for LSCB with schools and education settings, including DSL network
2. Delivered a range of multi-agency workshops on key topics to enable networking between services working with families and adults at risk of harm
3. Regular communication with other strategic partnerships including LSAB, Safe City Partnership, Health and Wellbeing Board and Scrutiny Panels regarding issues of concern for the LSCB and to develop peer scrutiny across these boards

[8] JTAIs assess how agencies work together in an area to identify, support and protect vulnerable children and young people

4. The 4LSCB areas of Southampton, Portsmouth, Isle of Wight and Hampshire regularly refresh 4LSCB safeguarding policies and procedures and highlight key documents via newsletters.

Impact of safeguarding partners working together

Section 11 Reviews

The LSCB gains assurance of how each agency ensures it is safeguarding and protecting children in a number of ways. For example the LSCB requests reviews from all statutory and other organisations that operate in the city to demonstrate how they are meeting their duties under Section 11 (of the Children Act). This is a self-assessment process - supporting agencies in achieving compliance through**:**

- Seeking assurance that services are compliant with safeguarding standards.
- Showcase areas of good practice where positive outcomes for children can be evidenced.
- Reflection on their safeguarding priorities and to identify areas for improvement.
- Feedback mechanism to Boards on progress against areas for improvement including any barriers to partnership working.

The 4LSCBs for Hampshire, the Isle of Wight, Portsmouth and Southampton deliver this process collectively to reduce duplication for organisations working across the area. For organisations working solely within Southampton their submissions were reviewed locally.

This year, action plan progress was reviewed for the following Southampton organisations:

- Children and Families Service
- Adult Services
- Housing Services
- Libraries
- Arts and Heritage and Libraries
- Licensing
- Youth Offending Service
- Southampton City CCG and ICU
- GPs (summary of safeguarding audit received in Sept 18)

In addition, the following agencies were reviewed through 4LSCB scrutiny arrangements:

- Hampshire Constabulary
- Southampton Central Ambulance Service
- University Hospitals Southampton (UHS)
- Hampshire and IOW Community Rehabilitation Company (CRC)

As part of the review, site visits took place with Board members and the support teams. The findings and feedback were discussed at Monitoring and Evaluation Subgroup. Written feedback has been submitted to all those that participated and the next round of reviews will take place during 2019.

The following were determined:

- Additional resources around participation of children
- New Restorative Practice / Child Friendly City project is positive investment
- Principal Social Worker resource and the Regional Adoption Agency work are progressing well
- Quality assurance of safeguarding work is increasing positively

- Inclusion of safeguarding statements in policy
- GP lead engagement with Child Protection conferences developing
- Increase in GP awareness raising and training activities regarding safeguarding issues
- Safeguarding issues have been made clearer in the Housing service, including within management roles and supported housing staff objectives and appraisals.
- The City Council Licensing department have demonstrated full engagement in the LSCB process and increased level of awareness of relevant safeguarding issues.

Action required:

- Need to identify clearer links to 4LSCB procedures and awareness of referral thresholds.
- Increase in confidence needed to work with children that have communication needs or English as an Additional Language (EAL)
- Reflective supervision for staff should be implemented to promote staff wellbeing and give the opportunity to reflect and improve on service
- More service led activities to disseminate learning from case reviews
- Annual appraisals to improve and include safeguarding / mandatory training
- Need to ensure Safeguarding messages clear in all staff induction
- Multi-agency information sharing needs to be reviewed
- Further understanding needed of resources for working with disabled children and families, training on safeguarding disabled children is also needed
- More focus needed on examples of good practice
- Further work to ensure dissemination and implementation of LSCB policies, procedures and resources – particularly:
  - Escalation / conflict resolution
  - Safer recruitment
  - Safeguarding supervision
- The inclusion of safeguarding standards within contracted services.

Multi-agency Audits

Joint Targeted Area Inspections (JTAI) are thematic inspections carried out by Ofsted, the Care Quality Commission, Her Majesty's Inspectorate for Constabularies and Her Majesty's Inspectorate for Probation with a focus on multi-agency safeguarding arrangements. The LSCB has aligned its multi-agency audit schedule to undertake a dry run of such an inspection according to national themes. This year the theme was children at risk of criminal exploitation. The findings and recommendations were translated into actions that fed into the MET plan that can be found on the LSCB website. The findings from this were also fed into the 4LSCB Child Exploitation Group, where actions and improvement work is coordinated and monitored.

