Dorset Council

Cabinet

Annual Safeguarding Report – Children's 2018-19

Date of Meeting: 10 December 2019

Portfolio Holder: Andrew Parry - Lead Member for Children's Services…

Executive Director: Sarah Parker, Executive Director – People Children

Executive Summary: This paper provides the Annual Safeguarding Report – Children's, which includes: Child Protection Conferences, an update on recent and ongoing Serious Case reviews, an update on the Safeguarding Children Partnership arrangements, Child Death Overview Panel, safeguarding oversight of unregistered placements and Child Exploitation.
Equalities Impact Assessment: There are no equalities implications arising from this report.
Budget: There are no budget implications.
Risk Assessment: This paper does not require a Risk Assessment.
Climate implications: None.
Other Implications: None
Recommendation: Members to consider and comment upon the adequacy of the plans/actions in the last section – 'Going Forward' to address the areas identified for improvement.
Reason for Recommendation: To be assured that plans are in place that identifies gaps and areas for development and will support practice improvement to strengthen outcomes for children.
Appendices: Appendix – Notes of the informal meeting of People Scrutiny on 20 November 2019.

Background Papers: None
Officer Contact: Name:Karen Elliott, Designated Safeguarding Manager Tel: Email: Karen.Elliott@dorsetcouncil.gov.uk

1. Safeguarding Children Partnership arrangements

1.1. Working Together to Safeguard Children 2018 introduces significant changes to multi agency safeguarding children arrangements and in particular replacing LSCBs with new safeguarding children partnerships. It names the lead representatives from each of the safeguarding partners as the local authority chief executive, the accountable officer of a clinical commissioning group, and a chief officer of police. They can delegate their functions although they retain accountability for any actions or decisions taken on behalf of their agency. It was agreed fairly early on that a Pan-Dorset Safeguarding Children Partnership (SCP) approach would be developed across the 2 newly formed unitary authorities and this went live on 1 August 2019.

1.2. The lead representatives identified the 4 following senior officers in their respective agencies who have responsibility and authority for ensuring full participation with these arrangements: Sarah Parker Executive Director of People – Children Dorset Council, Judith Ramsden Corporate Director of Children's Services BCP Council, Vanessa Read Director of Nursing and Quality Dorset CCG and Ben Hargreaves Chief Superintendent Dorset Police

1.3. The Pan-Dorset SCP will engage with other relevant partners on a regular basis to identify emerging safeguarding priorities and review impact of safeguarding arrangements including information sharing. The emerging priorities for the SCP that have been agreed are:

1.4. Contextual safeguarding which includes:

- On line safety
- Grooming
- Children who go missing
- Gang affiliation
- Child exploitation
- County Lines

Adolescents at risk which includes:

- Building resilience
- Complex case management
- Perception of knife crime

Parenting which includes:

- Parental substance misuse
- Early help
- Neglect

1.5. There are five subgroups that currently sit under the SCP which are: Safeguarding in Education, Strategic Training Group, Quality Assurance Group, the CAROLE Tactical Group and the Safeguarding Practice Review (formerly Serious Case Review) Group. In addition, there is a workstream developing the Learning Hub which will focus on neglect as its first priority.

1.6. The SCP aims to address safeguarding children priorities and improve outcomes for the safety and welfare of children and young people through a small number of task and finish groups. These will be co-ordinated with the work of other relevant strategic partnerships which have a role in safeguarding such as the Health and Wellbeing Board and the Community Safety Partnership. The links between them will be strengthened and so will be an area of focus for the SCP to consider.

2. Serious Case Reviews

2.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 set out the functions of LSCBs which included the requirement for LSCBs to undertake reviews of serious cases in specified circumstances – Serious Case Reviews (SCRs).

2.2 This changed with the new Working Together 2018 and the responsibilities of the newly formed SCPs together with new regulations - The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018; replacing Serious Case Reviews with National and Local Safeguarding Practice Reviews. This did not come into force until the SCP went live in August 2018, so the following all relate to Serious Case Reviews agreed under the old legislation.

2.3 A Serious Case Review (SCR) was a locally conducted multi-agency review in circumstances where a child had been abused or neglected, resulting in serious harm or death and there was cause for concern as to the way in which the relevant authority or persons had worked together to safeguard the child.

2.4 The purpose of an SCR was not to reinvestigate or apportion blame, but to establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.

2.5 For all SCRs, a multi-agency action plan is agreed, a Synopsis of Learning is published, and multi-agency training is provided for all practitioners.

2.6 In 2018/19 the following were either completed or published and the themes identified for learning are as follows:

- SCR 26 - Commissioned November 2017 and completed in June 2018 relating to a child killed in a road traffic accident whose mother was three times over the permitted alcohol limit.
  Learning - Use of escalation process, information sharing which includes domestic abuse forums and across borders, significance of engaging invisible fathers, substance misuse including functioning alcoholics and impact on children. Seeking and sharing information to inform assessments.
- SCR 31 - Commissioned October 2018 and completed in April 2019 relating to the death of a 16-year-old by ingesting illicit drugs who was a Looked After Child.

Learning - Management of high risk and complex adolescents including multi-agency management oversight, identification of the role of lead professional in each organisation to have that oversight. Data capture in relation to children who are missing, Return Home Interviews and cross boarder issues. IRO service and escalation process. Children who go missing form virtual school placements.

- SCR 22 was completed in November 2016 but not published until July 2018 relating to a 4-week-old baby who sustained serious injuries caused most likely by his stepfather.
  Learning – Referral Process, significance of bruising in non-mobile babies and the child protection and legal framework.

Current SCRs:

- SCR33 currently underway and is related to the death of a young child who had a chronic medical condition.
- SCR39 due to commence in November 2019 which relates to a teenager who died at home.

3 Child Death Overview Panel (CDOP)

3.1 CDOP in Dorset has been a Pan-Dorset function covering Dorset, Bournemouth and Poole reviewing all child deaths of children who live in the Pan- Dorset area. With the new Working Together 2018 requirements to cover a larger footprint in terms of number of deaths, the Pan-Dorset CDOP merged with Somerset's CDOP in July 2019.

