Wandsworth Safeguarding Children Board
Annual Report 2017-2018
As the Independent Chair of the Wandsworth Safeguarding Children Board (WSCB) I am pleased to present the Annual Report for the period April 2017 to March 2018. Local Safeguarding Children Boards (LSCBs) were established with the purpose of ensuring that agencies keep local children and young people safe and that where they have intervened they have made a positive difference in children’s lives. The WSCB has a really important role in coordinating and ensuring the effectiveness of what is done by each and every person involved in protecting children and it carries statutory responsibilities for safeguarding children in Wandsworth. It is made up of senior managers within organisations in Wandsworth who hold responsibility for safeguarding children in their agencies, such as children's social care, police, health, schools and other services including voluntary bodies. The WSCB monitors how they all work together to provide services for children and ensure children are protected.

The last year has seen the draft Working Together to Safeguard Children guidance published and consulted upon. We await the final publication of this document, which is anticipated in July 2018, which will influence and govern what new Multi-agency Safeguarding Arrangements will replace LSCBs by the Autumn 2019. With reduced capacity in many of the agencies due to reorganisation, we are looking at how we can reduce duplication and join up with other partnership groups and across boundaries as much as possible, with a real focus on making a difference to front line practice to safeguard children. Our challenge over the next year will be to ensure that replacing the WSCB with the new arrangements, is done carefully and builds on what we know works well. The next year will be challenging for all agencies and we will need to ensure the focus and delivery of services to vulnerable children, young people and families is not adversely affected.

Lastly, I would like to thank the Board staff, for their continued support in the smooth functioning and promotion of the WSCB. I would also like to thank members of the Board, from across the partnership of our voluntary, community and statutory services and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people safer in Wandsworth.

Nicky Pace, WSCB Independent Chair
1. How effective is the WSCB in improving the safety of children in Wandsworth? ................................................................. 7
2. Snapshot of Safeguarding in Wandsworth 2017-2018 ........................................................................................................... 8
3. WSCB Priorities 2017-2018, Progress ........................................................................................................................................ 10
   3.1 WSCB Activity .................................................................................................................................................................... 11
   Priority 1. Early Help ................................................................................................................................................................. 122
      Early Help/IPOC ...................................................................................................................................................................... 122
   Priority 2. Children and young people ........................................................................................................................................ 15
      Going missing from care, education and home ...................................................................................................................... 155
      Child Sexual Exploitation ....................................................................................................................................................... 155
      Radicalisation/ Prevent ............................................................................................................................................................... 155
      Self-harming behaviour .............................................................................................................................................................. 16
      Involvement in gangs .................................................................................................................................................................. 17
      Children with disabilities and special educational needs ..................................................................................................... 18
      Female genital mutilation ............................................................................................................................................................ 200
      Honour Based Violence/ Forced Marriage ............................................................................................................................ 211
      Involving young people ............................................................................................................................................................... 211
   Priority 3. Neglect ........................................................................................................................................................................ 211
      Domestic abuse ......................................................................................................................................................................... 211
   Priority 4. Children living away from their parents: .................................................................................................................. 24
      Children Looked After ............................................................................................................................................................... 24
      Privately fostered children .......................................................................................................................................................... 24
      Young people in custody ............................................................................................................................................................. 24
4. WSCB priorities for 2018-2019 ........................................................................................................ 25
5. Governance & Accountability ................................................................................................. 26
  5.1 Monitoring Sub-Committee .............................................................................................. 28
  5.2 The Serious Cases Improvement and Learning Sub-Committee .................................... 29
  5.3 Child Death Overview Panel .......................................................................................... 31
  5.4 Training and Workforce Sub-Committee .......................................................................... 35
6. Responsibility of the WSCB in relation to other strategic groups/boards ............................ 36
7. Communication and Publicity .............................................................................................. 37
  7.1 Newsletters and review of leaflets .................................................................................. 37
  7.2 Website ............................................................................................................................ 37
  7.3 Safeguarding Community Event 2017-2018 .................................................................... 37
8. Statutory reporting .................................................................................................................. 38
  8.1 Multi-agency safeguarding training delivery ..................................................................... 38
    Training attendee evaluation and impact ............................................................................. 40
    Training event participants evaluation .............................................................................. 40
    How we learned from the Data ....................................................................................... 40
    Learning from Experience and Annual Conference .......................................................... 41

  8.2 LADO (Local Authority Designated Officer) – allegations against staff ......................... 41
  8.3 Private Fostering .............................................................................................................. 44
  8.4 Children missing from home, care and education ............................................................. 45
    8.5 Child Sexual Exploitation (CSE) .................................................................................. 52
    8.5.1 Prevalence of sexual exploitation .............................................................................. 53
8.6 Child Protection information ........................................................................................................................................55
8.7 Children Looked After ..................................................................................................................................................60

9. Learning and improvement ........................................................................................................................................62
9.1 Multi Agency Audits & Reviews ...............................................................................................................................62
   IPOC/ MASH and Referral & Assessment Audit ..........................................................................................................62
   Private Fostering Audit ..................................................................................................................................................66

Section 11 ........................................................................................................................................................................68
   Practitioners’ Survey ..................................................................................................................................................69
   Strategic survey .........................................................................................................................................................73

Case reviews .................................................................................................................................................................77
   Serious case reviews ................................................................................................................................................77

10. WSCB dataset and performance management .........................................................................................................80
    Revised Dataset for 2017-2018: ......................................................................................................................................80
    Partner Agency Reports ..............................................................................................................................................83
Contents  APPENDICES (Published separately)

Appendix 1 - Glossary ........................................................................................................................................ Error! Bookmark not defined. 4


Appendix 3 – Wandsworth Borough Council - Children Service Reports ........................................................................ 6

Appendix 4 – Wandsworth Borough Council - Adults Services Report ........................................................................... 13

Appendix 5 – Wandsworth Borough Police Report ...................................................................................................... 16

Appendix 6 – Wandsworth Clinical Commissioning Group (CCG) Report ...................................................................... 20

Appendix 7 - St George's University Hospital Trust .................................................................................................... 24

Appendix 8 – Central London Community Health Report ............................................................................................... 25

Appendix 9 – Wandsworth Child Death Overview Panel (CDOP) Annual Report ............................................................ 26

Appendix 10 - Wandsworth Borough National Probation ............................................................................................... 28

Appendix 11 - Wandsworth Local Authority Designated Officer (LADO) Individual agency’s contribution to WSCB Annual Report ........................................................................................................ 30

Appendix 12 – WSCB Business Plan report 2017-2018 ................................................................................................. 31
1. How effective is the WSCB in improving the safety of children in Wandsworth?

This Annual report highlights progress and improvements across the partnership over the past year and evidences both joint working and single agency focus on safeguarding and promoting the welfare of our children and young people in Wandsworth. The report comments on the key areas of statutory responsibility of the Board, such as the work of the Child Death Overview Panel (CDOP), Multi-Agency Training, Private Fostering and allegations against professionals and the work of the LADO (Local Authority Designated Officer).

The Board has regularly reviewed the performance of professionals working with children through its programme of Multi-Agency audits and by examining the results of single agency audit work. During the last year, multi-agency audits have examined progress on cases and commissioned audits on the front door / Initial point of contact (IPOC) and Private fostering.

In addition to its audit work, the Board identifies ways to improve through its reviews of individual cases, including Serious Case Reviews (SCRs) and learning reviews. A Serious Case Review was initiated by the Board in July 2016 and a report completed in April 2017. For legal reasons it cannot yet be published, but the WSCB already disseminated the learning identified with partners and Learning from Experience Event was held on 26th June 2017 to pick up on initial learnings, including a revised Pre-Birth Assessment tool for practitioners. Training Courses have been delivered about (Vulnerable Babies, Vulnerable Parents – Serious Case Review (SCR) Practice and five Learning Briefing during September and October 2017. These were well received by professionals attended.

The Board has continued to review its processes for undertaking Section 11 audits in the last year. Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others are discharged having regard to the need to safeguard and promote the welfare of children. The S11 self-assessment questionnaires designed by the WSCB are the key tools being used by the Board to assess and monitor whether staff in all agencies are able to properly identify and safeguard children. It gives the board the opportunity to understand how well front line staff understand safeguarding across the partnership.

The Board has worked on developing and confirming its dataset over the last year to ensure we have the right information and data to measure activity, but more importantly identify where there are areas of concern about performance or practice in individual agencies. The data has enabled the board to focus on areas of multi-agency practice and the impact on safeguarding children. The WSCB dataset has been under revision, with the aim of streamlining the number of indicators and enabling more emphasis on commentary, analysis and narrative.

This Annual report covers the work of all the WSCB Sub-Committees of the Board and the activity over the last year. The report comments on the key areas of statutory responsibility of the Board, such as the work of the Child Death Overview Panel (CDOP), Multi-Agency Training, Private Fostering and allegations against professionals and the work of the LADO (Local Authority Designated Officer).
2. Snapshot of Safeguarding in Wandsworth 2017-2018

- **67,100 children live in Wandsworth (including 18 year olds)**
- **1295 families received early help support below the threshold for social care**
- **307 children were looked after at March 2018, compared to 289 at March 2017**
- **7,227 individual practitioners completed S11 Self-Assessment Questionnaire in 2018**

- **The average caseload for Children Service social workers is 16 across all teams**
- **There were 207 S47 assessments per 10,000 population – a decrease of over 30% from 2016-17**
- **There were 288 children on Child Protection Plans at March 2018 - reduced from 415 in 2017 - 18**
- **From January 2018 Wandsworth Health visiting service is provided by CLCH**

- **There were 47 children missing from education at March 2018**
- **The average time for a child to be placed for adoption was 594 days at March 2018**
- **There were 134 referrals to MARAC had children in the family; 50 re-referrals involved children**
- **There were four Privately fostered children at 31st March 2018 - one less than at 31st March 2017**

- **9261 contacts were received in Children’s Services**
- **22% of children looked after throughout the year were reported as missing**
- **29 referrals made to SEMAP during 2017-18, the number reduced due to a new system**
- **77% of all missing children were offered a return home interview**
The JSNA for the Wandsworth Health and Wellbeing Board has produced a very useful graphic (based on mainly 2017 data):

**The Needs (1)**

**Place**

- **10 Wandsworth Primary schools** are in areas that exceed the legal air pollution limits.

- **Housing estates** cover 10% of the area of the borough, and social housing accounts for 19% of property.

- Almost **a third (32%) of residents** rent privately, which is higher than the inner London average (29%).

**Start well**

- **10,385 children in low income families**

- **1 in 3 children leaving primary school aged 10-11 years were overweight or obese**

- **129% of 15 year olds** partake in 3 or more risky behaviors

- A significantly lower percentage of children have received their first dose of **MMR immunisation** by the age of two compared to England

- **1 in 4 children aged 5 have one or more decayed, filled or missing teeth**

- **14%** the percentage point gap in attaining a good level of development at the end of reception for children with free school meals, which widens to 24% by key stage 2
3. SCB Priorities 2017-2018 - progress

The Board is required to report on progress against its priorities, look forward and plan any changes to the safeguarding priorities for the local area for the next year. We have taken into account national priorities and local needs, findings and recommendations from the inspection and any issues arising from SCRs and multi-agency audits. When deciding our priorities, we acknowledge that our core business of safeguarding children is ongoing, including identifying, assessing and provided services and help to those children who need protection. In deciding the Board’s improvement priorities, we consider how well we have delivered our priorities from the previous year and if further work is needed.

WSCB’s key priority areas for 2016-18:

1. Early Help
   - Ensure services provide appropriate early help and intervention, consistent application of thresholds between preventative, targeted and specialist services and monitor the effectiveness of the Multi-agency Safeguarding Hub (MASH).

2. Children and Young People
   - Address the challenges and risks faced by vulnerable children and young people, in particular:
     - Going missing from care, education and home
     - Child Sexual Exploitation
     - Radicalisation
     - Self-harming behaviour
     - Involvement in gangs
     - Children with disabilities and special educational needs
     - Female genital mutilation
     - Honour Based Violence
     - Substance misuse

3. Neglect
   - Ensure that the issue of neglect receives due prominence in assessment, prevention and intervention work especially where there are concerns of
     - Domestic abuse,
     - Parental mental health
     - Substance misuse

4. Children living away from their parents
   - Ensure children not living at home are safe, receive high quality support to achieve better outcomes, which includes:
     - Children Looked After
     - Privately fostered children,
     - ‘Sofa surfing’
     - Unaccompanied minors
     - Young people in custody

When deciding priorities the Board recognised that the areas identified would require a two year work plan at least to make the necessary improvements.

The Board recognises that continues to use opportunities to meet with and hear from young people through mechanisms such as the Children in Care council (CLICK).
The key priority areas were agreed for 2017-2018 as:

- Early help
- Children and Young People
- Neglect
- Children living away from their parents

The Board previously decided to add some overarching core values that sit over our key priority areas for 2017-18. These are a direct result of the inspection of children’s services and capture some of our key areas for continuing development. Safeguarding children and young people are at the heart of what we do and our core values are:

- Effective child protection practice across all agencies
- Recognising and responding to diversity & equality
- The child is at the centre of everything we do
- Sharing information appropriately

There is a strong focus on improving practice to reduce risk and secure better outcomes for children. Agencies are not complacent and recognise where there is a need to improve systems and processes to ensure more consistent, safer and effective practice. The full report gives a detailed picture of how all partner agencies have worked together in the last year.

3.1 WSCB Activity

The WSCB has undertaken development work, encouraged and monitored partners under the range of agreed priority listed above, led by the Monitoring Sub-Committee and the Independent Chair.
Priority [1]. Early Help: Ensure services provide appropriate early help and intervention, consistent application of thresholds between preventative, targeted and specialist services and monitor the effectiveness of the Initial Point of Contact (IPOC).

Early Help / IPOC:
The Initial Point of Contact is the Local Authority’s first point of contact for safeguarding concerns. The model brings together a range of partners into a multi-agency team that is able to share information quickly and efficiently as soon as notification of possible harm to a child is received. Risk is assessed by making evidence-based decisions that take into account the information gathered and the risk assessment of each agency. The IPOC is located in the Front Door Service which also include the Referral and Assessment Service (RAS) alongside the Assessment Teams. IPOC is part of the ‘Front Door’ to Children’s Social Care.
IPOC was introduced by Wandsworth Children Service to improve the outcomes for Children and Young People. IPOC triage all the contacts received in a timely manner, allocate to social workers who will gather information about the family, risk assess and complete the Sign of Safety exercise to inform the decisions made.

A Manager in IPOC review the case mapping to have an oversight to make a final decision whether the threshold is met/ unmet and whether to Step the case down to Early Help or escalate it to MASH to undertake multiagency checks or to allocate to the appropriate Teams.