The LSCB also undertook an independent multi-agency audit, jointly with the LSAB relating to the transition of young people leaving care from child to adult mental health services during this year. An independent person is delivering this and the report is currently being drafted.

Case Reviews & Learning

Learning from cases is a vital way of informing improvements and practice and in preventing future harm to children. The LSCB worked to the following criteria for Serious Case Reviews in 2018-19, which as set out in Working Together to Safeguard Children and Young People 2015 was:

a) **Abuse or neglect of a child was known or suspected; and**
b) **Either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.**

Serious Case Reviews published 2018-19

The LSCB published the following Serious Case Reviews in the year 2018-19. Below is summary of the subject of those reviews, and a summary of the learning. Full details can be found by using the links to the LSCB website.

Allegations Against Foster Carers (published 2018) - this SCR related to the historic abuse allegations of children whilst in foster care by foster carers working for Southampton City Council & historically Hampshire County Council. The recommendations were largely around the recruitment of foster carers, improvements in the Foster Care service of the local authority, hearing the voice of the child and agencies responses when the abuse came to light. In response to the Review actions taken to improve safeguarding arrangements for children in foster care in Hampshire and Southampton. **6 step briefing**

Adam & Anna (published June 2019) - this SCR focussed on child sexual abuse within the family, sometimes known as Intra Familial Sexual Abuse (IFCSA). Adam and Anna (not their real names) were abused by their uncle who was convicted in July 2017 for multiple counts of abuse. The SCR examined the barriers to keeping Adam and Anna safe and the correlation between neglect IFCSA. The review also explored how effectively agencies worked together to identify and address the risk posed to the children and what can be learned to improve future professional practice. The recommendations largely focussed around training to ensure that practitioners can confidently recognise the signs of IFSCA and know what action to take. **6 step briefing**

Safe Sleep (published June 2019) **-** Two young babies, Billy and Reece (not their real names) died in Southampton in circumstances that were thought to be linked to co-sleeping. As well as commissioning a SCR into these deaths and in response to a number of cases related to co-sleeping at the Child Death Overview Panel (CDOP) the Safeguarding Partnership launched a Thematic Review to examine the issue of safe sleep. The learning and improvements for the SCRs regarding Billy and Reece and the Thematic Review were combined. The main areas for learning were the importance of conveying safe sleep messages to parents and tailoring those messages for the parents' needs. The Safeguarding Partnership undertook to develop a multi-agency

procedure to assist professionals in dealing with disguised compliance and resistant parents. The 6 step briefings are available as below.

Billy – **6 step briefing**

Reece – **6 step briefing**

Thematic Review – Safe Sleep – **6 step briefing**

Themes identified from this year's case reviews

The themes identified this year through all of the LSCB's case reviews and audit work are summarised below, these are reviewed regularly and influence the regular 'Learning from Case Reviews' briefings and workshops that the LSCB hosts:

Taking a family approach - including risks from a combination of domestic violence, substance misuse, alcohol and mental health issues

- Commonality of combination of issues in families, and increased risk of significant harm
- High risks posed to others as well as 'subject' of the casework. This includes wider family members and children where a combination of these issues is present
- Early identification and intervention reduces risk of harm
- Risk escalates quickly particularly where there is a combination of domestic abuse with mental health issue or substance misuse
- There is a need for further understanding of the impact of coercive control on families

Escalation

- Underpins the principle that 'Safeguarding is everyone's business... until the child /individual is safe'
- A need to constructively challenge if response is inadequate – this is both within own and across agencies
- A need to raise awareness of the 4LSCB / 4LSAB Escalation procedures
- Key factor in promoting the welfare of our children and adults at risk

Good communication between agencies and with service users

- When decision making and care planning, practitioners should work with the family determine common goals
- Safeguarding / protection overrides data protection legislation
- Effective communication and healthy working relationships are important part of good multi-agency practice
- Clarity of lead professional role is needed
- Establish the roles and responsibilities of each professional involved.