3.2 Between April 2018 to March 2019 there were 25 notifications of children who died who reside in Bournemouth, Poole and Dorset. This is a reduction from the previous year when there were 34. 13 of these children lived in Dorset. Of the total 25 deaths, 13 were expected and 12 were unexpected.

3.3 CDOP is also required to assess the preventability of each death by considering whether there were factors which may have contributed to the death and if so, whether these could be 'modified' to reduce the risk of future deaths. During 2018/19 CDOP identified modifiable factors in 50% of those reviewed which was an increase from previous years and is higher than the national average. It is possible that this could be due to the growing expertise of the Panel who now provide more robust scrutiny.

3.4 The modifiable factors identified include the following:

- The impact of alcohol use continues to feature in deaths associated with road traffic collisions and SUDI presentations.
- Maternal smoking during pregnancy and smoking by family members in the household continues to be a factor in child mortality.
- Maternal obesity continues to be a factor identified in premature birth and neonatal mortality.

3.5 CDOP identify any emerging learning points and report to the DfE for national data gathering and the SCP for consideration of appropriate action. Typically, this might be the initiation of a public health awareness message, the launch of a specific campaign

or working with partner agencies to improve the effectiveness or quality of their processes or procedures.

4. Unregistered Placements for Looked After Children

4.1 Dorset have a high number of Looked After children compared to our comparators. As a result, as with a number of other local authorities, we are occasionally challenged by the lack of suitable placement availability for children with very complex needs.

4.2 Such placements are generally needed for children aged between 14 to 17 years old. Dorset have 2 council properties staffed by a small number of agencies commissioned by Dorset Council that are used as single placements in these circumstances. We are currently in the process of registering these placements with Ofsted. Occasionally when necessary Dorset also use rented accommodation such as holiday lets. In both circumstances the priority is to identify an appropriate registered placement as a matter of urgency. Any unregistered placements have to be agreed by the Corporate Director with a weekly report provided to the Executive Director, Manager for the IRO service, the Corporate Parenting Officer and on a monthly basis to Ofsted. A separate report is provided for the Corporate Parenting Board as a standing agenda item to ensure appropriate scrutiny and oversight.

4.3 To make sure that these placements meet the needs of the young people in the same way that a registered provider would, Dorset have implemented a series of monthly visits similar to 'Regulation 44 of the Children's Homes Regulations 2015' visits, as an additional safeguard. This requires an Independent Person to visit a children's residential home on a monthly basis to:

- Provide an opportunity for any child, parent or member of staff who wishes to meet the visitor (in private if they wish) to do so. (This links in with Standard 2 of the Quality Standards whereby the Visitor is ensuring that Children and Young People's wishes and feelings are heard).
- Check on the physical condition of the home.
- Form an opinion on the standard of care provided.
- Check the Daily log, Complaints record, Sanctions record and Restraint record.

4.4 The visits have been carried out by one of the Child Protection Chairs and the Residential Services Manager.

5. Exploitation and County Lines

5.1 In order to help identify, respond to and prevent the criminal exploitation of children a new model has been introduced in Dorset to ensure the needs of children at risk of, or linked to, exploitation are met through effective, protective, multi-agency plans that are put in place quickly. This model is called CAROLE which stands for **C**hildren **A**t **R**isk **O**f or **L**inked to **E**xploitation and is the way all partners in Dorset are working together at a strategic, tactical and operation level to improve the effectiveness of our multi-agency response to child exploitation.

5.2 The CAROLE multi agency Tactical Group uses data, intelligence and knowledge to make sure we can provide effective responses and that professionals who work directly with children have the tools to put a multi-agency plan in place which is regularly updated and is effective.

5.3 Professionals working with children are using the newly developed Child Exploitation toolkit in any instance where they are concerned that a child is being exploited through sexual or criminal means. The Screening Tool and Risk Assessment helps identify and evaluate the cause of the concerns to determine whether further safeguarding investigations are needed.

5.4 When an assessment identifies a significant or moderate risk, there is a moderation discussion with the Police and Health. The purpose is to 'moderate' the assessments that are completed by all agencies to ensure we have a good understanding of CE risk across the County and that the right services can be put in place quickly to respond to the assessed risk and to ensure a consistent approach.

5.5 A Multi Agency Child Exploitation (MACE) meeting then takes place within 15 days where more detailed multi agency information is shared, the risk assessment analysed, and actions are agreed. A plan put in place to reduce the risks. The plans produced at the MACE Meetings will consider actions required to 'prevent' an escalation of the risks identified, 'protect' the young person from ongoing exploitation, and 'pursue' those exploiting the young person to disrupt their activity. MACE Plans are effective in managing risk through an understanding, and response to, young people's experiences of significant harm beyond their families, by recognising that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. The multi-agency planning, and contextual safeguarding works alongside whole family, relationship-based work with parents, carers and extended family to ensure children are protected within and outside of their homes.

6. Child Protection Plans

6.1 Where safeguarding concerns have been identified about a child, a Strategy Discussion will take place with police and other relevant agencies and a decision is made about whether section 47 enquiries need to take place. If the section 47 enquiries conclude that concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm a child protection conference is be convened.

6.2 The timing of the conference should depend on the urgency of the situation and respond to the needs of the child and the nature and severity of the harm they may be facing.' Working Together to Safeguard Children' states that it should take place within 15 working days of a Strategy Discussion, or the Strategy Discussion at which section 47 enquiries were initiated if more than one has been held.