Since the establishment of IPOC, there has been a Multi-Agency Audit commissioned on 1st January 2018, a report has been produced on 17th February 2018, the Audit covered the work of the Front Door and assessed the effectiveness of the new system.

**Early Help:**

The number of Early Help Assessments (EHAs) has reduced this year due to the review work of the Early HELP Pathway to ensure the support is given where there is concern about a child or young person that does not meet the threshold for social work intervention, so we are empowering those families, who have to overcome challenges like poverty, mental health and deprivation to become more resilient, addressing issues when they present at our Children’s Services Front Door which will contribute to keeping children safe from harm and abuse whilst families are enabled to reach their full potential. An EHA will be started with a family if a service has identified concerns and worries that
would require more than one agency to help improve outcomes. In Wandsworth there is a family EHA so one EHA could be cover the needs of one or more children in a family.

Most EHAs are open for around two years, but there are quite a number that remain open during a child’s school life, in this case the presenting issues will be due to a child’s ongoing SEND needs or because of a long term need of a parent e.g. mental health or learning need. For more information see Appendix 3. For the initial EHA the main generators are universal services, schools, children’s centres and health visitors. Of this group, primary schools have undertaken the most, given most children will have an EHA started between the ages of 3 and 5. For more information see Appendix 3.

The table below shows how many children and young people have accessed the Early Help Division from 1st April 2017 to 31st March 2018.
Priority [2]. Children and young people: Address the challenges and risks faced by vulnerable children and young people

Going missing from care, education and home:
Children who go missing from home, care and those missing from education continue to be a key priority area for the WSCB – see Section 8. We also recognise the increased vulnerability that children face when they go missing to issues such as child sexual exploitation, involvement in gangs and possible risk to radicalisation. As this is recognised across the board, mapping takes place at meetings such as SEMAP and GMAP and consideration also is given to whether the young person has been reported missing in the past, whether they are known to go missing frequently, etc. The Missing Sub-Group is facilitated by the WSCB.

For more detail see 8. Statutory reporting

Child Sexual Exploitation:
The learning from national serious case reviews concerned with Child Sexual Exploitation (CSE) has informed the development of multi-agency arrangements to tackle CSE in Wandsworth. The use of the play in schools - Chelsea’s Choice continued in 2017-2018 and funded by the WSCB, supported this process to raise awareness with young people at risk of exploitation. The play will be commissioned for further productions in 2018. Links with young people going missing are clearly known and recognised across the partnership and there is good information sharing. There has been a considerable amount of work focusing on young people at risk of CSE and missing in the last year including addressing the offer and take up of return home interviews. This is covered in more details in this report on Child Sexual Exploitation (CSE) and evidences the intervention by agencies to make children and young people safer. As this was an area identified by the inspectors as needing improvement, this remains an area of focus for the WSCB – the CSE Strategy and Action Plan was presented to the Executive Board.

For more detail see 8. Statutory reporting – below.

Radicalisation/ Prevent:
Wandsworth has had an active Prevent (the government anti extremism strategy) programme for the last few years. There is a clear delivery plan which aims to identify, prioritise and facilitate the delivery of projects, activities and interventions to reduce the risk of people being drawn into terrorism. It is divided into three areas of focus:

1. Work streams - institutions – working with sectors and institutions where there is a risk to radicalisation.
2. Individuals – preventing people being drawn into terrorism and ensure that they are given appropriate advice and support.
3. Ideologies – responding to the ideological challenge of terrorism and threat we face from those that promote it.

This plan is subject to on-going review and activities include:
• Workshop to Raise Awareness about Prevent’ (WRAP) to key partners in the Borough. This includes Council staff, schools, early years settings, safeguarding leads, police etc.

• Working in partnership with HE/ FE Prevent coordinators to report on action plans at St George’s University, Roehampton University & South Thames College.

• Identifying reference networks.

• Building capacity in vulnerable groups to deliver interventions.

• Maintaining and developing Channel Panel meetings (a multi-agency approach to safeguard vulnerable people by identifying individuals at risk, assessing the nature of risk and developing the most appropriate support plan for that individual).

Eighty six practitioners attended a Workshop to Raise Awareness about Prevent (WRAP).

Self-Harming Behaviour:

Self-harm – Ongoing concerns were raised nationally and by schools, the local hospital and Child and Adolescent Mental Health Services (CAMHS) that there appeared to be a rise in children displaying and presenting for services in relation to self-harming behaviour. This matter was also recognised by the Health and Wellbeing Board (HWBB) which is leading on the CAMHS Transformation Plan. This Plan outlines the strategic priorities for Wandsworth to 2020. This has led to increased capacity and capability for the local CAMHS. The WSCB also agreed to undertake a multi-agency audit on self-harm, which was finalised and presented at the WSCB Board in 2017, to understand the impact of intervention on reducing deliberate self-harm. Initial findings from the audit were:

Children are helped by interventions but pathways and processes varied between agencies.

Key themes:

• The importance of work being truly multi agency and the opportunity for practitioners to meet regularly, review the plan and the impact of the work.

• A common understanding among professionals of the interventions in place, their purpose and the desired outcomes.

• Importance of gathering information from family members and not the YP in isolation so as to gain a holistic understanding of the child’s world.

• Need to look at role of social media etc.

Recommendations include:
Official

- Training on risk management and risky behaviours
- Clarity on use of Early Help Assessments in self harm cases.
- Guidance needed on engaging parents.
- Guidance for schools to be promoted.

These recommendations were addressed in 2017-2018.

**Involvement in working with Gangs:**
The vulnerability of young people involved in gangs is managed effectively through the police led Gangs Multi-Agency Panel (GMAP) arrangements and addresses these issues alongside the YOS and Children’s Services. In 2017-2018, an indication of gang activity and the correlation with safeguarding is the number and percentage of Children’s Services assessments that identify gang involvement or risk of gang involvement. Last year more information was provided in the referral forms regarding which gang they have links to but the proportion of referrals has remained consistent.

**Rolling 12 month gang crime data:**

**Gun Crime**
- 14 Firearm incidents (6 lethal/7 Non-lethal) - 50 year before.
- 3 of the Lethal Barreled was Gang related – 50% of lethal.

**Knife injury under 25**
- 54 incidents compared to 47 the year before - +14.9%
- 10 of them Gangs related to 11 the year before.

**Knife injury over 25**
- 56 incidents compared to 43 the year before - +30.2%
- 2 of them Gangs related to 2 the year before.

**Headlines:**
- 36 fewer gun related crimes.
- 1 less Gang related knife crime (under 25yrs) - although an increase in 7 offences overall.
- Gang related knife crime (over 25yrs) stays the same - although an increase in 13 offences overall.
**GMAP purpose:**
The over-arching purpose of the Wandsworth GMAP is to safeguard the communities from this type of serious criminal behaviour by identifying lead agencies and monitoring interventions to individuals and families that ideally prevent association with/involvement in gang behaviour, disrupt criminal behaviour and provide support and exit strategies where appropriate.

**The stated aims and objectives of the GMAP process are to:**
- To minimise the risk of harm to individuals and the communities of Wandsworth, particularly those most affected by serious violent crime and gang style activity.
- To provide effective safeguarding that maximises the safety of victims of and those involved in serious violent crimes associated to gang behaviour.
- To minimise the risk of harm to those involved in or who witness crimes related to serious violent crime associated to gang behaviour.
- To actively share information between the partner agencies represented on the Multi-Agency Gang Panel.
- To take account of the specific issues around women, girls and younger siblings associated with gang and serious youth violence

**The need for a multi-agency approach**
It is widely recognised that any approach to tackling gang associated behaviour and serious violence must encompass a multi-agency approach. No one agency holds all of the relevant information, knowledge and experience to tackle these issues alone.

Effective intervention is highly dependent on agencies working together to identify and address the needs of individuals. The GMAP enables the available information to be shared across relevant partner agencies in relation to identified individuals, their families and wider locations and identify one lead agency to coordinate the multi-agency response in each case. This will result in a clearer picture of the need and the risk posed. This also supports a more comprehensive action plan to be developed to intervene at the earliest opportunity.

Plans for the future will consider bringing together these areas recognising vulnerable young people at the risk posed by exploitation.

**Children with disabilities and special educational needs**
The Children with Special Needs and Disability multi-agency safeguarding group is focusing on specific aspects of its work programme at each meeting. The group also needs to understand the outcome of the disability question which was included in the Section 11 Audits for 2018 and any key actions particularly in relation to raising awareness that might arise as a result. It reports to the HWBB’s Child Health Overview and Clinical Reference Group (CHOCRG) has been re-established to progress the needs of this vulnerable group of children. The group has continued to review the Kingston SCR report and recommendations and met three times during 2017-2018.
The local offer

- The local authority has a comprehensive local offer, which is for all children and young adults aged 0-25 who have special education needs and disabilities.

Children known to the 0-25 Disability Social Work Team

The number of the child protection within the 0-25 Disability Social Work Team in 2017-18 were 2 (only one child had a disability) as of March 2018 but during 2017/18 were 11 (2 of which did not have a disability).

The number of children looked after 0-25 Disability Social Work Team in 2017/18 were 2 as at end of March 2018 but 10 children during 2017/18

Developing the 0-25 Disability Social Work Team

The 0-25 Disability Social Work Team has continued to come together through the year and there has been progress in the following areas

- Putting in place appropriate workforce development to enable social workers in the team to work with both children and young adults – key strands include Care Act, Mental Capacity Act and Safeguarding training so that managers can fulfil responsibilities in relation to both child protection and safeguarding vulnerable adults.
- Developing robust duty processes to manage both incoming referrals and also the range of reviews which need to be carried out for those children / young people who are accessing packages of support, but whose needs are largely stable.

There is further work to be done in relation to:

- Working with the Youth Support Service to finalise the pathway that would support young people with high levels of vulnerability but who do not have the levels of disability that would be expected to be supported by the 0-25 Disability Service, especially now in light of the End to End Review.
- Having a clear pathway for young people’s whose main area of need is mental health and where specialist expertise is required to ensure effective planning for the young person’s support / placement.
Official

- Developing improved processes for tracking young people through the preparing for adulthood phase so that young people can achieve positive outcomes in relation to employment, independent living, maintaining good health and accessing appropriate social and leisure activities.

**Female Genital Mutilation (FGM):**
An audit of FGM was carried out at St Georges Hospital Trust and it was presented to the SCIL Sub-Committee Meeting on 15th April 2016. The implementation of the action plan was being monitored during 2016-17 and 2017-18. An FGM Task and Finish was established and was still in operation by March 2018. It has been agreed to re-audit this area of work to measure progress, this will report during 2018/19.

The local prevention strategy and guidelines and the FGM Mandatory Reporting & Safeguarding pathway are well used.

Katherine Low Settlement “KLS”, a multi-purpose local charity, have continued to support 21 FGM Champions. A small group of champions have worked to support professionals in health and education settings by raising awareness of FGM, the law and referral pathways to support. They have linked in particular with the Community Health Team and have delivered training sessions at Health Visitor Training. The Champions have provided a support and signposting service to women from potentially-practicing communities and have provided one-to-one support as well as hosting coffee mornings. It is notable that the community champions have found the work challenging and it has been difficult to maintain a consistent number, however, the training has given a number of women with the confidence to enable them to find paid employment.

A new approach was put in place, Chair of the SCIL Sub-Committee commissioned work on developing a WSCB Task & Finish Group to take the work forward and ensure that the champions concept. This resulted in the National FGM Assessment tool being adopted and used by St George’s Hospital. It was agreed that the use of this tool would be included in the FGM reaudit. A Survivors Support Network was set up for (mainly) Somali women, which out of FGM discussions restructured to become a Women’s Health Empowerment Group with a focus on keeping fit and public health areas.

The Home Office FGM ‘passports’ have been distributed (via the CCG) to all Wandsworth GP practices, these documents are invaluable for women and girls who are travelling to FGM practicing countries. The passports were distributed to 700+ women at ESOL classes at South Thames College.

The website [www.wandsworth.gov.uk/vawg](http://www.wandsworth.gov.uk/vawg) provides professionals with instant access to advice on how to deal with various forms of VAWG abuse. The abuse abroad booklet contains practical advice and information about FGM, forced marriage, modern slavery and human trafficking and travel to war zones which includes radicalisation. Leaflets have been updated to include up-to-date information in an easily accessible format and with a recognisable branding across all products.
**Honour Based Violence/ Forced Marriage:**

These priorities are addressed through the WSCB Training programme and will be a key part of the Engagement Plan being developed in 2018.

Community Safety have led on the development of a leaflet with Karma Nirvana – [www.karmanirvana.org.uk](http://www.karmanirvana.org.uk) – a national charity supporting victims of honour-based abuse and forced marriage. This is available on the WSCB Resources webpage: [http://www.wscb.org.uk/wscb/info/5/resources](http://www.wscb.org.uk/wscb/info/5/resources)

It is now stated policy that all cases of forced marriage and honour based violence that come to the attention of services, including the police, should be referred to the MARAC.

**Involving young people:**

This is an area that has been identified as a priority for the WSCB in 2018-2019 as for capacity reasons the Board has had a limited engagement with young people directly, though reports have been received on elements of participation by local authority services including the Report on Youth Council and CLICK.

Young people participated indirectly through engagement in the 2017 Annual Conference and them being encouraged to perform at the professionals and community engagement events. A key priority for the next version of the Business Plan is an Engagement Plan which will address the need to hear the voice of the child much more clearly. Proposals to link this with the data and intelligence gathering of the Board will also look to monitor participation, including through audit, continuing the work that the Child Protection Conferences audit begun in 2017. Agency reports for 2017-2018 and going forward specifically require key agencies to evidence how they are enabling participation and hearing the views of young people and families, ensuring that this are being used to direct service improvement.

| **Priority [3]. Neglect:** Ensure that the issue of neglect receives due prominence in assessment, prevention and intervention work especially where there are concerns |

The Board is very aware from its previous audit and case review work that the early identification of neglect when parenting deteriorates is a critical issue for safeguarding children. Children living with the ‘toxic trio’ of domestic violence, parental mental ill-health and substance misuse, often experience significant emotional and physical neglect. This in turn significantly impairs the child’s health and development, leads to poor progress at school and limited life chances.

We recognise there is more to do especially in providing Early Help to more children and parents to prevent the escalation of concerns. We have therefore agreed that this area will continue to remain a priority for the LSCB. We will be reviewing the strategy, incorporating the learning from our local partnership review that highlighted neglect as key issue within the reviews.