The importance of the voice of the child

- Professionals must ensure they see the child face to face
- Teenagers should not elicit any less response than a younger child; their voice should be sought & heard

- The child's voice should not be over-shadowed by the parent or care giver. Where this is the case the practitioner should note is as a concern and seek to engage with the child alone. If this is not possible, this concern should be escalated.
- Practitioners should consider the daily lived experience of the child, ie the impact of abuse and neglect and the potential long-term significant harm.
- The practitioner should be alive to non-verbal means of communication, eg actions, reactions, or silence, or inability to engage with the child due to the parent or care giver.

Disguised Compliance & Hostile families

- Professional curiosity is key and professionals should be encouraged to triangulate findings to test a hypothesis.
- Cases show that intentional deception / control of professionals often exists where parents or care givers are minimising or denying abuse and neglect.
- In cases of disguised compliance and/or hostile families parents or care givers can display various levels of engagement with practitioners from different agencies, eg choosing to engage with one particular service to detract from a lack of engagement with another
- Professionals can become over optimistic about progress being achieved, delaying timely interventions for families
- Aggressive / intimidating family members can influence responses in that professionals become hesitate to engage with them, or only 'act on the positives' without challenging a lack of tangible progress for the child.

Intra familial Child Sexual Abuse (IFCSA)

- Awareness of indicators of risk and specialist responses is low
- IFCSA is not always apparent until disclosed and often other presenting factors (such as neglect) are noticed first
- Some children and young people may try and seek help indirectly e.g. unusual or challenging behaviour
- Children and young people may attempt to seek help in non-verbal ways
- Sexual abuse during childhood may be a risk factor for perpetrating IFCSA.
- Childhood Sexual Abuse is strongly associated with the following adverse outcomes in adulthood: physical health problems, including immediate impacts and long-term illness and disability poor mental health and wellbeing, externalising behaviours such as substance misuse, 'risky' sexual behaviours, and offending, difficulties in interpersonal relationships, socio-economic impacts, including lower levels of education and income, vulnerability to re-victimisation, both as a child and as an adult[9].

Impact of Neglect and Self-Neglect

- Children spend long periods of time subject to interventions from services with limited impact
- Early intervention is a key factor in reducing harm – long term impact = higher risk of harm
- The combined issues of domestic abuse, mental health and substance misuse together with neglect are interlinked and often coexist.
- Housing issues such as rent arrears and anti-social behaviour apparent in many neglect cases.
- There is a link between experience of neglect as a child and in adolescence and self-neglect as an adult.

Using history to inform current practice

[9] source https://www.csacentre.org.uk/research-publications/key-messages/intra-familial-csa/

- Existence of quality chronologies with clearly identified risk factors improves outcomes for child and adults these need to be more than a simple timeline – include qualitative information, analysis and narrative.
- The history of the family should be made available to multi-agency professionals so it can inform all levels of interventions and assessments.
- Need to include patterns or trends noticed for the family / individual. Include patterns of behaviour, crisis times and 'peaks' of risk to help predict and prevent future harm.
- Consideration should be given to include previous generational case/family history to form a holistic view.

Regular and effective supervision

- This is an area of repeat concern across agencies in our case reviews. Each agency should have:
    - A written policy for the supervision of staff working with children, young people and families which reflects LSCB supervision standards
    - A process for handling complaints and disagreements with regards to safeguarding supervision.
    - Safeguarding supervision provided by an appropriately experienced supervisor that is regular, planned with protected time & one-to-one or group basis.
    - A written agreement that explains the purpose, value and importance, the roles of the supervisor and supervisee should be agreed. A record of each supervision should be kept in line with the specific organisation's own supervision policy and/or agreed processes.
- Decisions relating to children, young people and families should be recorded (or cross-referenced) on the child/young person or family's case file or record. There is a duty to escalate the following concerns should they arise within safeguarding supervision discussion:
    - Child/family member may be at risk of significant harm.
    - There is unsafe practice placing people at risk.
    - There is illegal activity.

Non accidental injury / under two year olds

- Premature babies may be more vulnerable to abuse and neglect, also can present additional challenges for parents/carers to manage
- Professional optimism may lead to risks being underestimated
- Full and robust parental assessment / capacity assessment crucial in predicting risk of harm
- Professionals need to engage with all the adults in a baby's life, including fathers / partners
- Think whether the "risks" to the infant are being over shadowed by the parental needs, especially where vulnerable parents
- Need to recognise pre-existing patterns in parental / adults behaviour which may pose a risk to the baby.