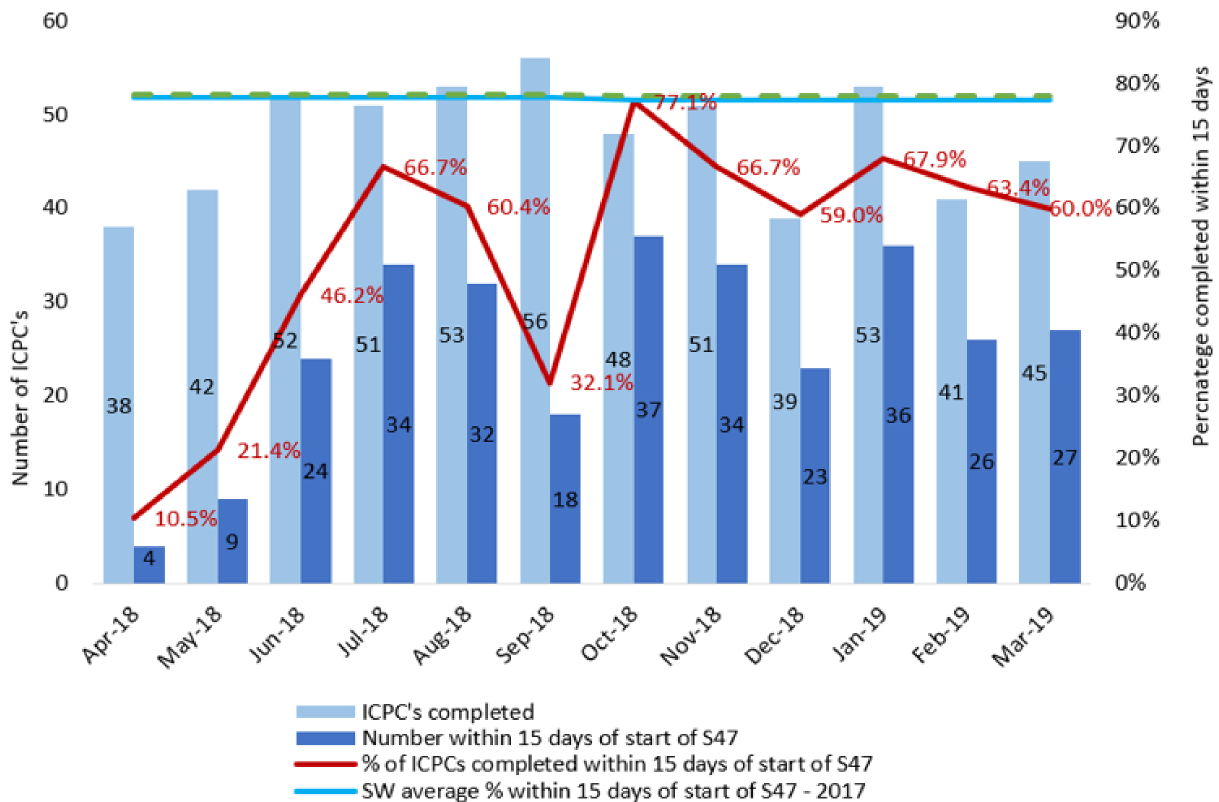
6.3 The conference is a multi-agency meeting with professionals who know the child where a decision is made as to whether a multi-agency Child Protection (CP) plan is required to safeguard the child.

6.4 The table below shows the number of children who were the subject of a conference alongside the number of conferences which have taken place during the year. Some conferences will consider sibling groups and not all conferences result in a child becoming subject to a CP Plan and

April 2018 to March 2019	Number of children conferenced	Number of conferences
ICPC	569	276
RCPC	879	436
Total	1448	712

6.5 As detailed above, Working Together states that a conference should take place within 15 working days of a Strategy Discussion. The table below details the timeliness of this performance indicator per child.

Timliness of Initial Child Protection Conferences (ICPC)s



6.6 In April 2018 there were sickness and recruitment issues within the business support team (ICRS) who arrange all conferences reducing their capacity to respond to requests immediately which accounts for the very poor performance of only 10.5%. However, this does not account for the generally poor performance overall which is more usually due to information being provided late to ICRS by the social work teams.

6.7 Timeliness continues to be an issue and is due to a combination of late notification to ICRS and social work teams not providing the required information within the agreed timescales. There are occasions when there is not a room or CP Chair available, but this is not significant. Each conference which is likely to be late is highlighted to the senior manager for their information and avoiding action where possible, and escalated to the Designated Safeguarding Manger.

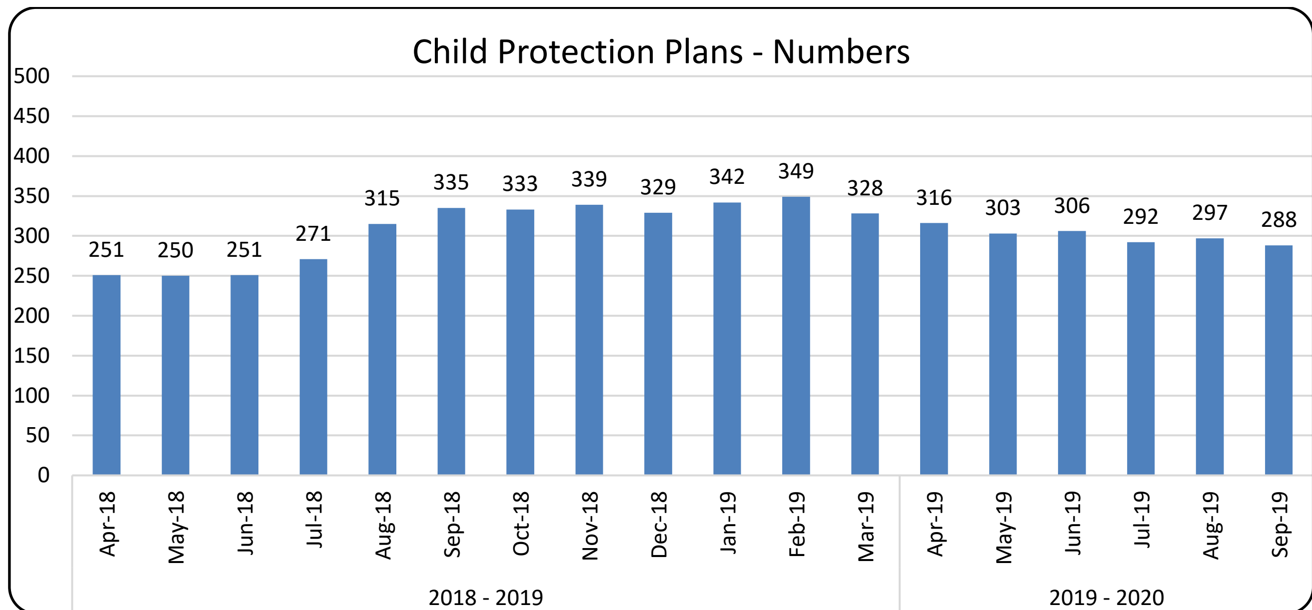
6.8 It was agreed in October 2018 that because of poor conference attendance by partner agencies (quoracy) due to the short notice provided, that we would always give them 5 working days' notice for an Initial Child Protection Conference (ICPC). This has ensured that quoracy generally remains high which enables effective and improved multi agency decision making but has impacted on timeliness.