**Domestic Abuse:**

and provides some bespoke services in respect of VAWG. This contributes to a greater understanding of issues related to VAWG and ensures that high-risk victims of VAWG are identified and have responded by the appropriate use of an effective and robust multi-agency framework. During 2017 – 18 the Multi Agency Risk Assessment Conference (MARAC) met every four weeks on average and discussed 134 high-risk cases where children were involved that to minimise risk of harm through a multi-agency response.

No. and % of MARAC referrals where there are children in the family

<table>
<thead>
<tr>
<th>Date of MARAC</th>
<th>No of Referrals</th>
<th>No of Referrals with children directly involved*</th>
<th>% of total referrals with children involved</th>
<th>No of Children directly involved*</th>
<th>No of victims aged 16-17</th>
<th>No of perps aged 16-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>27/04/2017</td>
<td>22</td>
<td>11</td>
<td>50%</td>
<td>23</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25/05/2017</td>
<td>25</td>
<td>17</td>
<td>68%</td>
<td>32</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22/06/2017</td>
<td>25</td>
<td>9</td>
<td>36%</td>
<td>19</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20/07/2017</td>
<td>22</td>
<td>6</td>
<td>27%</td>
<td>9</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>17/08/2017</td>
<td>18</td>
<td>10</td>
<td>56%</td>
<td>20</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14/09/2017</td>
<td>17</td>
<td>5</td>
<td>29%</td>
<td>11</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>12/10/2017</td>
<td>21</td>
<td>11</td>
<td>52%</td>
<td>28</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>09/11/2017</td>
<td>21</td>
<td>13</td>
<td>62%</td>
<td>27</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>07/12/2017</td>
<td>29</td>
<td>12</td>
<td>41%</td>
<td>19</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>04/01/2018</td>
<td>16</td>
<td>6</td>
<td>38%</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>01/02/2018</td>
<td>18</td>
<td>8</td>
<td>44%</td>
<td>15</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>01/03/2018</td>
<td>28</td>
<td>13</td>
<td>46%</td>
<td>30</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>29/03/2018</td>
<td>24</td>
<td>13</td>
<td>54%</td>
<td>22</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>286</td>
<td>134</td>
<td>47%</td>
<td>263</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

Police data analysis provided that 2188 domestic abuse reports over the twelve months from April 2017 to March 2018. The borough remains one of the safest inner London boroughs with a total of 6.96 offences per 1,000 residents making Wandsworth the 3rd safest with the Inner London area.

**Project Tearose**

The police, in conjunction with the local authority launched ‘Project Tearose’ during 2015-16, and this has continued very successfully in 2017-2018. If police respond to a domestic incident and there are children present then his or her
head-teacher or school safeguarding lead will be told by 9 am the next morning of what has happened. This is to make sure that a support network is put in place and the child’s teachers are aware. The school will work with the parents, Police and Children’s Social Care to help the child. The school is only told what they need to know. Information is shared confidentially through secure email, by trained police officers. The majority of Wandsworth schools are involved in the project and the plan is to expand it further to more schools across London. The feedback from schools have been extremely positive, as this has enabled them to better support the young person the following day, having a better understand of why he or she might be behaving in a more distracted or withdrawn manner. It has been a very successful initiative.

The following Data was shared about the Tearose notifications to Wandsworth schools:

<table>
<thead>
<tr>
<th>School Year</th>
<th>Total Number of Tearose Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 - 2017</td>
<td>1328</td>
</tr>
<tr>
<td>2017 - 2018</td>
<td>1150</td>
</tr>
</tbody>
</table>

Review of the Tearose Project:

An evaluation was carried out in May 2017, the outcome was positive. The following questions were asked and feedback was given about the project:

What difference did the referral make to the child? (What were you able to do for that child you would otherwise not be able to?)

“I was able to talk to child that morning and the child told me what happened at home and how she felt/ what she was worried about and she was less anxious.

“We were aware of incidents that occurred the night before, we are able to act that day and ensure the child is safe. If the child is not in school the next day we are able to inform the appropriate professionals and ensure a welfare check is requested.”

“Able to look out for change in behaviour or attitude”

“Better understanding of child’s behaviour. Referral to learning mentor for therapeutic intervention”

“Because the child did not disclose anything, we would not have otherwise known about the incident and would not have been able to provide the support and understanding for a difficult period of time for that child. We were able to make adjustments and allowances that were subtle but which supported the child in a period of difficulty for them. We have also been able to reach out to parents and to enable a conversation which might otherwise not have taken place, which has also had a positive impact on the child.”

“Prepare for any upset that child may have. Keep a closer watch on both siblings.”

“They were supported appropriately”

Future possibilities include a roll out of the approach across London, and an extension of the methodology to other areas, e.g. incidents of reported bullying in the community which may impact on pupils in school, missing children notifications, pupils who have been arrested.
• Parental mental health
• Substance misuse

Priority [4]. Children living away from their parents: Ensure children not living at home are safe, receive high quality support to achieve better outcomes

Children Looked After:

The WSCB recognises that placing children in care out of borough can be challenging in terms of safeguarding and promoting their welfare. There are arrangements in place for responding to children who go missing from care. There is more work needed to scrutiny actions taken to find missing children, undertake return home interviews consistently and learn from what they say and what is known about the ‘push and pull’ factors that lead them to go missing and to prevent this happening again. There is a continuing focus to increase the number and proportion of children in Wandsworth fostering placements, so that CLA are placed closer to their schools, family, friends and communities. For more detail please see Section 8. Statutory Reporting, Children Looked After

Privately fostered children:

Raising awareness of Private Fostering has proved challenging in 2017 - 18, not least because of changes in management in Children’s Services and declining national activity, numbers are always considered to be under represented. Numbers identified remain static and very likely under reported. See 8. Statutory reporting – Private fostering below.

Young people in custody:

The work is continuing on concerns about the number of young people under 18 kept in police cells overnight under the age of 18, which are seen as too high. However, at any one time there can be five young people in cells around London. The MPS have demonstrated a clear commitment to keeping the numbers down and ensuring that there is good communication with other support teams, notably Emergency Duty Teams to provide alternative Local Authority accommodation. A concordat on the issues remains unsigned in London between police and children’s services, but is expected to operational in 2018 – 2019.
WSCB’s key priority areas for 2018-19:

1. Safeguarding All Children

2. Vulnerable Children and Young People

3. Risk to Adolescents

4. Children Emotional Health and Wellbeing

Vulnerable Children and Young People

Address the challenges and risks faced by vulnerable children and young people, in particular:
- Going missing from care, education and home
- Child Sexual Exploitation
- Radicalisation
- Self-harming behaviour
- Young carers/Children who care
- Involvement in gangs and county lines.
- Children with disabilities and special educational needs
- Female genital mutilation
- Honour Based Violence
- Forced Marriage

Risk to Adolescents

Tackling the risks to adolescents, particularly those associated with exploitation (including harmful sexual behaviour and online abuse) violence and neglect.

Children Emotional Health and Wellbeing

To ensure that Young People’s Mental Health is prioritised

WSCB priorities for 2018-2019:

The WSCB Priorities have been streamlined and refined for 2018-19.
4. Governance & Accountability

Safeguarding is everyone’s business. For services to be effective, each professional and organisation should play their full part. The service user should be central to service delivery. For services to be effective they should be based on the needs and views of children and young people, their families and vulnerable adults. As such, all key strategic plans whether they be formulated by individual agencies or by partnership forums should include safeguarding as a cross-cutting theme to ensure that existing strategies and service delivery as well as emerging plans for change and improvement include effective safeguarding arrangements that ensure that all people of Wandsworth are safe and their well-being is protected. The WSCB has the responsibility to scrutinise and challenge these arrangements across the partnerships within Wandsworth. These partnerships include the Health and Wellbeing Board (HWBB), Safeguarding Adults Board (SAB) and Community Safety Partnership (CSP), as well as the newly formed Corporate Parenting Panel (CPP). The current joint governance protocol will be updated to include the link with the CPP.

The Improvement Board continued to operate in 2017-18 in Wandsworth to ensure that safeguarding performance for the local authority improve as the Local Authority was in special measures since February 2016 – see Improvement Board – progress below

The WSCB has a Three-tier structure: An Executive Board, a Network Board (which was used for a Development Day) and four Sub-Committees. The Executive is the strategic and decision making body made up of all the director level or equivalent representation the statutory partners and some key other partner agencies, which meet at least six times a year. We also have a Faith, Community and Voluntary Sector’s representative set on the Board. The Executive annually reviews the safeguarding priority areas, taking into consideration any key safeguarding issues brought to its attention by frontline workers; the outcome of the monitoring, analysis and recommendations undertaken by the WSCB Sub-Committees; key issues identified through audit and review processes; the analysis of local data provided to the WSCB through its dataset; and reflecting on regional and national issues.

The Network Board was a broader operational board, which included a wide representation from all statutory agencies and other agencies in the borough such as all the school sectors – primary, secondary, special and independent schools, as well as the voluntary sector. It focussed on the implementation of the strategic drive set by the Executive. The Network Board was used last year as a Development Day in January 2018. As the Executive Board membership has grown to cover all statutory partners it was proposed to the Executive Board that the Network Board was no longer needed. This matter will be discussed further at the next Executive Board on 18th May 2018 with the view that we do not hold these meetings in future.
All the Sub-Committees (SCs) reports to the Executive Board. Each Sub-Committee has a clear mandate as set out in its Terms of Reference.

**The WSCB will:**

- Take responsibility for monitoring action to improve safeguarding including action plans arising from Serious Case Reviews.
- Hold the other boards to account on matters of safeguarding in all its activities, providing appropriate challenge on performance and results of performance indicators.
- Undertake audits and feedback results to the other boards, advising on ways to improve and highlight areas of underperformance.
- Feedback learning from Serious Case Reviews and ensure that the lessons are learnt.
- Highlight gaps in service for the other boards to consider as part of its commissioning process.

During 2017-18 the WSCB had four functioning Sub-Committees, as well as key standing groups (PIXI Panel, S11 Audit Review Group, etc).
5.1 Monitoring Sub-Committee:
The Monitoring sub-committee undertakes the quality assurance and scrutiny role on behalf of the WSCB. It meets six times a year. During the last year it called in over 30 reports for scrutiny and to seek assurance that service delivery is contributing to better outcomes for children and young people in Wandsworth. Reports are sent on to the Executive Board where appropriate. The areas reviewed by the Monitoring SC include:

- Anti-bullying Strategy
- Online Safety
- Gangs Multi Agency Panel
- Female Genital Mutilation
- Violence Against Women and Girls
- Prevent/Radicalisation and Extremism
- Children with a Disability and Special Educational Needs
- Children’s Services Review
- LADO Annual report
- MASH annual report
- Private Fostering Annual Report
- Section 11 report
- Annual Multi Agency Training delivery report
- CAMHS
- Gangs Multi Agency Panel
- Young Carers
- MAPPA Annual report
- MARAC annual report
- Early Help
- The WSCB Annual report
- Sexual Exploitation Multi Agency Panel
- Missing Children
- School Nursing Service
- Quarterly Children Protection reports
- Review of the Neglect Strategy
- Data reports
- Children Looked After
- WSCB Bereavement Guidance for Schools
- The Virtual School
- Independent Review Officers annual report
- Social Work Health Check
- Children & Yong People’s Participation
- Chelsea’s Choice evaluation – drama production on sexual exploitation for schools
5.2 The Serious Cases Improvement and Learning Sub-Committee:
The Serious Cases Improvement and Learning Sub-Committee (SCIL) leads on Multi-Agency audits, reviewing learning from single agency safeguarding audits, considers whether a case meets threshold for undertaking a serious case review (SCR) or Local Partnership reviews. It will coordinate any SCRs as required. It also reviews learning from other SCRs. It will convene extraordinary meetings to consider specific cases for review or area of concern; there were three of these in 2017-18 to consider whether the threshold for a Serious Case Review is met. It also reviews learning from SCRs published by other authorities across London and Nationally.

Reports on SCR/ Learning Reviews learning included reviews from:

- Child J by Kingston LSCB – including actions for Wandsworth
- City & Hackney LSCB
- E Children Learning Review with Croydon
- Southwark LSCB

Learning Lessons from Baby Eliza Serious Case Review:

All Local Safeguarding Children Boards follow the statutory guidance in Working Together to Safeguard Children 2015 when considering the threshold for conducting a serious case review (SCR), This should take place if a child abuse or neglect is known, or suspected in a case and a child has died or a child has been seriously harmed and there is cause for concern about how the authority or other organisations or professionals worked together to safeguard the child. The WSCB has undertaken a Serious Case Review on Baby Eliza* in 2016-17. The SCR was about baby Eliza who received serious injuries whilst living at home with her mother. Eliza’s mother was recognized as a young parent who suffered from gendered abuse across her childhood and into adulthood; from child sexual abuse to child sexual exploitation then domestic abuse. The mother experienced separation and disrupted attachments from her family as child who moved between care arrangements in her family and was in public care as a teenager; she experienced harm/ abuse and was a missing child. In light of child protection concerns about neglect and harm to animals her first child was removed.

Her own history impacted upon her parenting capacity. Professionals worked with the family recognized their sympathy for her as a child who had been looked after and was also a vulnerable care leaver. The SCR highlighted the potential to identify with the abused child within the adult who was a parent. The possibility that practitioners may have over identified and whether this unconsciously impacted on decision making and response to concerns was noted. Professionals initiative to ask questions and show curiosity about the role of men and fathers; their history of parenting and relationships was also raised.
What was learnt from the SCR? The WSCB recognised the learning highlighted in this SCR as listed below:

- Pre-Birth Assessment Guidance was revised and reissued to ensure that pre-birth procedures are understood & followed.
- Information sharing should be prioritised by all agencies to ensure the welfare of the baby.
- Importance of detailed safeguarding information being included in referrals for services to help identify the child needs.
- A recognition that mental ill-health, substance misuse and domestic abuse have an impact on capacity to parent to inform a risk assessment for a vulnerable child and not diminished in consequence of sympathy for a vulnerable parent.
- The benefit of precision in professional exchanges e.g. status of a service user’s given address and commonality of terms (core group v team around the child). The WSCB has now changed the terminology and asked professionals to use the term Core Group in line with the Child Protection Procedures.
- The WSCB will need to continue to hold professionals and organisations to account to support them to challenge perceived errors of professional judgments.
- Professionals will need to continue to encourage full involvement of GPs.

**Learning Lessons from E Children Learning Review:**

The multi-agency learning review was carried out by WSCB in partnership with a neighbouring Borough’s LSCB. This review considered the permanence planning, decision making and protection of two Black British children now aged 10 and 13 who have been adopted by their former Foster Carers. The review considered the period between 2004 and 2015.