Safe Sleep

- Safe sleep messages not heard and acted upon when delivered to some parents, particularly where there are additional needs or vulnerability
- Advice should be scaled according to parent's needs and targeted for those in 'high risk' groups (young, Child Protection history, premature babies...etc.)
- Professionals should consider sleeping arrangements in assessments and ask to see these when working with a family with a young baby.
- Risk of overlay increases when a parent sleeps on a sofa, armchair or airbed with a baby

- Increased risk of Sudden Infant Death Syndrome (SIDs)[10] if parents have been drinking alcohol or taking drugs
- Risks also increased if a baby is premature (born before 37 weeks), or has a low birth weight (less than 2.5kg or 5.5lb).

Future Reviews

In 2019-20 the LSCB anticipates there will be a number of Serious Case Reviews published. Recommendations and learning will feature in the Annual Report for that year. The Board is confident that next year's learning and resulting improvements to services will build on those made this year.

Child Death Overview Panel (CDOP)

In 2018/19, the 4LSCBs of Hampshire, Isle of Wight, Portsmouth and Southampton operated separate CDOP functions. During this year Southampton reviewed 48 child deaths. This number includes all child deaths, many of which were expected, for example due to illness. Overall 23% of the total of 4LSCB reviews were associated with one or more modifiable factors that may have contributed to the death of the child. The top five most frequent modifiable factors were smoking in pregnancy, smoking in the household, substance misuse, care of baby and co-sleeping. The themes will be taken forward are as follows:

Smoking	Smoking in pregnancy & in the household	• Smoking in pregnancy is associated with adverse outcomes for infants such a low birth weight – a known risk factor for infant mortality • Mothers from lower socio economic groups are more likely to smoke during pregnancy	• Focus on quitting smoking before or during pregnancy through tailored smoking cessation programmes for pregnant women, with targeted support in areas of greatest deprivation. • Greater concerted local action required to help reduce smoking in pregnancy to 6% or less by 2022 as per the Government's Tobacco Control Plan.
Maternal Health	Substance Misuse	• Maternal health is imperative to the health outcomes of children, particularly in the early years. • Substance misuse (ie taking drugs and alcohol), poor nutrition and obesity during pregnancy are associated with adverse outcomes for infants.	• Nationally, women should be supported from pre-conception through to the post natal period, for example by investing in the *Healthy Child Programme,* so that the programme begins prior to conception, extends home visits to beyond 2.5 years, and ensures that children/families receive continuity of care. • Locally, continue to engage clinical, social and public health to encourage women of reproductive age to adopt a healthy lifestyle, stop smoking, and achieve a healthy weight before conception.
Co-sleeping;	Co-sleeping; care of baby	-	• Continue to promote safe sleep messages and support the Lullaby Trust's annual awareness campaign. Ensure that all staff are fully aware of current policies and guidance and communicate the risks of unsafe sleeping with parents and families.

The CDOP arrangements for Southampton will change in line with new statutory guidance. There is a requirement within this that a CDOP operates with a minimum number of child deaths above the rate that Southampton experiences. This is to enable generation of themes according to modifiable factors, and as such it is likely that there will be a regional arrangement with Hampshire to enable the threshold to be met.

[10] Sudden infant death syndrome (SIDS) '*sometimes known as "cot death" – is the sudden, unexpected and unexplained death of an apparently healthy baby*'. https://www.nhs.uk/conditions/sudden-infant-death-syndrome-sids/

Engagement and Awareness Raising

The LSCB engages with the public, professionals and families throughout the year in a number of ways. This is to ensure that its work remains focussed on the issues that make a difference to those working with families and the children at the centre of its safeguarding activities. Public awareness raising takes place through engagement with public facing events and activities, including road shows, training vents and exhibitions as well as direct work via media and social media. During the year the LSCB delivered activities and awareness raising work to mark the following events:

- Maternal Mental Health
- Mental Health Week
- Foster Carer Fortnight
- Child Safety Week
- Clever Never Goes campaign
- Domestic Violence – Football World Cup Campaign
- Safer Sleep Week
- CSE Awareness Raising Week
- Safer Internet Day
- Young Carers Week
- Preventing Violent Extremism
- Love Don't Hate – Hate Crime Awareness
- Anti Bullying Week