6.9 The lack of health information for school age children has been generally very poor so was perused through the DSCB which resulted in the CCG recruiting 2 Specialist Safeguarding Nurses in April 2019. This is already having a significant impact on the

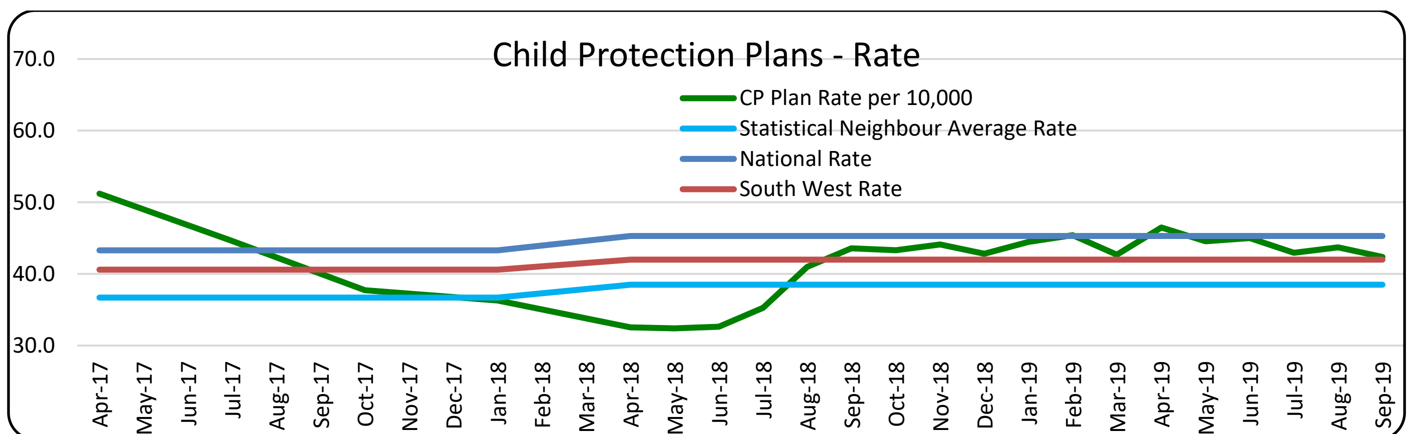
contribution of health for school age children at conferences. They are also supporting the work being undertaken with GPs due to a very poor response rate to requests for reports for conferences.

6.10 At the end of March 2019 there were 328 children subject to a Child Protection (CP Plan) in Dorset.

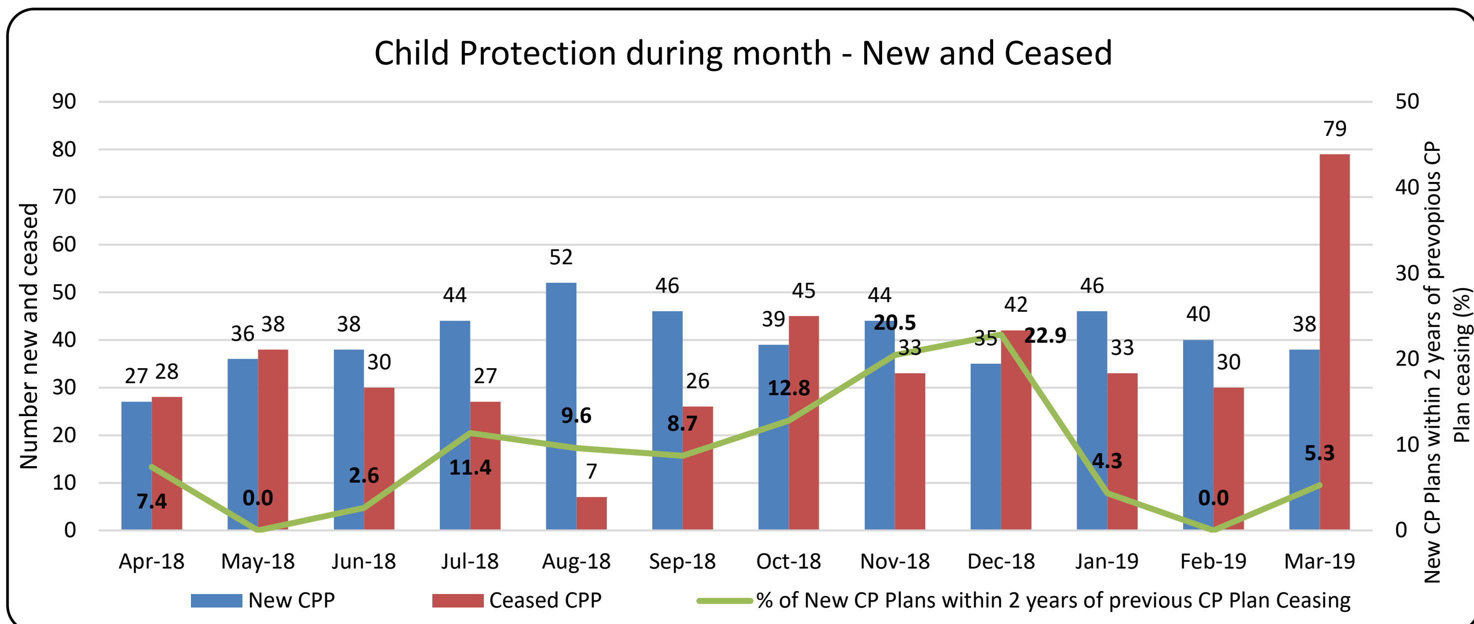
6.11 The table below shows the number of children subject to a CP Plan over 2018-2019 peaking in February 2019 and then reducing and continuing with a downward trend to date.