When the children were placed together in what was their foster home, they had no previous relationship as one of them a baby joining her older brother. The adoptive parents were originally Independent Fostering Agency (IFA) carers who then moved across to become Wandsworth Foster Carers. The adoptive parents had an older birth child and were a suitable match in terms of identity and culture. During the placement a number of child protection concerns arose particularly in relation to sexualised behaviour and how this was understood.

There were also challenges in addressing safe care, requests for financial support and structural changes to the family home.

Key learning
• The review identified failings in the protection of the children. There were missed opportunities to assess the children’s safety by carrying out Section 47 child protection enquiries in 2011, 2014 and March 2015.

• Statutory guidance within London Child Protection Procedures and National Fostering Standards was not followed.

• Need to ensure that standards of approval for foster carers are high that Fostering and Adoption panels fulfil their role in scrutiny and challenge.

• The need to review the permanence plan for the children when concerns arise including the question of whether siblings should be placed together or apart.

• To understand the role that complaints and requests for finance may have when addressing safeguarding.

• Dynamics of disguised compliance need to be understood and recognised.

• Understanding the importance of internal escalation of concerns and across the partnership within Wandsworth and the neighbouring Borough led to questions about professionals understanding of their responsibility and process for LSCB escalation.

Learning from the review will be presented at the WSCB Learning from Experience events on 24th April 2018 at Wandsworth Professional Development Centre (WPDC) based at Burntwood Academy.

5.3 Child Death Overview Panel:
The Child Death Overview Panel (CDOP) function is to review all Child deaths who are Wandsworth residents. As of 1st April 2008 all LSCBs must have arrangements in place to respond to and review child deaths in their borough, as outlined in Working Together To Safeguard Children 2015, Chapter 5. These arrangements are to include:

• An overview of all child deaths (under 18 years, excluding those babies who are stillborn) in the LSCB area undertaken by a panel (para 5.8 – 5.10); and

• A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child (para 5.12 – 5.28).

The overall principles are that in all cases enquiries should seek to understand the reasons for the child’s death, address the possible needs of other children in the household, the needs of all family members, to monitor the support services offered to families and, also to consider any
lessons to be learnt about how best to safeguard and promote the children’s welfare in the future. All families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind.

Full details of activity are in the CDOP annual report, see Appendix 8.

**Number of Deaths Reported to the Wandsworth SPOC – 1 April 2017 to 31 March 2018**

There were a total of 67 deaths reported to the Wandsworth Single Point of Contact from 1 April 2017 to 31 March 2018. 25 (37%) of these deaths are Wandsworth resident children and will be reviewed by the Wandsworth CDOP Panel. The remaining 42 (63%) were children resident in other areas and these were passed onto the relevant Local Authority SPOC.
**Multi-Agency Rapid Response Meetings**

A response meeting is required for unexpected deaths with a view to ensuring any investigation and support is appropriate from the beginning. All agencies and professionals who have been involved with the child’s family are expected to attend. The multi-agency response process is now working well. The meetings are generally held within one week of the death being notified and attendance is always very good. These meetings continue to be a very valuable way of sharing information, identifying any additional investigative actions and arranging support for the family.

There were 6 unexpected deaths reported to the SPOC during 01/04/2017 and 31/03/2018. 5 of these were subject to multi-agency rapid response meetings. All 5 response meetings were held within 5 days of the death. Case F had the longest delay due to the weekend.

Case C did not have a multi-agency rapid response meeting as this death occurred abroad. There was a delay of nearly a month in the Foreign Office informing the Wandsworth SPOC of the death. It was felt that a meeting would not be useful as there was very little information to share, the family were not known to any services and the parents and siblings had died in the same incident.
Wandsworth CDOP Bereavement Counsellor

The first Wandsworth CDOP Bereavement Counsellor left post in October 2016. The Bereavement Counselling Service began functioning again in January 2018 and the post was made substantive in March of this year.

The new Bereavement Counsellor is contacting families who have suffered a child death in the last year offering support and advice. The Counsellor is also actively involved in the rapid response process offering support to schools, GPs and acute teams following the death of a child under their care.

The priorities for the Wandsworth Child Death Overview Panel for 2018/19 are as follows:

1. The impact of the Children and Social Work Act 2017 on the child death review process
2. The impact of Working Together 2018 on the child death review process
3. Implementation of the new child death review process under the new Child Safeguarding Arrangements
4. Possible amalgamation with neighbouring CDOPs to cover a larger footprint as suggested in the new child death review process guidelines
5. Implementation of eCDOP – ensuring all active panel members are fully understanding of the functions of eCDOP
6. Reviews to be completed within 6 months of notification, where no other agency is conducting an internal review or investigation
7. Continue to develop the CDOP Bereavement Counselling Service

5.4 Training and Workforce Sub-Committee:
The key function of the Training and Workforce Sub Committee is to oversee the WSCB training offer ensuring the provision of high quality multi-agency training programmes, which support professionals and volunteers working in local statutory, private, voluntary and independent sectors to safeguard and promote the welfare of children and young people. The WSCB training offer is well evaluated and the uptake of training has increased year on year. The Sub-Committee is chaired by the Designated Nurse for Safeguarding Children, employed by the CCG.

The subcommittee during 2017/18 has overseen the WSCB training offer through the following:

- Performance reports received from the WSCB Trainer on the attendance and evaluation of courses.
- Report from the WSCB Business Manager on the findings relating to training from the Section 11 online and strategic questionnaires.
- Independent report on the quality of training which included the observation of training and interviews with trainers.

The priorities set for 2017/18 focussed on increasing the accessibility and relevance of the LSCB training offer through a flexible delivery format reflecting both national and local safeguarding issues. Specific areas of work for 2017/18 were:

- To increase take up of training by voluntary and community sectors to progress nearer to 10% target

The take up of training by voluntary and community sector continues to be a priority in 2018/19 as the target of 10% has not yet been achieved

- Develop opportunities to involve service users/ voices in the planning and delivery of multi-agency safeguarding training

The training offer does now include service users in the delivery of some training and this will continue to be a priority for 2018/19

- Continue to work with the WSCB to improve the application of learning from local S11 audit data to ensure we continue to achieve effective and relevant training event content

The subcommittee has received updates on the finding of section 11 and this has informed the 2018/19 training offer.
- Deliver three Learning From Experience (LFE) events and a conference focusing on safeguarding children and young people from the risk of gangs (gun, knife crimes).

There have been two LFE focusing on the learning from local and national serious case reviews. The first related to injuries in young children and the second to children in care and care leavers. Both events were well attended and evaluated. The WSCB Conference (2017) addressed the very high profile topic of knife crime and was a very stimulating event using videos, drama and speaker who had first-hand experience of violent crime.

The sub-committee priorities for 2018/19 are:

- Ensure the WSCB training offer is robustly and effectively evaluated to ensure high quality courses responsive to the training needs of the workforce and community.
- Review the WSCB Training Strategy 2017/18 and update.
- Promote attendance at multi-agency safeguarding training - attendees are reflective of the multi-agency workforce and community groups.
- Develop the WSCB Training offer to include the participation of service users in the delivery of courses.
- Deliver ‘Learning from Experience’ Events to disseminate the learning from Learning Reviews/ Serious Case Reviews/ Case Audits
- Support the delivery of the WSCB Annual Conference.

6. Responsibility of the WSCB in relation to other strategic groups/ Boards:
The WSCB is not a delivery or commissioning body, it has a scrutiny and challenge role – this is explicit in Working Together to Safeguard Children, 2015. However it would expect to initiate activities which investigate and improve practice in safeguarding. It has the authority to call any agency represented on the HWBB, SAB or CSP to account for its safeguarding activity. The work of the WSCB contributes to the wider goals of improving the well-being of all children. Within the wider governance arrangements its role is to ensure the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard and promote the welfare of children. The WSCB continues

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1 LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding. WT15, Chapter 3, 3
to work with partnerships to ensure procedures and processes are in place to minimise risk and maximise the safety of children and young people in Wandsworth. In 2017-2018 the key connection was with the Improvement Board for Wandsworth’s Children’s Services.

7. Communication and Publicity:

7.1 Newsletters and review of leaflets:
The WSCB aims to produce two newsletters per year at the minimum containing key messages from Serious Cases Reviews, Learning from Reviews, Training Events, new developments and introducing new members of the WSCB to the partnership, etc. The WSCB Board published two Newsletters during 2017-18. They can be found and downloaded from the website under News and Events section. Please click on the following link: [http://www.wscb.org.uk/wscb/info/95/news_and_events](http://www.wscb.org.uk/wscb/info/95/news_and_events)

The WSCB has created a range of leaflets to raise awareness with members of the public and those working in Wandsworth. Many leaflets were updated during 2017-18 and are published on the website and can be downloaded via [www.wscb.org.uk/resources](http://www.wscb.org.uk/resources). Free copies are provided to agencies when requested.

7.2 WSCB Website:
The WSCB website, [www.wscb.org.uk](http://www.wscb.org.uk), remains the key repository for information and communication of the Board’s messages. All WSCB policies and strategies are now available to download there and kept current. The site attempts to be as accessible as possible as it is also a vital gateway to services for the community as well as partner agencies. A number of the key referral forms are also available through the site, including Early Help Assessments and Children’s Services, plus referrals for CSE and the LADO etc.

7.3 Community Events to promote the Safeguarding of Children in 2017-18:
The WSCB Board, Wandsworth Community Safety and Public Health are working together with the Association of the Somali Community and organised a Ramadan Iftar Event due to take place on 06th June 2018. This event aims to engage the Community members in issues linked with Public Health, Prevent, Anti-Terrorism, Community Cohesion, DV, FGM and Safeguarding of Children.

Prevent Coordinator attended a joint Community Activity in Tooting High Street with the WSCB Board Business Manager, Police and Voluntary Organisations on Sunday 06th May 2018 to raise awareness about Safeguarding Children, Hate Crime, Knife Crime and Islamophobia.
Prevent Coordinator attended a joint meeting with WSCB Board Business Manager, WSCB Multi-Agency Safeguarding Trainer, Wandsworth LADO, Police and Faith Community Leaders at Wandsworth Police Station on 13th November 2017. The meeting discussed ways of cooperation and agreed further community events.

Prevent Coordinator attended a joint Community Activity at Gatton Mosque in Tooting with the WSCB Business Manager, WSCB Multi-Agency Safeguarding Trainer, Police, Voluntary Organisations and Faith Communities to raise awareness about the Safeguarding of Children, preventing young people from being drawn into radicalisation and awareness about the services that can be provided to support children and families, this open day took place on 22nd of November 2017.

5. Statutory Reporting:

8.1 Multi-Agency Safeguarding Training delivery:
The WSCB is committed to providing high quality learning opportunities for the children and young people’s workforce in Wandsworth to ensure it is capable and confident to safeguard children and young people. Training is driven by an understanding of the skills, knowledge and abilities that the workforce requires to achieve good outcomes for children and their families. The multi-agency safeguarding training programme is delivered in line with the key safeguarding priority areas identified and agreed by the WSCB. There is an expectation that the workforce will access the multi-agency training in addition to single agency training provision, as it promotes improved inter-agency working on all aspects of safeguarding children. The programme is regularly reviewed to ensure it takes account of local and national changes.

Wandsworth is due to have a full re-inspection by OFSTED. The previous OFSTED report published on 26th February 2016, stated that multi-agency safeguarding ‘training is provided in relation to the key priorities of the Board, using learning from case audits and internal management reviews’. The report further stated ‘an extensive and appropriate range of multi-agency training has been developed and delivered on behalf of the LSCB’.

The WSCB has seen improved performance of the training programme in 2017-2018. Highlights include:

- A broad and varied multi-agency safeguarding training programme was offered to the children’s workforce – 317 training events were delivered with 6,574 attendances; an increase of 22% in courses offered with 39% increase in attendances
- Increase in offers and attendance to the voluntary and community sector from 7.1% to 8% progressing towards to the target of 10%
• Training attendee on the day and impact evaluations were positive overall - 98% of attendees in the sample either ‘strongly agreed’ or ‘agreed’ that the training event will help them do their job better
• 52 training events specifically for school staff (whole workforce and Designated Safeguarding Leads) which includes key safeguarding subject areas such as
  Difficult conversations around FGM or challenge to partners
• Delivery of a modular blended learning training programme for Designated Safeguarding Leads in Early Years settings, equipping DSL’s to embed safeguarding practices within schools, for a summary of schools training delivery.
• Promoting learning across the multi-agency workforce from Serious Case and Learning Reviews: 2 Learning from Experience (LFE) Events.
• Extension of the online e-learning safeguarding programme course completions during the year extended and improved on knowledge and skills. For a breakdown of attendance by course
• Delivered Advanced SoSWB training to 38 practitioners to become Practice Leads in SoSWB, in 2016/17 in 2017/18 we trained a further 21
• Annual Safeguarding Conference 97 in attendance
• Annual SoSWB practice celebration – showcasing practice across children’s social care and multi-agency partners

<table>
<thead>
<tr>
<th>Number of events offered, delivered and cancelled</th>
<th>2016-17</th>
<th>2017-18</th>
<th>change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total no. of events offered</td>
<td>218</td>
<td>234</td>
<td>+7.34%</td>
</tr>
<tr>
<td>Total no. of events delivered</td>
<td>197</td>
<td>200</td>
<td>+2.00%</td>
</tr>
<tr>
<td>Total no. of events cancelled due to low numbers</td>
<td>5</td>
<td>19</td>
<td>+280%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bookings and attendance</th>
<th>2016-17</th>
<th>2017-18</th>
<th>change</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of requests to attend multi-agency safeguarding training received</td>
<td>8,191</td>
<td>7,795</td>
<td>-4.83%</td>
</tr>
<tr>
<td>No. of requests to attend multi-agency safeguarding training confirmed</td>
<td>7,290</td>
<td>6,682</td>
<td>-8.34%</td>
</tr>
<tr>
<td>No. of multi-agency safeguarding training attendances</td>
<td>6,574</td>
<td>6,176</td>
<td>-6.05%</td>
</tr>
</tbody>
</table>

Practitioners or volunteers who applied for courses may not be confirmed on a course either because the training is not appropriate for them or if their application is not approved by their manager.
The largest sector that accesses the safeguarding training is schools.

**Training attendee evaluation and impact:**
Monitoring and evaluating the impact of training is regarded as central to ensuring that the multi-agency safeguarding training offer is good quality. The ‘Code of Practice’ on Wandsworth TPD Online also states that the TDS uses ‘effective monitoring and evaluation systems, including seeking out and acting on user feedback to inform the quality of provision’. This is achieved by the use of pre, post and 3 months post evaluations. When an individual books a place on a training event, the ‘Terms and Conditions’ they agree to specify that ‘Each attendee will be expected to give an evaluation of the event. Depending on the activity this may be in the form of a feedback sheet at the end of the event but could also include an online evaluation of the impact that the activity has had on practice from 3 months after the event’.