The LSCB offers a thorough multi-agency training calendar of events, workshops and core training. This includes 2-hour 'weekly Wednesday workshops', which are learning and networking opportunities for staff and volunteers across sectors and disciplines to attend. These have had good attendance averaging 25 attendees per session. Topics covered include;

- Fabricated and induced illness
- County Lines drug supply and child criminal exploitation
- The role of Local Authority Designated Officer (LADO)
- Trafficking
- Safe Sleep
- Mental Health
- Fire Safety

In addition regular half-day sessions are held for topics of local and national interest to the multi-agency audience, these included:

- Introduction to Child Neglect
- Learning from Case Reviews
- Child Sexual Exploitation
- Harmful Cultural Practice; Female Genital Mutilation, Forced Marriage and HBV
- Domestic Abuse
- Substance Misuse

The LSCB works closely with the LSAB to provide a coordinated 'LSB' training offer. This enables a family approach to be taken via the training, and offers networking opportunities across the disciplines working with children and adults.

The LSCB also delivers regular 'Level 3' multi-agency safeguarding training. There are two days available and professionals can decide which is most appropriate for them. The days focus on 'Identifying Needs and Making a Referral' and 'The Child Protection Process'. This was a change from previous years when training lasted two days and it was felt that one day would be more time efficient for professionals, with the option to attend the day most appropriate for their learning needs.

Attendance at the events is generally good, but this can be affected by workload and prioritisation of the sessions. The LSCB is considering options to promote attendance.

Comments from evaluations include:

Inspiring and motivating trainer

Thank you, thought provoking

I understand the different services better

Very informative and engaging

Next Steps and Priorities for 2019-20

The recently announced changes to the safeguarding system set out in new Working Together guidance will be progressed in the early part of 2019-20. At the time of writing the LSCB has agreed to reform as the Southampton Safeguarding Children Partnership (SSCP) during 2019-20. In itself the transition to this arrangement will be a priority project for the partners. In addition, and following analysis of local learning themes and activities described in this report the LSCB has agreed to focus on priority areas as below under the new SSCP.

1. Child Neglect
2. Child Mental Health (Safeguarding)
3. Intra familial sexual abuse
4. Family Approach to safeguarding
5. Exploitation of children
6. Safe Sleep
7. Non accidental injury to under 2 year olds

Within the new partnership arrangements the LSCB (soon to be SSCP) has agreed to focus its work on ensuring 'learning into practice' is a key focus in all its activities. Where priorities are shared with other LSCBs in the Hampshire and Isle of Wight area, collectively to be known as the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Partnership, there will be joint focus and activities. Where priorities are key for Southampton only, the new SSCP will coordinate assurance and improvement work through a newly formed sub group to be known as the Safeguarding Practice Improvement Group (SPI Group) and the refreshed sub group coordinating activity in response to lessons learned in case reviews.

Priority	Lead	Timescale
Neglect	SSCP	Q1
Child Mental Health	SSCP	Q2
Intra familial Sexual Abuse	SSCP	Q3
Family Approach to safeguarding	HIPS	Q1-3
Child Exploitation	HIPS	Q1-4
Safe Sleep	HIPS	Q1-4
Non Accidental Injury	SSCP	Q1-4

For further details of new partnership arrangements and plans please see Southampton Safeguarding Children Partnership website.

Appendix 1: LSCB Finance

LSCB partners agreed to the following contributions to cover 2016 – 17:

Board Partner Agency	Contribution 2018-19
Southampton City Council	£82,200
Southampton City CCG	£34,196
Hampshire Constabulary	£13,482
National Probation Service	£2,757
Hampshire & IOW Community Rehabilitation Company	£1,348
CAFCASS	£445
Total:	**£134,428**

In addition to this, Board partners contributed a supplementary amount for learning and development, totalling £20,144. This funds the multi-agency Level 3 Working Together to Safeguard Level 3 Training and also to help contribute to specialist trainer costs and venues for specific courses and workshops as and when required.