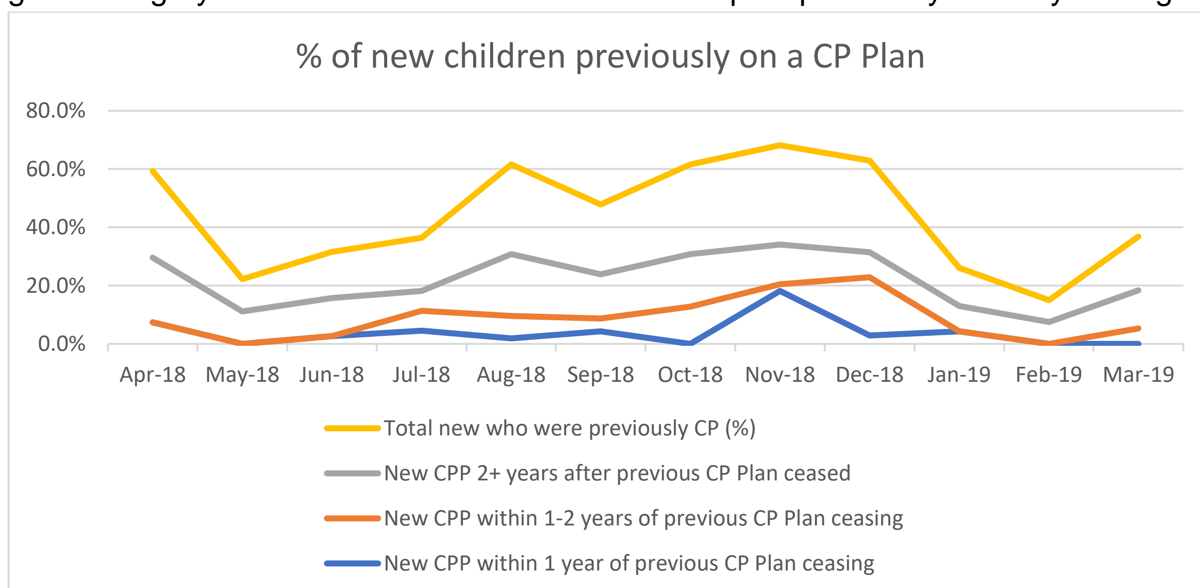
6.12 The rate detailed below shows a very low rate in April 2018, rising and levelling off in September 2018 to generally remain between the south west and statistical neighbour rate. The small peak in April 2019 was most likely due to the formation of the two new unitary authorities with the immediate loss of 22 children subject to a CP Plan who lived in Christchurch.



6.13 The table below details the number of new and ceased plans each month with the grey line detailing the percentage of those new CP Plans within 2 years of a previous CP Plan ending.



6.14 The table below details the percentage of new children being made subject to a CP plan again. The grey line shows most of these were on a plan previously over 2 years ago.



6.15 Some analysis of this took place by an external auditor who looked at children made subject to a CP plan for a second time between September 2018 and January 2019. Of those children (55):

- 24% had been the subject of a CP plan within the previous 12 months.
- 27% had been the subject of a CP plan within the previous 1-2 years.
- 49% had been the subject of a CP plan over 2 or more years ago.

6.16 Overall 64% of all repeat CP plans were as a direct or indirect result of the risk posed by domestic abuse to the children in the family. Over 60 % featured parental substance misuse in the form of either drugs or alcohol (or both) and 47% featured poor maternal mental health, often where abusive relationships had been present.

6.17 The general themes identified included:

- a lack of evidence of effective tools/measures being used to support both identification and assessment of domestic abuse, neglect and substance misuse.

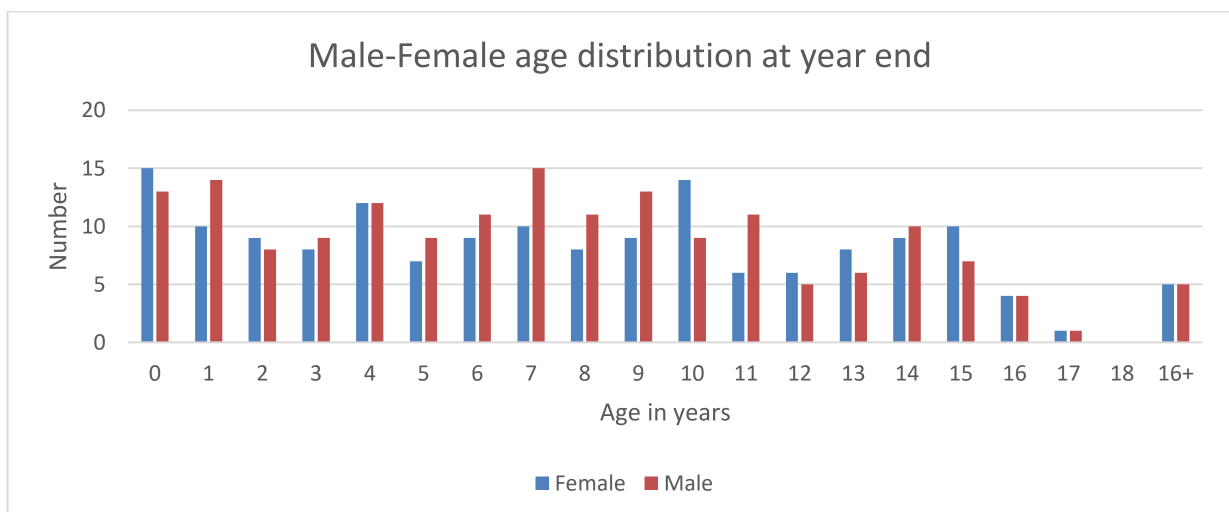
- evidence of patterns of behaviours in parenting recurring throughout children's lives with no effective change and sometimes a lack of professional curiosity as to why this may be and/or consideration as to the cycle of change.
- inconsistency in the understanding in relation to the typologies and therefore dynamics of domestic abuse, particularly in relation to Coercive Control.
- a lack of intervention/programmes available for families who want to stay together where there is domestic abuse.
- at times there is a reliance on separation and/or no further physical incidents in judging whether the risk is reduced. This approach does not consider that the risk often increases at separation and this may also lead to disguised compliance in families.
- In relation to Neglect, there is minimal evidence of the use of home conditions scale or graded care tool to develop targeted plans or measure effectiveness.

6.18 Other themes identified were similar to those identified and continue to be identified in the monthly managers audits such as drift and delay, poor CiN planning, frequency of supervision and outline CP plans not always translated into detailed and focussed plans at core groups.