**Training event participants evaluation**
Participants of multi-agency safeguarding training events are asked to complete two short ‘on the day’ questionnaires. At the beginning of each event they are asked to complete a pre-event evaluation and at the end of the training they also complete a post-evaluation questionnaire. All participants are also invited to complete an impact questionnaire (at least three months after the event delivery date).

The first two questions on the pre, post and attendee impact-evaluations are the same to help measure distance travelled. The third question on the pre and post-evaluations is also the same.

**How we learned from the data**

The WCSCA pays close attention to all training attendee feedback and uses it to inform the development and improvement of future training events. The WCSCA encourages staff and managers to regularly discuss learning from training during supervision and impact on practice.

**Key points** - The impact evaluation from managers in this reporting period tells us that a high percentage of staff (over 77%) who have attended training courses have been ‘very’ or ‘extremely’ helped by the learning acquired. With 73% of managers embedding discussion about learning from training into supervision compared to 67.6% in 2016/17.

**Key points** – Despite a high number of cases across the continuum featuring parental mental ill health, domestic abuse and substance misuse as risk factors there appeared to be fewer practitioners accessing these courses in 2016/17. To encourage partner agencies to access more
multiagency based offers the above courses will be offered as ‘Trigger trio’ looking at multi agency assessment, analysis and impact on children.

Learning from Experience and Annual Conference
As part of the key role of the WSCB to promote learning across the multi-agency workforce ‘Learning from Experience’ (LfE) events are held to share learning from serious case reviews and audits. During 2017-2018 the Board organised and delivered:

Workshop in June 2017 - Baby Eliza SCR (not published) - Vulnerable babies vulnerable parents
WSCB Annual Conference in December 2017 - Safeguarding young people: Prevention and intervention of knife crime
Safety of children looked after SCR in April 2018 – (Learning from E Children and Child Y not published SCR) for evaluation of the events
Subsequently the key learning objectives from each of the events were integrated into the multi-agency training offer.

8.2 LADO (Local Authority Designated Officer) – allegations against staff:
Working Together to Safeguard Children 2015 places a duty on Local Authority’s to “put in place arrangements to provide advice and guidance on how to deal with allegations against people who work with children to employers and voluntary organisations. Local authorities should also ensure that there are appropriate arrangements in place to effectively liaise with the police and other agencies to monitor the progress of cases and ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process”. (Chapter 2, Section 6). This function is carried out by the Local Authority Designated Officer (LADO).

All agencies that provide services for children; provide staff or volunteers to work with; or care for children are required to have a procedure in place for managing and reporting allegations, which is consistent with statutory guidance (Working Together to Safeguard Children 2015 (updated in 2017), London Child Protection Procedures and Keeping Children Safe in Education 2016). The guidance outlines the requirement of the LADO to oversee the effectiveness, transparency and record retention of the process, not only in terms of protecting children, but also to ensure that staff or volunteers who are the subject of an allegation are treated fairly and that the response and subsequent actions are consistent, reasonable and proportionate.

Statutory guidance (Working Together to Safeguard Children 2015 (updated in 2017), London Child Protection Procedures and Keeping Children Safe in Education 2016), places a clear responsibility on organisations to report to the LADO where it is alleged that a member of staff or volunteer who works with children has:

- Behaved in a way that has harmed a child, or may have harmed a child;
• Possibly committed a criminal offence against a child or related to a child;
• Behaved towards a child or children in a way that indicates that they may pose a risk of harm to children.
• Referrals often do not result in ASV Meetings, but instead the LADO provides oversight, advice and support in relation to the disciplinary process, changes needed to safeguarding policies and procedures or training needs.

Where the above criteria are met, the LADO is responsible for chairing a strategy meeting to consider whether there should be:

• A police investigation of a possible criminal offence.
• Enquiries and assessment by children’s social care about whether a child is in need of protection or in need of services.
• Consideration by an employer of disciplinary action in respect of the individual.

The LADO’s key role is to provide advice and guidance to employers and voluntary organisations, and to:

• The LADO’s key role is to provide written advice and guidance to employers and voluntary organisations.
• Liaise with the Police and other agencies, including Ofsted and professional bodies, such as the General Medical Council.
• Monitor the progress of referrals to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.
• To provide oversight of the investigative process through to its conclusion.
• Chair Allegation against Staff and Volunteers (ASV) Meetings, previously known as LADO Strategy Meetings and establish an agreed outcome of the LADO process.
• Facilitate resolution to any inter-agency issues.
• Liaison with other Local Authority LADOs where there are cross boundary issues.
• Collect strategic data and maintain a confidential database in relation to allegations.
• Disseminate learning from LADO enquiries through the children’s workforce.
• Respond to non recent allegations of abuse in the same way as contemporary allegations. This is important as the person who the allegation is made against may still be working with children and it will be important to investigate whether safeguarding measures are needed in relation to their current employment or in relation to their contact with children within their family and social network.

Referrals to the LADO Service
The number of LADO referrals has steadily increased since 2012. However there has been a huge spike this year for the following reasons: a) training has increased the understanding of the LADO process, b) every referral has been recorded whether it meets the threshold or not and c) the LADO now offers a Consultation Service, which means that many more agencies have contacted the LADO for guidance and advice in relation to safeguarding concerns around staff and volunteers who work with children.
Graph below shows the Number of referrals to the LADO Service

During this reporting period significantly more referrals have been made by educational and health professionals, social workers and OFSTED. The analysis in relation to this is explained later.

In contrast fewer referrals have been made by parents directly to the LADO. In 2016/2017 (40) referrals were received, which decreased to (26) this year. This may be because: a) social workers have made referrals to the LADO on their behalf, b) parents have reported their concerns
directly to OFSTED or c) parents feel that their concerns are being addressed appropriately by agencies and they do not feel that they need to involve the LADO themselves.

Only (1) referral was made by a faith professional this year. Unfortunately this data was not previously recorded, so there is no comparison. It is however clear that more work is needed in this area.

**Nature of Allegation**

This year the highest single category of referrals was “other”, rather than one of the four main categories of abuse. This category includes: concerns in relation to professional conduct, failure to follow protocol, standards of care and other general safeguarding matters.

There has also been an increase in referrals relating to physical abuse, which changed from (68) in 2016/2017 to (97). This is mostly in relation to inappropriate handling and restraint in schools and in-patient hospital wards.

Private life concerns were not previously recorded, but related to (56) referrals this year. This is understandable due to the update in the LADO procedures. Training in relation to this has resulted in a significant increase in referrals from Social Care in particular.

The LADO continues to assist the police and other agencies in relation to non-recent allegations of abuse. During this reporting period, there have been (2) new referrals in relation to non-recent physical abuse, and (7) new referrals in relation to non-recent sexual abuse. In addition a high profile police led case is ongoing, for which the LADO has maintained Feedback from agencies on the development of the LADO function is very positive. For the full Annual report on LADO please click on this Link:

[Wandsworth LADO Report 2017-18](#)

### 8.3 Private Fostering:

The number of children known to be living in private fostering arrangements in Wandsworth at the end of March 2018 was four. Between 1st April 2017 and 31st March 2018 there were three new notifications received (compared to four in 2016-2017). Statutory visits were within timescales for all cases.

In previous years there had been a dedicated post for privately fostered children that fulfilled the statutory responsibility of being the allocated social worker for this cohort of children, as well as moving forward the awareness campaign within the borough. Between 1st April 2017 – 31st March 2018 the service experienced a number of difficulties which detracted from pursuing a full awareness raising campaign. These difficulties included a number of changes of social workers and manager in the Intensive Intervention team led to gaps in the strategic arrangements for awareness raising and in the application of a programme of publicity and awareness campaigning. This is also in the national context of the closure of the British Association for Adoption & Fostering in 2015 – now replaced by Coram BAAF Adoption and Fostering Academy - which did a good deal of UK wide campaigning. The fostering recruitment officer will help the service develop a strategy and
publicity campaign as part of the work with fostering. The apparent continuing challenges of not having a dedicated post and low awareness of private fostering is an area of concern for the WSCB, alongside issues raised through the audit of cases and has been raised by the Independent Chair to Children’s Services previously, and will be revisited during 2018-2019. Responsibility for private fostering has moved within Children’s Services back to the Families and Communities Service, then to the Specialist Services which is developed a Private Fostering Board to specifically address the issues.

8.4 Children Missing from Home, Care and Education:
Children who go missing from home, care and those missing from education continue to be a key priority area for the WSCB. We also recognise the increased vulnerability that children face when they go missing to issues such as child sexual exploitation, involvement in gangs, possible risk to radicalisation. As this is recognised across the board, mapping takes place at meetings such as SEMAP and GMAP and consideration also is given to whether the young person has been reported missing in the past, whether they are known to go missing frequently, etc.

Missing Episodes

1171 missing episodes were recorded on Mosaic, the IT system, in 2017/18, which is an increase from 1057 episodes in 2016/17. 1,057 missing episodes were recorded on Fwi, the IT system, in 2016/17, which is a decrease from 1,290 episodes in 2015/16. There was a 55% increase in missing episodes between 2014/15 and 2015/16 which was largely attributable to improved data recording and this now appears to have stabilised.
The trend in missing episodes over the last year is an increasing one. This is partially due to seasonality; the summer holidays led to a marked reduction in the number of reports of missing young people in 2014/15, 2015/16 and 2016/17. One prolific missing young person generated high levels of missing episodes in Q4 2017/18.

**Gender**

<table>
<thead>
<tr>
<th>Gender</th>
<th>No of Young People</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>140</td>
<td>47%</td>
</tr>
<tr>
<td>Male</td>
<td>157</td>
<td>53%</td>
</tr>
<tr>
<td>Total</td>
<td>297</td>
<td>100%</td>
</tr>
</tbody>
</table>

The gender split is fairly even with 47% being female, last year, males accounted for a slightly higher proportion of missing young people at the rate of 53%.
Findings of 2017-18 Missing Analysis

- In 2017-18, 298 individual young people are recorded going missing 1219 times. This is an increase compared to 2016-17; although it has remained below 2015-16 numbers. However, looking at monthly trends showing that first half of 2017-18 saw large number of missing episodes and this has reduced in the second half of the year.
- There has been a slight increasing trend in missing episodes between 2016-17 and 2017-18, whilst the number of young people going missing each month has remained similar. This suggests some young people are going missing more often. However, numbers of young people have also decreased during the second half of 2017-18, as with missing episodes, suggesting strategies are beginning to impact and reduce the number of young people going missing.
- The majority of missing young people (mispers) only went missing once (57%) – but those who went missing twice or more accounted for the large majority of missing episodes (86%).

Age and Gender

- 53% of mispers were male and 47% female in 2017-18. However, girls accounted for 52% of missing episodes, showing they are slightly more likely to go missing more often. 55% of those who went missing 6 or more times were girls.
- Young people aged 16 or above were most likely to go missing, accounting for half of all missing episodes in 2017-18, followed by 14 to 15 year olds, accounting for 37% of all missing episodes. This is similar to last year’s pattern. Older young people are also more likely to go missing more often. Only 33% of young people who went missing once in 2017-18 were aged 16 or above, compared to 41% of those who went missing 2-5 times in the year, and 64% of those who went missing 6 or more times.
- Looking at age and gender, 16 and 17 year old girls were the most likely to go missing, accounting for 17% and 13% of all 2017-18 missing episodes respectively. This is similar to the findings of last year’s analysis. 15 year old boys were the most likely age group of boys to go missing, accounting for 13% of all 2017-18 missing episodes.

Ethnicity

- Black or Black British young people are starkly over-represented, at 41% of all mispers and 47% of those who went missing twice or more (repeat mispers) – compared to making up 22% of the local school population. Mixed young people are only slightly over-
represented (15% of mispers compared to 13% of school population), but are more likely to go missing more, making up 20% of repeat mispers.

- White young people are under-represented, at 28% of all mispers compared to 44% of the school population – although it is similar proportion to those open to Children’s Services (30%). Asian or Asian British young people are under-represented, making up only 9% of mispers and 5% of repeat mispers, compared to 18% of the school population and 11% of those open to Children’s Services.

**Case status**

- 83% of those who went missing in 2017-18 were known to Children’s Services at April 2018.
  a. Children in Need (CIN) made up 43% of all mispers, but they were less likely to go missing repeatedly, accounting for 20% of missing episodes.
  b. 8% of mispers were subject to a child protection (CP) plan, accounted for a similar proportion of missing episodes (7%). There were a small number of young people subject to CP plans who went missing repeatedly.
  c. Looked after Children are much more likely to go missing repeatedly; a third of all mispers were in care (31%), but these young people accounted for 66% of missing episodes. CLA make up 76% of those who went missing 6 or more times during the year.

**Looked After Children**

- A fifth of children who were in care during 2017-18 went missing at least once (19%). 14% went missing more than once.
- Just under half of CLA mispers were girls (49%), but girls accounted for 53% of missing episodes. This is in line with the pattern seen above, where boys are slightly more likely to go missing, but girls are more likely to go missing more often. CLA most likely to go missing are 17-year-old boys (21% of CLA mispers) and 17 year old girls (18%). However, 16-year olds accounted for the most missing episodes (20% of all CLA missing episodes).
- Black or Black British CLA went missing more often than would be expected (46% of CLA mispers compared to making up 37% of the CLA population). The same pattern is seen for White CLA (32% of all mispers compared to 26% of CLA population).
- Less Mixed young people went missing than would be expected (15% of CLA mispers, compared to 25% of CLA), but they accounted for 24% of missing episodes – so were less likely to go missing, but went missing more often if they did.

**Links to other risk factors**
Of 50 young people open to the Sexual Exploitation Multi-Agency Panel (SEMAP) at some point during 2017-18, 62% (31) went missing at least once and accounted for 24% (292) of all missing episodes during the same period. Over half were CLA and 98% were girls. There is also overlap with the two lists mentioned above (3+ High Risk missing episodes and Top 20 Missing).

Of those 82 young people with an active YOT intervention at March 2018, 18% had been reported missing between September 2017 and March 2018 (15 young people). This is 8% of those reported missing (181 young people) in the same period. Two-thirds were CLA, and 86% were boys. Again, there is overlap with the two lists mentioned above (3+ High Risk missing episodes and Top 20 Missing).

At 12/04/18, 4 were receiving active intervention from Ending Gangs & Youth Violence (EGYV) Team – none are on the top High Risk episodes or Top 20 lists. One young person is known to the EGYV team and receives ad-hoc support, and is on Top 20 missing for 2017-18.