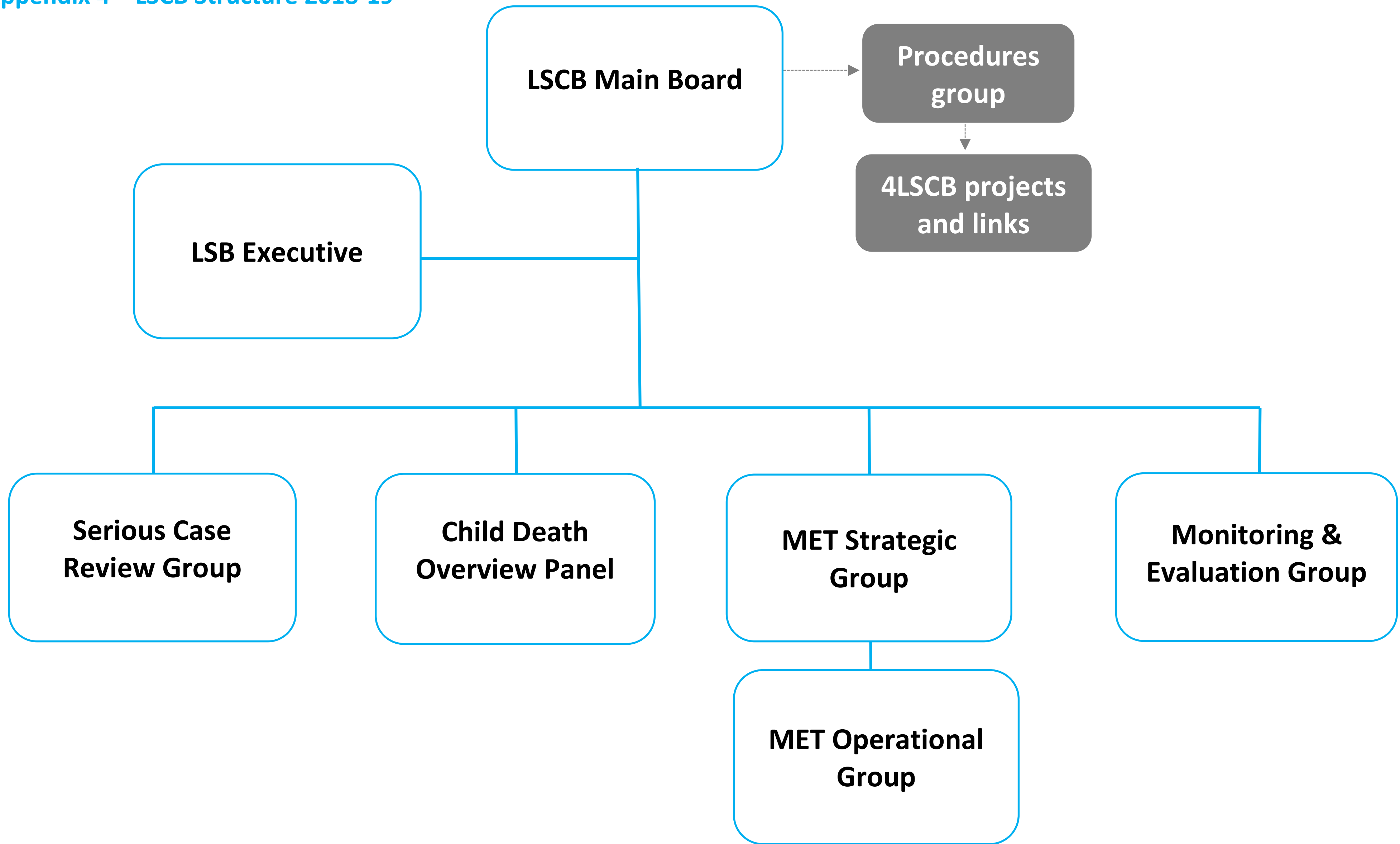
Appendix 2 LSCB Membership

Agency	Position
Independent Chair	Independent Chair
Southampton City Council	Director of Children and Families Director of Housing, Adults & Communities
Hampshire Constabulary	Chief Supt Public Protection
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
Primary School Rep	Primary Heads Conference Representative
Secondary School Rep	Secondary Schools Conference Representative
Special Schools Rep	Special Schools Conference Representative
Further Education Rep	Further Education Representative
Voluntary & Community Sector	SVS – Southampton Voluntary Services
Legal advisor	SCC Legal
Designated Health Professional	Designated Nurse & Designated Doctor
Principal Social Worker	Principal Social Worker
Director of Public Health	Consultant in Public Health
Lead Member for Children’s Services	Lead Member
LSCB Business Unit	Board Manager & Business Coordinator
LSCB Lay Member	Lay Member