6.19 This report was referenced in the monthly managers audit report shared with all managers for reflection and discussion with their teams.

6.20 The development of a 'Dashboard' in July 2019 for managers and CP Chairs, facilitates the ability for closer monitoring and scrutiny of certain indicators - Repeat CP Plans, duration of CP Plans and statutory visits. This will support the quality assurance function of the CP Chairs to help identify where they need to concentrate their efforts.

6.21 At the end of March 2019 there were 13 more boys than girls subject to a CP Plan; the table below illustrates the distribution through all ages.

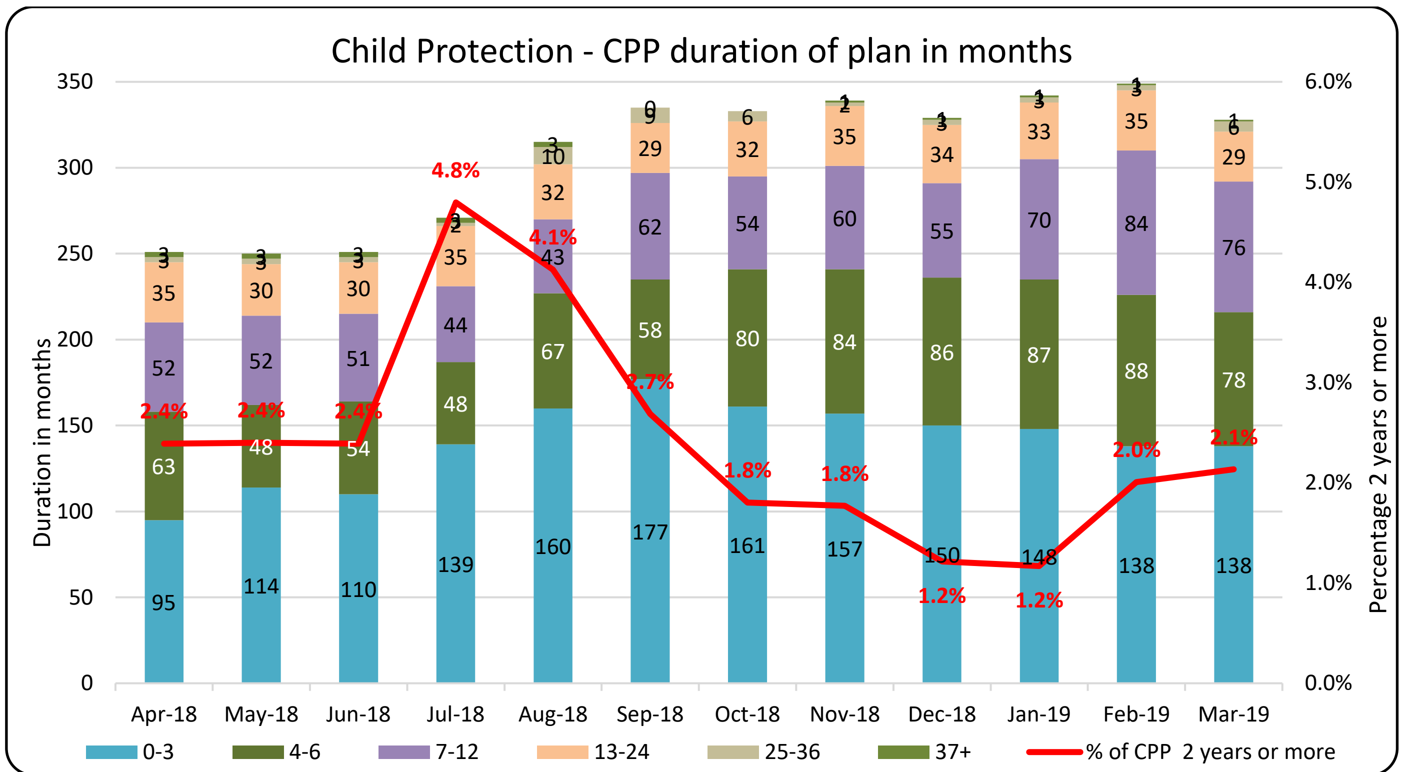


6.22 The age range where there are more boys subject to a CP plan is between the ages of 5 and 9 years old which roughly correlates with an increased number of boys Looked After for this age group which needs further exploration.

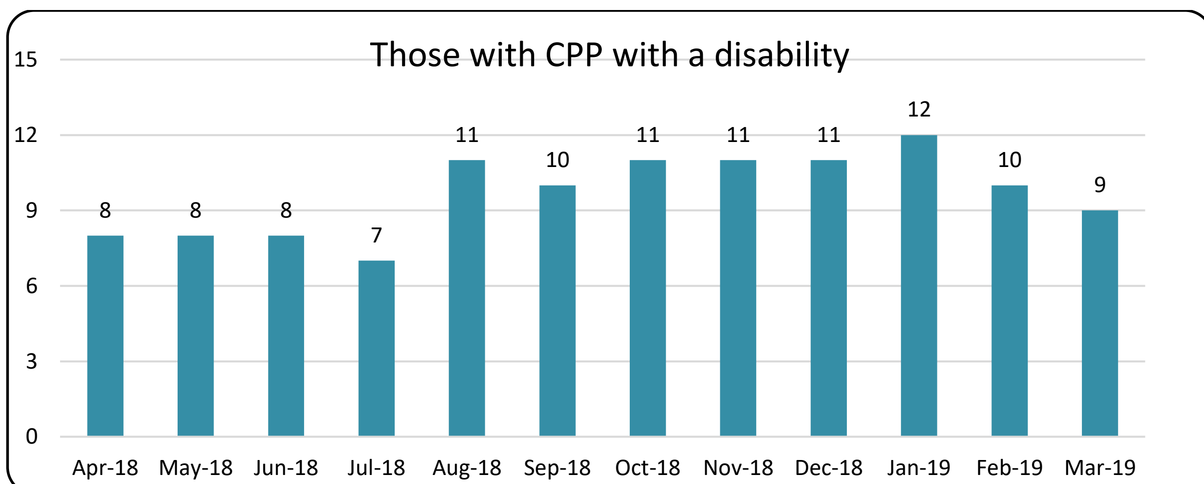
6.23 Overwhelmingly the ethnicity of children subject to a CP Plan at the end of March 2019 was White British (72%). Concerningly 22% had either nothing recorded or had 'not

stated' as recorded. This changed dramatically in September due to a concerted effort to update demographics to specifically include ethnicity because Dorset had been notified of the visit by Ofsted. It is likely that had Ofsted not been visiting this level of poor recording of ethnicity would likely have continued.