There is limited data available on young people’s involvement in county lines. However, 1 young person with 3+ High Risk missing episodes during 2017-18 was remanded into secure custody for a county-lines related offence in April 2018. The EGYV team know of 3 young people with actual evidence of their involvement in county lines but none had missing episodes recorded on Mosaic during 2017-18.

**Return Home Interviews**

- During 2017-18, a return home interview (RHI) was offered after 76.4% of missing episodes. For 3.4% of missing episodes, an RHI was not offered. However, this leaves 20.2% of missing episodes where it is not recoded on Mosaic whether an RHI was offered or not. This makes it difficult to tell if performance relates to changes in the number of RHIs offered or issues with recording practice. It is likely that both factors have played a role during the year. This is being followed up by the Assistant Director (Children & Families) and Head of Specialist Services.

- During 2017-18, a return home interview (RHI) was accepted by 55% of young people and 41% declined, of those who were offered an RHI. 4% of missing episodes where an RHI was offered do not have recorded whether it was accepted or not. There has been a steady increase in the proportion of RHIs accepted, peaking at 75% for CLA and 69% for non-CLA at March 2018.

- Fluctuations in performance during 2017-18 has been seen due to issues with Barnardo’s contract and missing workers, as well as social workers practice (not offering or arranging RHIs, and not recording whether an RHI has been offered or accepted). From 15th April, the contract has been brought in-house from Barnardo’s and the posts are being recruited to permanently by the CSE/Missing Team Manager, and the team is working hard to improve RHI practice across the department.
During the year, 43 young people who went missing were not offered an RHI at any point – most only went missing once (72%). Of those who were offered RHIs, 70 young people who went missing once declined an RHI. Of 10 repeat mispers who declined every RHI offer, 7 declined 2 RHIs offered. The report also shows 21 repeat mispers who accepted at least one RHI during the year, but declined more than half of those RHIs offered to them. Of these, 6 were on Top 20 missing list and 4 on the most high risk episodes list.

**Children Missing Education**

The Education Welfare Service monitors and takes appropriate action to support all pupils who are at risk of missing education and out of school, as well as those leaving and starting at non-standard transition points. Children are usually deemed to be missing education, and therefore not at that point on the roll of a school, due to being newly arrived in the borough and, in the majority of cases, parents will be somewhere in the process of making applications for schools. In a very small number of cases, children missing education (CME) checks are made to establish each child’s whereabouts.

Snapshots of the numbers of children missing education and out of school are taken at various points in the year. Taking a like-for-like comparison of the figures at both March 2017 and March 2018 snapshots during this reporting period, the numbers of children missing education and out of school remain low, with the majority of children out of school for shorter periods. However, children can be out of school for longer periods where more complex issues, such as those related to housing, can delay the start date for a child’s school placement. This number varies over time.

**CHILDREN MISSING EDUCATION – FAMILIES MOVING INTO THE AREA**

1. Data snapshots taken over the last 12 months show variations over time in the numbers of children whose families have moved into the borough and miss education for short periods whilst parents/carers apply for a school place. At the November 2017 data snapshot, there had been a slight reduction in the number of children out of school from 61 to 59.
2. At the most recent data snapshot taken in January 2018, there was a further decrease in the number of pupils out of school from 59 to 46.
3. The majority of children (32 out of 46) have been out of school between six and sixteen weeks. This amounts to 70% of the total number. Fourteen children have been out of school for over sixteen weeks, making up the remaining 30% of this group. It is important to note that even in the most complex of cases, no pupil has been out of school longer than eight months.
4. The graph below shows the percentage of children out of school between the school academic year of 2016 and 2018 to date and the extent to which school holidays, at Easter, summer and Christmas, temporarily delay the application process due to school closures.
5. The numbers of children out of school are usually somewhat lower in the secondary phase due to short-term educational provision for new arrivals to the borough being accessible at the Wandsworth Interim School Project (WISP). This is not currently available in the primary phase.

6. Secondary school-aged pupils who are newly arrived in the borough access the WISP, based at Francis Barber PRU (Pupil Referral Unit). Pupils who move into the area are offered temporary educational provision until a school place is found for them. There are currently ten pupils attending the WISP.

7. From the Ofsted inspection of November-December 2015, inspectors found: ‘innovative and effective responses, such as the Wandsworth Interim School Project (WISP), enable secondary pupils new to the area to be educated temporarily while a permanent school place is arranged.’

CHILDREN MISSING EDUCATION - LEAVERS AND STARTERS
8. A cross-service working group involving the EWS and Pupil Services Section, along with Schools IT and Corporate IT, was set up to develop a new secure, single point of entry for school requests regarding pupils leaving a school at a non-standard transition point, as well as notifications on starters.

9. The new leavers and starters tracker system was launched by the EWS in January 2017 to facilitate schools’ and the Local Authority’s (LA) compliance with the revised Education (Pupil Registration) (England) (Amendment) Regulations 2016 and in accordance with statutory guidance issued by the DfE.

10. A central database has been set up to log all notifications about any child leaving and starting a school. This is overseen by the LA CME administrator based within the EWS.

11. As set out in the statutory guidance, schools are expected to inform the LA within five days of adding a pupil's name to the school admissions register at a non-standard transition point. This is conducted via secure email. Similarly, where the destination of the child leaving is known, schools complete and submit an electronic leaver request, also within five days.

12. With one or two exceptions, all schools in both the state and independent sectors make regular returns. In the very few cases where school returns ‘drop off’, which usually occurs at the start of each term, schools are formally reminded in writing of their statutory safeguarding duty to provide information on children leaving and starting at non-standard transition points. In addition, the EWS liaises with school link inspectors, who follow up concerns with headteachers.

CHILDMISSING EDUCATION – REFERRAL ROUTES

13. Notifications are received from school admissions about resident pupils who may be out of school. Referrals are also received from other LAs, social care, health, schools and other agencies – in and out of the borough. The EWS works with school admissions and parents to reduce the time children and young people are out of school. Where appropriate these young people are placed through the In Year Fair Access Protocol.

14. A number of measures have been put in place to make the LA’s procedures around CME more effective in order to reduce the time children and young people are out of school, namely; simplifying databases holding information about vulnerable groups of children; creating clear category markers to make system navigation easier and tracking and monitoring better; strengthening joint-working procedures, with both state and independent school sectors; and speeding up the time checks are made with schools by increasing dedicated admin support, which in turn frees up the CME lead officer for more direct work tracking cases.

8.5 Child Sexual Exploitation (CSE)

1. There are now three separate SEMAP operational panels held on a monthly basis. Professionals must submit a SEMAP notification and risk assessment for each case they request to put forward. They must also open and complete a CSE risk assessment on Mosaic. This process ensures the notifying professional has assessed whether CSE is a high (Red), medium (Amber) or low risk (Green) according to specific factors/evidence, and it also leaves an audit trail of risk over time so that we can measure and analyse whether a case has escalated or
Reduced in risk. Before each meeting the Head of Specialist Services, CSE and Missing Team Manager and CSE Consultant Social Worker review all notifications and adjust meeting agendas to reflect the notifications received.

<table>
<thead>
<tr>
<th>RAG-rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Children whose sexual exploitation is evidenced, often self-denied and where coercion/control is implicit.</td>
</tr>
<tr>
<td>Amber</td>
<td>Children whose risk is evident; there is evidence of targeting, concern about coercion and control and there are clearer indicators.</td>
</tr>
<tr>
<td>Green</td>
<td>Children who are at risk; indicators suggesting risk but often no clear evidence just concern.</td>
</tr>
</tbody>
</table>

2. For high risk notifications, we have SEMAP Red operational panel, for medium to low risk notifications we have SEMAP GREEN and AMBER operational panel, and for any notification linked to a young person who has left care, we have Care Leavers SEMAP. All cases are presented to the appropriate panel by the notifying professional— the multi-agency membership will then support them with actions that could progress risk reduction and safe management of the individual. Cases are then agreed by the panel to be reviewed again within 1-2 months depending on issues and risk highlighted.

3. During each panel, actions are logged and emailed to the notifying professional to aide in swift progress. Full minutes are then distributed within 1 week of the meeting and are the responsibility of the lead/notifying professional to upload onto the child’s record (on Mosaic).

8.5.1 Prevalence of Child Sexual Exploitation:

Number of SEMAP Referrals:

1. There has been a significantly smaller number of SEMAP referrals this year compared to last year, reducing from 65 in 2016-17 to 29 in 2017-18. This is partly due to a stricter referral process, whereby the CSE/Missing team reviews and decides in advance whether a referral should be discussed at the meeting or not. The CSE Consultant Social Worker also offers weekly consultations for multi-agency practitioners, which is likely to have improved the quality of referrals.
### SEMAP referrals by quarter and year

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>18</td>
<td>12</td>
<td>8</td>
<td>15</td>
<td>53</td>
</tr>
<tr>
<td>2015/16</td>
<td>13</td>
<td>11</td>
<td>32</td>
<td>12</td>
<td>68</td>
</tr>
<tr>
<td>2016/17</td>
<td>16</td>
<td>18</td>
<td>18</td>
<td>13</td>
<td>65</td>
</tr>
<tr>
<td>2017/18</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>29</td>
</tr>
</tbody>
</table>

### Referrals during 2017-18

1. There was a notable reduction of 55% less referrals to SEMAP during 2017-18 than the previous year, with 29 referrals in 2017-18 compared to 65 in 2017-18. This is in part due to a stricter referral process, whereby the CSE/Missing team review notifications before they are discussed at the multi-agency panel, to agree whether they are appropriate for referral.

2. The initial RAG-ratings for each referral were still mostly Amber, in line with previous year, but there were fewer immediate Red ratings and immediate 'Cease to Review (CTR)' ratings compared to 2016-17. In line with this, there were more immediate Green RAG-ratings. However, 1 young person was immediate CTR in May 2017 but then re-referred in November 2017 and rated Red immediately. It is recommended that this case is reviewed to understand whether something could have been done differently to prevent risk increasing in this way.

### Live caseload at March 2018

3. The live caseload has reduced from 62 at March 2017 to 31 at March 2018. It is positive that fewer young people are being monitored as at risk of CSE, although it is important to remain aware it could mean less young people who are at risk are being identified appropriately.

4. At March 2018, 2 young people were RAG-rated Red, 18 Amber and 11 Green. Compared to the live caseload at March 2017, there are fewer young people rated Red (6% compared to 23%), more rated Amber (58% compared to 48%) and Green (36% compared to 29%).

5. The remaining 8 young people are care leavers and monitored by the separate care leaver panel, which is a new addition during 2017-18 in recognition that risks do not disappear upon a young person turning 18 years old. As a result of this panel, Personal Advisors gain advice from multi-agency network, including specialists, on how best to support their young people. This has resulted in a network meeting with adults safeguarding being set up for May 2018 for one young person and a referral currently being progressed for another young person to the community multi-agency safeguarding panel.
8.6 Child Protection information:
These investigations relate to Section 47 of the Children Act 1989, which places a duty on a local authority to investigate and make inquiries into the circumstances of children considered to be at risk of ‘significant harm’ and, where these inquiries indicate the need, to decide what action, if any, it may need to take to safeguard and promote the child’s welfare.

S47 investigations continued to be undertaken where significant concerns were raised. Following a thorough review of MASH post the OFSTED inspection, a new system was put in place (The Initial Point of Contact – IPOC), which has contributed to a more consistent and balanced prevention strategy.

Prevent
- Prevent the occurrence of child sexual exploitation by raising awareness and undertaking work with children and young people to address risk factors.

Identify
- Effectively identify young people at risk of exploitation through coordinated partnership working. Put in place robust plans to address the identified risks.

Engage
- Provide services that young people and their families are able to engage with in order to address the risk of sexual exploitation and wider factors.

Impact
- Ensure that services deliver interventions that have an impact on the young person’s life and effectively reduce the risk of sexual exploitation.

Disrupt
- Disrupt the activity of perpetrators, using arrests and seeking prosecutions wherever possible, to reduce the occurrence of child sexual exploitation.

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process of decision-making and the application of threshold to referrals that are being received through the front door in comparison with the periods prior before the OFSTED Inspection in 2015.

The number of Child Protection Plans have reduced in the last year. The figures shows that as previously, the majority of children are subject to Child Protection plans under the category of emotional abuse. Most children in this cohort have been exposed to and harmed by domestic abuse. Neglect follows a similar pattern. Children subject to plans for physical abuse rose and peaked in August 2017, but since have then reduced slightly. Throughout 2017/18 additional practice improvement work has focussed upon ensuring that the threshold for statutory intervention was being understood and consistently applied. The WSCB has revised the Threshold document in March 2018. Audit has indicated that progress is being made in this area.

Plans made in relation to sexual abuse have continued to reduce as well this year. This should be seen within the context of overall reduction of the numbers of children on CPP. In April 2017 there were 26 (9%) CPP for sexual abuse and by March 2018 this was 8 children (2%). The national average for sexual abuse is (4%). There has been significant work to reduce children put on Child Protection Plans.
Lots of good work has been inputted in 2017-2018 by the Child Protection and Planning Team to address the rise in the number of children on CP Plans and this work has been fruitful. This includes practice improvement sessions within team meetings and clear management guidance. Plans should not end at three months unless children become looked after otherwise change may not be well established and sustainable.
The number of children on plans longer than two years is low and has been reducing, and cases at 15 and 24 are subject to robust scrutiny at the Child Protection Quality Assurance Panel. This also now reviews cases of children under five on plan for more than nine months.

**Demographics – Ethnicity, Age and Gender**
The majority of children currently subject to CPP are white. However, Black or Black/British children are over represented. In Wandsworth the 2011 Census found that 44% of the 0-19 population was BME. The January 2016 Schools Census showed that 57% of Wandsworth pupils who were resident in the borough were BME. 22% were Black/Black British. This is the most up to date data available.

Similarly BME children are disproportionately over represented within the children looked after population.
The majority of children subject to CPP are of school age. This reflects the extent of schools ability to identify and refer vulnerable children at risk of harm as a universal service with a high level of daily contact. In total there are 298 (72%) school age children on CPP in August 2017 and by March 2018 this had increased to 116 (100%). The number of children aged 16 or more has reduced consistently since May 2017 (8%) and was (6%) by March 2018. A greater emphasis has been placed upon their protection and the use of child protection procedures has been reinforced.

In light of the need to protect children over the age of 16 year old work was done to look at other models of managing adolescent risk. A Child in Need Team for Adolescents was created by Wandsworth Children Social Care.

Across the year the numbers of children aged less than 12 months increased however the percentage in December 2017 within the context of overall increase in CPP numbers was (12%) compared with (0%) in March 2018.

8.7 Children Looked After:

Numbers of Children Looked After

At 31st March 2018 307 children were looked after (CLA) by the Local Authority, this compared with 289 children who were looked after (CLA) by the local authority in March 2017. The number of CLA children continued to increase.