Appendix 3 - Glossary

4LSCB	Joint working group LSCBs from Hampshire, Isle of Wight, Southampton, Portsmouth
CAFCASS	Children and Families Court Advisory Services
CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CPC	Child Protection Chair
CP/ CPP	Child Protection/ Child Protection Planning
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
CYP	Child and Young People
CYP's/CYP Report	Children and Young Peoples 'At Risk' Police Report
EHE	Elective Home Education
GP	General Practitioner
Hampshire CRC	Hampshire Crime Rehabilitation Company
HCC	Hampshire County Council
HFRS	Hampshire Fire and Rescue Service
HMI	Her Majesty's Inspectorate
HMPPS	Her Majesty's Prison and Probation Services
HRDA	High Risk Domestic Violence
ICPC	Initial Child Protection Conference
JTAI	Joint Area Targeted Inspection
LA	Local Authority
LAC	Looked After Child
LADO	Local Authority Designated Officer
MARAC	Multi Agency Risk Assessment Conference
MASH	Multiagency Safeguarding Hub
MET	Missing, Exploited and Trafficked
MSP	Making Safeguarding Personal
NEET	Not in Education, Employment or Training
NPS	National Probation Service
PIPPA	Prevention, Intervention and Public Protection Alliance
RSH	Royal South Hants Hospital
SAR	Safeguarding Adult Review
SCR	Serious Case Review
SCC	Southampton City Council
SCAS	South Central Ambulance Service
SHFT	Southern Health NHS Foundation Trust
Southampton City CCG	Southampton City clinical Commissioning Group
Southampton LSAB	Southampton Local Southampton Adults Board
Southampton LSCB	Southampton Local Safeguarding Children Board
SVS	Southampton Voluntary Services
Transition	Refers to a child / young person moving from children to adult services
UBB	Unborn Baby
UHS	University Hospital Southampton NHS Foundation Trust
YOS	Youth Offending Services

Appendix 4 – LSCB Structure 2018-19



Appendix 5 – Functions of the LSCB and its sub groups

The **Main Board** is attended by panel of senior officers from all safeguarding partners in the city. Together they form the core decision making body for the partnership and have a constitution, which details their responsibilities. Meeting runs quarterly.

The **Executive** incorporates Children's & Adults Boards. It is attended by senior representatives from the three key safeguarding partners (Police, Health & Council) plus the Independent Chairs of both Boards. The Executive plans for Main Board meetings, receives reports on progress from each of the Sub Group Chairs to monitor progress and also controls the budgets for each Board. Meeting runs quarterly.

The **Serious Case Review Group** receives referrals for reviews and determines whether they meet criteria for a Serious Case Review. The Group initiates and monitors delivery for Serious Case Reviews or Partnership Reviews where cases do not meet the criteria. It ensures that resultant learning is shared with partners to help prevent the circumstances occurring again and links with Child Death Overview Panel. Meetings run quarterly.

The **Child Death Overview Panel** reviews all child deaths and in order to identify learning and/or trends. Meeting runs quarterly.

The **Missing, Exploited and Trafficked Strategic Group** provides strategic guidance to the operational MET Group. It sets the MET Action Plan, focuses on issues including missing children, those at risk or involved in gangs, child criminal exploitation (including child sexual exploitation), and children at risk of or subject to trafficking or modern slavery. Receives the Problem Profile from Hampshire Constabulary and considers responses to highlighted problems. Meetings run quarterly.

The **MET Operational Group** meets bi-monthly to consider MET issues within Southampton and operational responses to these. It is attended by agencies including the Police, Children's Services, Voluntary Sector (including Barnardo's ICTA Service and No Limits) and Housing. Patterns, trends and areas of interest identified from the monthly MET case review are considered at this meeting. The MET case review meeting is held monthly and contributed to by key partner agencies to discuss intelligence and oversee local practice/responses to individual children who are at risk of exploitation, going missing from home or from care, as well as looking at perpetrator and location hotspot disruption.

The **Monitoring & Evaluation Group** delivers monitoring and evaluation activity to drive improvements in services to safeguard and promote the welfare of children and young people. It receives presentations on Section 11s, has oversight of multi-agency data, delivers thematic audits, and shares good practice. Meetings run quarterly.

The **4LSCB-coordinated work** includes 4LSCB Policy and Procedures Group and Project Management for the future coordination of 4LSCB work.