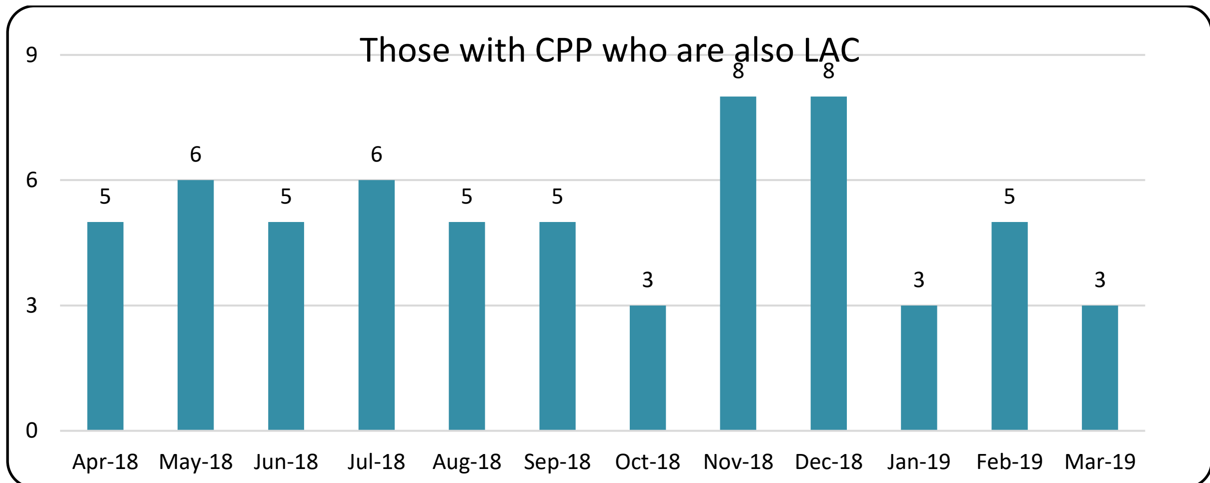
6.24 The table below shows the duration of child protection plans with the red line detailing the overall percentage of those currently on a CP Plan for 2 years or more. At the end of March 2019, it had reduced to 2.1%. There was one child that has been on a CP Plan for longer than 3 years but was de planned in April 2019.



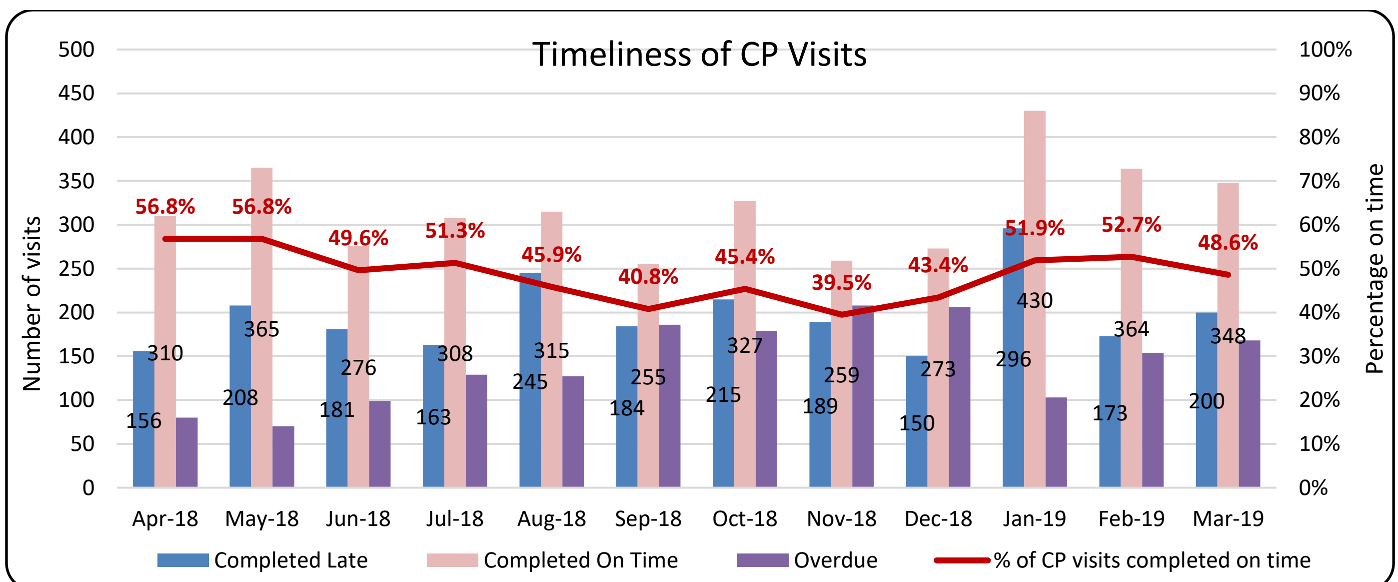
6.25 The below table details those children on a CP Plan who have a disability recorded on mosaic. This does not accurately reflect a true picture and numbers are likely to be more because we know that disabilities are not always recorded properly on mosaic by the social workers.