<table>
<thead>
<tr>
<th>No. of CLA</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outturn</td>
<td>286</td>
<td>289</td>
<td>287</td>
<td>288</td>
<td>288</td>
<td>274</td>
<td>279</td>
<td>291</td>
<td>297</td>
<td>298</td>
<td>301</td>
<td>304</td>
<td>306</td>
</tr>
</tbody>
</table>

Children with multiple placements

The percentage of children with three or more placements has showed an increase during 2017-2018, in line with the increase in CLA numbers. The increased levels of performance management of placement through placement planning meetings, permanency planning and use of placement support services is helping to limit placement moves to a more reasonable level. It is a challenging target to maintain because of many unpredictable factors in placements especially amongst the older age group, but heightened awareness by staff and increased rigour of the regularity of visiting contribute to better placement management.
More foster homes are being recruited to keep children in care closer to Wandsworth and local services. Fewer children experience 3+ placement moves and the turbulence of change. The number of children ‘staying put’ is increasing so giving them stability for longer. The recruitment of mentors, skills workers and independent visitors has increased so providing more children and young people with a source of support and stability.

<table>
<thead>
<tr>
<th>No. of CLA</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of CLA with 3+ Placements</td>
<td>34</td>
<td>31</td>
<td>28</td>
<td>32</td>
<td>29</td>
<td>33</td>
<td>34</td>
<td>33</td>
<td>34</td>
<td>34</td>
<td>31</td>
<td>34</td>
<td>32</td>
</tr>
<tr>
<td>No. of CLA @ end of the month</td>
<td>288</td>
<td>289</td>
<td>288</td>
<td>290</td>
<td>289</td>
<td>279</td>
<td>280</td>
<td>286</td>
<td>297</td>
<td>298</td>
<td>300</td>
<td>301</td>
<td>304</td>
</tr>
<tr>
<td>% of CLA with 3+ Placements</td>
<td>11.8%</td>
<td>10.7%</td>
<td>9.7%</td>
<td>11.0%</td>
<td>10.0%</td>
<td>11.8%</td>
<td>12.1%</td>
<td>11.5%</td>
<td>11.4%</td>
<td>11.4%</td>
<td>10.3%</td>
<td>11.3%</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

**Looked After Children Visit Timeliness**

Visit performance has fluctuated in 2017-2018 and declined, as the number of required visits has increased at a faster rate than the number of visits undertaken. Managers have addressed this by tightening up the performance management of the regularity of visiting and placed a higher premium on writing up visits and direct contact with children in care placements.

All out of borough placements are visited with the same frequency and CLICK, the Children in Care Council, has introduced a pen pal service for those further away and uses social media to contact more distant placements.

<table>
<thead>
<tr>
<th>Looked After Children Visits timeliness</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of CLA visits On Time</td>
<td>248</td>
<td>256</td>
<td>263</td>
<td>243</td>
<td>252</td>
<td>233</td>
<td>242</td>
<td>244</td>
<td>270</td>
<td>258</td>
<td>265</td>
<td>271</td>
<td>283</td>
</tr>
<tr>
<td>No. of CLA visits Due</td>
<td>286</td>
<td>289</td>
<td>287</td>
<td>288</td>
<td>288</td>
<td>274</td>
<td>279</td>
<td>291</td>
<td>297</td>
<td>298</td>
<td>301</td>
<td>304</td>
<td>306</td>
</tr>
<tr>
<td>% whose latest visit was undertaken on time</td>
<td>87%</td>
<td>89%</td>
<td>92%</td>
<td>84%</td>
<td>88%</td>
<td>85%</td>
<td>87%</td>
<td>84%</td>
<td>91%</td>
<td>87%</td>
<td>88%</td>
<td>89%</td>
<td>92%</td>
</tr>
</tbody>
</table>
Missing children and those at risk of CSE are reviewed regularly and strategy meetings held on the third episode. Return home interviews are offered to all after each episode.

**The ‘Voice of the Child’**

Children’s views are reported in CLA visits and reported by CLA SWs in their reviews. CLICK has trained young people to chair their reviews, encouraged participation and attended some reviews as a supporter. Surveys conducted by CLICK on Reviews, contact, semi independence units have impacted on the way services are delivered.

**9. Learning and Improvement**

**9.1 Multi-Agency Audits & Reviews**

**9.1.1 IPOC/ MASH and Referral & Assessments Audit**

The Serious Case and Learning Implementation (SCIL) Sub-Committee commissioned an independent audit of the effectiveness of the Front Door services which include IPOC/ MASH and Referral and Assessment Service in January and early February 2018.

The ‘front door’ adopted a new model of working in October 2017 which incorporates one point of contact (IPOC) and includes closer working between the children’s social care (CSC) assessment service and an expanding early help service (EH) as well as continued multidisciplinary working with other statutory partners. The aim of this overview was to test effectiveness of this model along with quality of work within the ‘front door’ service as a whole.

**Summary of overall findings**

*The interface between early help and statutory work is clearly and effectively differentiated*

Good multidisciplinary preparation for setting up IPOC/MASH helped establish common language and understanding of thresholds. There is a stable team of well qualified practitioners in IPOC and evidence of continuing multidisciplinary communication which help support consistent interpretation of threshold. Where there had been previous contacts in the sample of audited cases, the contacts were largely prior to IPOC. However there is learning to be gained from understanding why further contacts/ referrals are received for families offered an early help service where threshold was not met. Early help managers expressed confidence to take cases back to IPOC where they identified risk.
Audited cases suggest that step down to early help services where no role for CSC is found following assessment is not yet fully embedded as team round the child (TAC) meetings are not always held. Where held, they were noted to be effective especially where the lead practitioner was in a school.

AT 3 is acting as a pilot in relation to policy and practice when there is challenge of threshold interpretation about referrals passed from IPOC for S17 assessment. The TM is authorised to record evidence for stepdown and to make arrangements for the family to be offered an EH service. Sample cases examined suggest care must be taken to retain a distinction between meeting threshold and parental willingness to engage with service. Several of the cases in the pilot challenged threshold interpretation in relation to parenting practice. During the review action was taken to enable managers in IPOC and the assessment teams to discuss these cases as part of continuing learning about threshold bandwidth.

It was not clear from sampled cases how the interface between early help and statutory services was operating in relation to the children with disability (CWD) team. This matter was taken up by senior managers during the review.

**Identifying and responding to children’s needs and appropriate thresholds**

There is consistent timely response to contacts and identification of referrals. (This review did not examine quality and source of contacts). There is a strong sense of partnership working and ownership in IPOC/MASH that helps maintain consistent practice and to accommodate any fluctuations in demand. Well experienced permanent managers ensure full account is taken of the requirements set out in legislation and guidance about the need to obtain parental consent for enquiries to be made, and when this can be overridden. Some technical and organisational difficulties were identified that impede efficient information sharing between agencies and recording on Mosaic which practitioners were working around.

The Signs of Safety (SoS) approach to work is liked and well embedded. This helps consistency and efficiency of judgement about threshold and also provides a standard means of communication between professionals about risk and needs.

Interventions were proportionate and evidence seen that the type of assessment (S47 or S17) may change in the light of emerging issues and risks while the practitioner is working with the family.

**Making good decisions and providing effective help (assessment + planning)**

Child Protection (CP) enquires are timely, informed by decisions made in a strategy meeting led by a suitable worker. Few strategy meetings involve more than police and social work practitioners. Children are seen straight away and urgent action taken as necessary to protect...
children. Opportunity for consultation with a CP specialist and or LADO is mostly taken. Conferences are timely, families have access to a SW report prior to conference.

Quality of assessments in a sample of audited cases ranged from ‘good’ to ‘inadequate’ with the majority falling into the broad category of ‘requires improvement’.

Good ability to quickly engage and communicate well with children was demonstrated. Visits to families were well recorded. Clear management direction was given on allocation and each stage of workflow authorised in a timely way.

Common and key areas for improvement related to the quality of the assessment. This included ensuring all relevant children and adults were seen, that information requested from other local authorities/agencies was followed up and that there was full exploration of all issues. More was required in respect of workers own observations of the child, relationships and family dynamic, analysis including impact of diversity, hypotheses and reference to the body of professional knowledge. Sometimes there was delay in starting the assessment or completing the write up. Assessments were sometimes too superficial with too narrow focus on the presenting issue. When to make an early transfer of a case to child in need (CiN) service is discussed in Part 2 of this report.

There is clear policy about transfer of cases to CiN /looked after children (LAC) service but this is not yet well embedded. Case handover does not systematically give children and families the quality of experience practitioners aspire to.

**Management oversight of frontline practice**

All managers are suitably qualified and experienced. Almost all are permanent staff. All work stages are authorised in a timely way. Use of SoS recording format promotes good communication and consistency of approach during the workflow process and is sometimes used in supervision. While good direction is given on allocation for assessment, AT managers do not always provide sufficient challenge and oversight to assure good quality of assessment and timeliness in relation to the case rather than the statutory maximum for S17 assessments.

There remains a high proportion of agency staff but there is clear progress in recruiting, converting good agency staff to permanent contracts and retaining permanent workers. There is emphasis on creating internal opportunity for workers to continue to develop professional skills and progress their careers within Wandsworth.

In response to work volume and the drive to improve service quality, temporary funding has been provided for a fourth assessment team. The aim is to provide three weeks for workers to complete the majority of their assessments between their ‘duty’ weeks when they are responsible for all new referrals for assessment. Impact is to be evaluated.
Conclusion and Recommendations

Over a two year period, changes have been made on a number of fronts to improve service quality at the ‘front door’ of children’s services. This review has sought to test the effectiveness, efficiency and sustainability of arrangements and the quality of service being delivered and to identify where improvement can still be made on this continuing journey.

In summary organisational arrangements, an agreed theoretical model, accompanying policies and processes are in place. Workflow is effective and threshold consistently applied. There are some areas where efficiency can be enhanced and some service interfaces where practice is still bedding down. Overall there remains room for improvement in the quality of assessments. Staff aspire to deliver a good service. The following recommendations aim to address these matters and to help build checks and challenge into the system.

It is recommended:

A comprehensive document is produced for IPOC that describes the service, thresholds and timescales and includes operational policies.

Senior management within children’s services consider funding 4 changes to Mosaic that would address current IPOC workflow inefficiencies arising from capability or configuration of the client record system. (Trigger pending cases, show real time workload of IPOC SWs, move direct from MASH episode to referral, agency checks sign off).

Service managers for children’s CiN and CWD services confirm threshold for CWD service and agree practice for ‘step down’ of referrals and assessments from CWD to EH service.

Senior management within children’s services identify timescale and basis for evaluation of impact of the fourth assessment team.

A review of business support needs is undertaken in response to the new model of working (IPOC/MASH) and the additional assessment team. This review should examine evidence for reported under capacity of team BSO posts leading to lack of evidence of communication with families and partner agencies about outcome of assessments. It should also examine capacity to load information received from partner agencies onto Mosaic so there is certainty it is available to IPOC managers when making decisions about risk and referral.

The chair of the current IPOC steering group consults with the wider strategic network with a view to achieving more effective multidisciplinary strategic governance arrangements to support operational practice in IPOC/MASH. Immediate operational issues being priority afforded by school designated safeguarding officers to timely response to requests for information checks and unreliability of the secure emailing facility.
Supervisors and managers in assessment teams are assisted to increase effectiveness of their oversight of cases, in particular to challenge the quality of S17 assessments. To ensure assessments are of sufficient depth and scope and benefit from professional knowledge and analysis. Also that work starts in a timely way and the assessment and move on is completed as soon as it is right for the case rather than within maximum time permitted.

Periodic audits are made of contacts passed to early help that become repeat contacts and cases where early help practitioners subsequently identify risk of harm, in order to assist with continuing appraisal of threshold interpretation. Periodic audits are made of re-referrals of cases stepped down to early help services following S17 assessment with a view to assisting organisational learning and service improvement. Periodic discussions are held where all ‘front door’ assistant/team managers can consider sample cases that have challenged threshold interpretation or raised practice matters with a view to organisational learning and potential service improvement. Periodic discussion is held between managers in assessment and CiN teams to assist embedding of case transfer arrangements and identification of cases that should transfer early because assessment is expected to require differently paced work.

9.1.2 Private Fostering Audit
The WSCB SCIL Sub-Committee commissioned the Private Fostering Audit in January 2018. The Audit looked at 13 cases where a child has been privately fostered. Of these 13 cases, 3 were designated as open and 10 were closed. Of the 3 open cases, one young person had become LAC a short time after the private fostering assessment and the remaining 2, were children who had been privately fostered for a number of years. 2 were judged to be required improvement and 1 was judged to be inadequate.

Key issues arising from the audit of open cases:

• Chronologies were not routinely available on the cases. In some cases there were a number of chronologies but these were not aligned.

• Assessments not routinely following Private Fostering guidelines.

• Departmental confusion about long term plans

• Lack of consistent contact with schools

• Evidence that frequent changes of designated SW and Manager impacted on the work – there has been a lack of detailed handover of cases and concerns, so key issues have not been followed up. In one case since May 2017, there has been 4 different SW’s carrying out visits.
• Frequency of visits - there was a gap of over 7 months when the next visit was carried out (14/7/16). The management notes on frequency of visits were not clear.

• Inconsistency with regard to recognising the importance of adult holding PR for a child.

• The majority of assessments of private foster carers contained a signed consent form allowing for agencies to be contacted. However, the case records did not always contain the references obtained or copies of medical/ DBS checks.

• The open cases conveyed a sense that the SW role was seen as monitoring rather than challenging irregularities or concerns

**Conclusion:**

It was evident from reviewing the case files of the open cases and dip sampling issues in the closed cases, that the many changes of Social Workers, together with changes in Management of those cases, has impacted on the work. There have been inconsistencies with regard to following plans through and transfer of work has not been helped as there has been an absence of detailed handovers.

• There is no clear work flow that appears to direct the work after the initial assessment.

• Visits appear to be monitoring rather than directing work.

• Management decision, such as decreasing visits does not appear based on evidence of the case or needs of the child.

• It is not clear how the different strands of work are prioritized. For example, there is a focus upon ensuring that initial assessments of the PF carer are completed in time, where a child may only be in the country for a short period of time.
Section 11 Self-Assessment Audit

Section 11 (4) of the Children Act 2004\(^3\) requires each person or body to which the duties apply to have regard to any guidance given to them by the Secretary of State and places a statutory requirement on organisations and individuals to ensure they have arrangements in place to safeguard and promote the welfare of children. Working Together to Safeguard Children 2015\(^4\) states that one of the key functions of a Local Safeguarding Children Board is “monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve”. The WSCB discharges this function by carrying out a Section 11 assessment on an annual basis. This provides information from all the relevant partners and the Local Authority which is analysed and enables WSCB to evaluate the effectiveness of the partnership workforce’s safeguarding knowledge and practice.