6.26 The table below details those children at the end of each month who were also looked after. Children and their families should not be subjected to two processes running alongside each other particularly when in the court arena as they are safeguarded and monitored by other means appropriately. These numbers should remain low and there is a continued focus on these children, but some managers at times are reluctant to agree to de planning. Where this is an issue it is raised with a more senior manager for their action



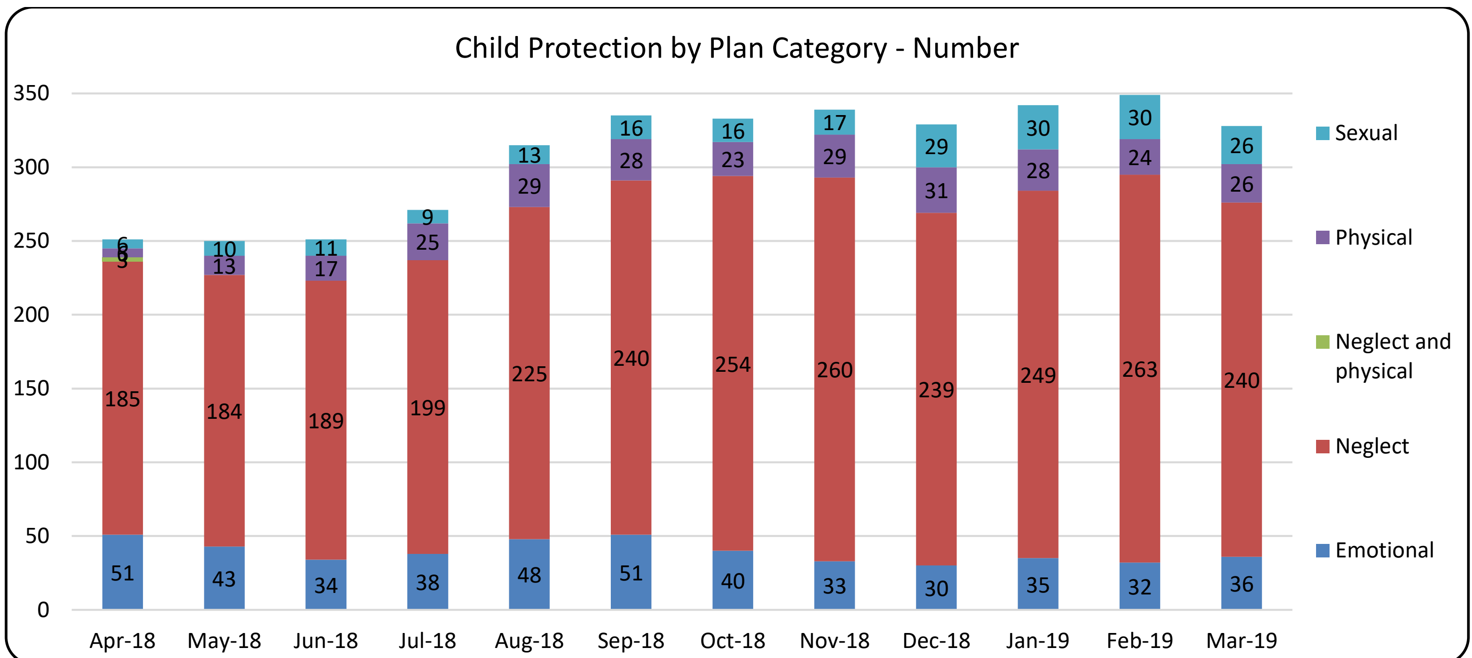
6.27 The table below shows timeliness of Child Protection visits with the red line detailing the percentage of visits completed on time. There has been a continued focus on this indicator with a Management Instruction Note issued and reporting on this in the monthly audit report which unfortunately has had little or no impact. This is further complicated by the way that mosaic records calendar days, not weekly or fortnightly. This has caused significant confusion for social workers who do not fully understand why if they visit one week and then the next week, they are still advised that the visit is late.



6.28 Further analysis of this indicator more recently shows that most visits that are now recorded as being late are generally only between 1-3 days late. There is now work being undertaken with the mosaic team to be able to more accurately record weekly and fortnightly in mosaic

which will mean that if children are visited in the correct week, they will not be counted as late.

6.29 The table below indicates the category of abuse.



6.30 ‘Neglect’ is by far the most used category which is due to the inclusion of children who are witnessing or hearing domestic abuse being included. This is because there is a view that their parents or carers are neglecting to protect them from the potential emotional harm from the presence of domestic abuse in the home and are therefore not categorised under ‘Emotional’. This accounts for a higher percentage of ‘Neglect’ and a lower percentage of ‘Emotional’ categories used than our comparators. Otherwise the differences are broadly similar to our comparators.

6.31 Referrals to the Advocacy Service for children being conferenced was extremely poor during 2018/19 despite CP Chairs asking the question during the conference and raising this with managers. In view of this and there being a similar problem for looked after children in their LAC Reviews an ‘Opt out’ process was agreed for all children aged over 8 years old. This was implemented in April 2019 and has increased both the referral rate and subsequent offer of an advocate for all children aged 8 or over for children being conferenced which is very positive.

6.32 Previously minutes of conferences were being handed to the allocated social worker with the agreement that they would take these and go through them with families. Rarely was there any evidence of this taking place and on many occasions, families told us that they had never had them. We subsequently implemented a safe way of emailing these to families to help them better understand why decisions had been made and what was expected of them to make their children safer. Feedback from families has been very positive.

6.33 Regular team meetings take place with CP Chairs and the business support staff who support the conference function where our performance data is scrutinised and ideas for improvements and developments are discussed and acted upon.

7. Going Forward

7.1 We recognise that the current format for holding conferences in Dorset needs to change to improve outcomes for children. Initial work was carried out following consultation with Essex with some basic changes being made but further changes were put on hold due to a change in the strategic direction of children's services overall. A workshop is now being facilitated under the Blueprint for Change with the CP Chairs together with the IROs on 12 November 2019 to look at what we can do more of and better, to support and improve outcomes for children and in particular looking at the child's whole journey.

7.2 The following are areas identified for improvement with some already having taken place since April 2019

- Strengthen the QA role of the CP Chair further to reduce drift and delay.
- Strengthen the escalation process to include tracking centrally to target where we can make more of a difference.
- Enhance the tracking of distribution of Cards designed by children for children to support their understanding of 'what is going on' and to be able to better hear their voice.
- Develop a mosaic monitoring form for each CP Conference that is currently tracked manually.
- Work with the mosaic team to identify and record what factors that impact on parenting are present for families whose children are conferenced to inform practice and learning.
- Develop a midway brief review by the CP Chair to reduce drift and delay and highlight any concerns at the earliest opportunity.
- CP Chairs to become part of the managers who moderate audits to raise their profile and support their role as consultant experts.
- Exploration of a whole authority response to parental issues such as domestic abuse, substance misuse and parental mental health given its prevalence in families where children are subject to a CP Plan.