The WSCB process involves a practitioner’s survey and a strategic survey. The practitioner’s survey has now been used for some years and provides a high level of data from frontline staff across all agencies. Therefore, the process has become a familiar one to most agencies and is seen by most of the safeguarding leads as an opportunity for agencies to self audit and identify issues that require action as well as it provides the data required by the WSCB. The process is steered by a Multi-Agency Working Group which works well together.

The survey is circulated to safeguarding leads across the WSCB and each is expected to ensure as many staff as possible complete the survey. Larger organisations are expected to ensure a minimum of 10% of the workforce complete the survey. The results of the survey are analysed and summary of the response data is provided which enables the organisation to put together an Action Plan to address any gaps or weaknesses identified as a result of reviewing the summary.

Each designated lead is also required to complete the strategic survey and assess practice in their agency against the eight Section 11 requirements. Comments are invited against each requirement and the agency should be prepared to provide evidence to support their self-assessment if required.


All statutory partners and a selection of other partners are then invited to meet a panel of WSCB representatives for an interview/discussion. Feedback from these sessions is recorded and key points are included in the Section 11 Report to WSCB.

**Practitioners’ Individual Survey:**

A new online process was used in the last two years in response to requests from some partners to ease the burden of managing a high number of paper forms. To encourage greater participation by individual agencies, 13 agency specific questionnaires were created that has the first 6 questions in common. The result was positive, as we collected 7,226 responses, a large increase from the previous years and the highest record achieved locally and has put Wandsworth SCB in the lead nationally. The number of practitioners participated increased by 2,415 comparing to 4,811 in 2017 and 5100 in 2016.

The online system is a specialist survey software that is suitable for Section 11 Audits. The process was made easier in 2018 as agency specific surveys were created and the number of questions were aligned and reduced to focus on the main issues to ensure the survey remained relevant to all the practitioners involved. Once practitioners had completed the survey, the WSCB Manager sent reports (created by the specialist software) out to each agency enabling them to review the responses from their staff teams and feedback the findings to services or individual practitioners as appropriate. The analysis of responses and feedback process continued and the Board facilitated 27 interviews with the WSCB partners’ representatives part of the challenge structure.

As a result of the feedback received from agencies and input from the working group and those who contributed to the panel, changes to the process will be made before the 2019 Section 11 Audit, to ensure that individual services, e.g schools and nurseries, get more ongoing information on response levels, which proved difficult to provide with this year’s survey as we did not have a list of the PVI Nurseries who participated and summaries were only filtered and shared upon request.

Some agencies did not require participants to provide their name and role (although the working group had agreed it was preferable to ask participants to provide this information). This caused some difficulties for those agencies in monitoring completion rates and in analysing their returns effectively, and in some instances had an adverse effect on the level of responses received. There were concerns expressed about the loss of ownership of the process for leads in individual agencies and the challenges in being able to monitor completion rates while the survey was being undertaken. Therefore, it is suggested that names and role will be used in all questionnaires.
In addition, prepopulated choice of Agency Name to be listed as practitioners recorded their agency name differently and this presented as a challenge when filtering and creating response summaries for some of the agencies. The proposed additional work in the survey will provide a more accurate results.

The majority of agencies welcomed the new online system, particularly as it reduced workload, but also noted the challenges detailed above. The Agencies welcomed the reduction in the size of the survey reducing the questions from 40 questions in total to 26 and 16 questions in one survey. All surveys created this year were user friendly and quick to complete for individuals. Each survey took around 10 to 15 minutes to complete on average – produces a very large amount of data, which can make analysis time consuming. In 2019, we need to continue to reduce the number of questions to pick up the key issues, e.g. ensuring practitioners know how to respond to concerns about a child; that all practitioners know who to report concerns to in their organisation etc. will continue to be a priority for 2019.

The use of differentiated questionnaires to meet the different needs of the workforce, organised around agreed key themes, while retaining some key questions for all, has been welcomed and the plan is that we continue to use the same system in future.

The table below demonstrates that the response levels were excellent in Education, in the Early Years sectors, Childminders, Housing, Library Service, Children Centres and from GPs, but requiring improvements for others, for example, St George’s Hospital, Mental Health Trust, Children’s Services and the Faith, Voluntary and Community Sector. No response was received from Taxi firms or Hotels although they were contacted. It is acknowledged that some of the poor returns were due to poor communication rather than poor engagement with the process. In order to ensure an improved level of returns next year the working group will update the list of leads from agencies and sections and the S11 Audit will be circulated more effectively. In addition, the returns will be monitored and any agency with a low level of return will be contacted directly to encourage them to remind staff to complete the questionnaire. Our target is to achieve at least 7,500 individual returns in 2019.

The Board is looking to develop an Engagement Plan with Faith, Community and Voluntary Sector in 2018 - 2019 to improve communication.

<p>| Section 11: Breakdown of Responses by Organisation/ Sector: |
| What type of organisation do you work for? |</p>
<table>
<thead>
<tr>
<th>Organisations Name:</th>
<th>Response Percent</th>
<th>Response Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Schools Section 11 Practitioners Questionnaire 2018</td>
<td>58%</td>
<td>4195</td>
</tr>
<tr>
<td>2 Early Years PVI Section 11 Audit Practitioners Questionnaire 2018</td>
<td>15%</td>
<td>1118</td>
</tr>
<tr>
<td>3 General Section 11 Audit Questionnaire 2018 (Housing, Probation, Libraries, Leisure, Faith, Community and Voluntary Sector).</td>
<td>6%</td>
<td>411</td>
</tr>
<tr>
<td>4 Wandsworth GP Surgeries Section 11 Audit Questionnaire 2018</td>
<td>4%</td>
<td>293</td>
</tr>
<tr>
<td>5 Children Services Section 11 Audit Practitioners Questionnaire 2018</td>
<td>4%</td>
<td>270</td>
</tr>
<tr>
<td>6 Children Centres/ EYISS/ Early Help/ Youth Services Section 11 Audit Practitioners Questionnaire 2018</td>
<td>3%</td>
<td>182</td>
</tr>
<tr>
<td>7 Wandsworth Police Section 11 Audit Questionnaire 2018</td>
<td>2%</td>
<td>179</td>
</tr>
<tr>
<td>8 ChildMinders Section 11 Audit Practitioners Questionnaire 2018</td>
<td>2%</td>
<td>144</td>
</tr>
<tr>
<td>9 St George's Hospital Practitioners Section 11 Audit Questionnaire 2018</td>
<td>2%</td>
<td>131</td>
</tr>
<tr>
<td>10 Adult Service Section 11 Audit Questionnaire 2018</td>
<td>1%</td>
<td>97</td>
</tr>
<tr>
<td>11 CLCH Wandsworth Community Services Section 11 Audit Questionnaire 2018</td>
<td>1%</td>
<td>81</td>
</tr>
<tr>
<td>12 Priory Hospital Section 11 Audit Questionnaire 2018</td>
<td>1%</td>
<td>78</td>
</tr>
<tr>
<td>13 Mental Health Trust Section 11 Audit Questionnaire 2018</td>
<td>1%</td>
<td>47</td>
</tr>
</tbody>
</table>

Answered 7226
**Analysis of Key Questions:**

*Please note not all respondents answered every question – therefore some results may not accurately reflect knowledge held*

- **Do you have a Safeguarding Responsibility within your role?**
  
  On average 88.06% of respondents across the partnership workforce answered ‘Yes’

- **If you have safeguarding concerns about a child, do you know who you would talk to in your organisation?**
  
  On average 93% of respondents across the partnership workforce answered: ‘Yes’ and identified the correct person

- **If you have safeguarding concerns about a child or young person, when would you report it to the Safeguarding Person for your School/Organisation/setting?**

- **When should a Referral be made to IPOC?**
  
  97.82% said: ‘As soon as practically possible, that day’

- **What types of concerns does the Local Authority (LADO) investigate?**
  
  On average 92.7% selected: ‘When a Professional/Volunteer/Colleague has harmed a child or put a child at risk’.

- **When sharing information about a child safeguarding concern which one of the following statements describes what you should do?**

  On average 95.31% selected: ‘If I am concerned about a child and have decided to share information, the information I share must be accurate, relevant, proportionate and shared with the correct agency via an appropriate secure method of sharing information’.

- **Would you feel confident to use a 'whistleblowing' process in your organisation if you felt it was necessary?**

  64.15% said Yes.

- **Which is the most important question to ask Adult clients with regard to child safeguarding?**

  Three Agencies completed this question and their answers reflected the following averages:

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you live with or have any caring responsibilities for any child?</td>
<td>81.06%</td>
</tr>
</tbody>
</table>
Official Are you Alcohol Dependent? 7.06%
Were you ever a victim of abuse? 11.51%

- **When was the last time you attended Children Safeguarding Training?**

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Percentage (Practitioners)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the last Year</td>
<td>79.72% (5761 Practitioners)</td>
</tr>
<tr>
<td>Within the last 3 Years</td>
<td>15.29% (1105 Practitioners)</td>
</tr>
<tr>
<td>More than 3 Years ago</td>
<td>1.03% (75 Practitioners)</td>
</tr>
<tr>
<td>Never/don’t know/can’t remember</td>
<td>3.94% (285 Practitioners)</td>
</tr>
</tbody>
</table>

The responses overall indicate a very encouraging level of awareness of safeguarding across the range of services to children and families in Wandsworth, particularly in respect of their knowledge of what to do when there is concern about a child. It was also encouraging to note the high levels of training attended across agencies.

**Strategic Survey:**

In April 2018, a ‘Strategic Questionnaire was sent to all agencies asking for a self-assessment of safeguarding practice under each of the eight standards of Section 11 and to provide executive level signoff of that statement. This was put into operation concurrently and complemented the practitioners’ survey and is therefore reported here. By 25th July 2018, 61 agencies, including schools, Police, Health, Children’s services, Housing & Leisure providers, Community Organisations and a Faith Organisation had made a return and more will be encouraged to complete. All agencies were asked to assess if their practice against each standard was Met, Partially Met or Not Met. If any standards were not fully met, the agency have been asked to provide details of what actions were planned to make the necessary improvements. Equally, all agencies were required to assure that, if requested, evidence is available to support the self-assessment.

**The Average Responses so far indicate a high level of reported compliance with Section 11 Standards:**

92.78% are Met/ 5.58% are Partially Met/ and 1.64% are Not Met
**Standard 1: Senior Management commitment to the importance of Safeguarding and promoting children’s welfare**
Met: 96.7% - Not Met: 1.67% - Partially Met: 1.6%

**Standard 2: A clear statement of the agency’s responsibility towards children is available**
Met: 98.3% - Not Met: 0.0% - Partially Met: 1.7%

**Standard 3: A clear line of accountability within the organisation for work on safeguarding and promoting the safeguarding of children**
Met: 96.7% - Not Met: 0.0% - Partially Met: 3.3%

**Standard 4: Service development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of children & families**
Met: 88.5% - Not Met: 0.0% - Partially Met: 11.5%

**Standard 5: There is effective training on safeguarding & promoting the welfare of children for all staff working with or, depending on the agency’s primary functions, in contact with children and families**
Met: 90.0% - Not Met: 1.7% - Partially Met: 8.3%

**Standard 6: Safer recruitment procedures including vetting procedures and those for managing allegations are in place**
Met: 95.1% - Not Met: 0.0% - Partially Met: 4.9%

**Standard 7: There is effective inter-agency working to safeguard and promote the welfare of children**
Met: 90.0% - Not Met: 0.0% - Partially Met: 10.0%

**Standard 8: There is effective Information Sharing**
Met: 86.9% - Not Met: 0.0% - Partially Met: 13.1%
### Action Plans

A number of action plans have been received from agencies following on from the practitioners’ survey, notably from schools, but numbers of these overall are low to medium. WSCB will need to send a reminder to ensure actions plans have been completed by agencies and returned.

**Recommendations:** The table below highlights the recommendations relating to the Section 11 Process itself, in addition further recommendations made following the analysis of the returns and as a result of the challenge conversations.

<table>
<thead>
<tr>
<th>Recommendation [1] Relating to Section 11 Process</th>
<th>Action to be taken</th>
<th>Lead Person/ Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>To continue to use Agency Specific Questionnaires in 2019. To ensure that all Questionnaires include the name of the Practitioner completing the survey and their organisations. Where possible, to include the name of the organisation in the pick list to facilitate the filtering process and for more accurate Data. To ensure that the agreed questions to be used for all agencies that they use the same wordings and seek information within the same timeframe.</td>
<td>To discuss with the S11 Working Group and to continue to use Agency Specific Questionnaires in 2019. To design S11 Questionnaire 2018 in way that capture the information required. We do need to collect the name of the practitioner to ensure that we are able to assist organisations to encourage participation and also to provide support to all individuals where necessary. To ensure consistency. Also to ensure clarity for Practitioners to understand the questions correctly.</td>
<td>WSCB Manager and Section 11 Working Group. By December 2018</td>
</tr>
<tr>
<td>To continue to use a set of key questions for staff in all agencies. To continue to have differentiated questions that specific to the work each agency e.g. Schools/ Early Years/ Health/ Specialist Services and all others.</td>
<td>To consult with Agencies to what they want to see in the Questionnaire 2019. To provide the key questions only for the Agencies that do not have regular direct contact with children.</td>
<td>WSCB Manager and Section 11 Working Group. By December 2018</td>
</tr>
<tr>
<td>Discussion about whether the Section 11</td>
<td>To discuss this item with the WSCB Partners at the</td>
<td>WSCB Manager and Section 11 Working Group. By</td>
</tr>
<tr>
<td>Recommendation [2] Relating to Issues Arising from the Section 11 Audit Analysis</td>
<td>Action to be taken</td>
<td>Lead Person/ Timescales</td>
</tr>
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<tr>
<td>To review the current Training offer and to ensure that the areas where Training was identified as a need such as: FGM, Violence in the name of honour, Peer on Peer Abuse, Contextualised Safeguarding, Bullying and Radicalisation to cover new areas the workforce require Training on.</td>
<td>To discuss this matter at the Training &amp; Workforce Sub-Committee.</td>
<td>WSCB Business Manager to raise with the Chair of the Training &amp; Taskforce Sub-Committee by October 2018.</td>
</tr>
<tr>
<td>To follow up the FGM Audit to ensure that is being completed by St George’s Hospital and to understand the reasons for the low referrals rate to IPOC</td>
<td>To discuss further at the FGM Task and Finish Working Group.</td>
<td>WSCB Business Manager to raise with the Chair of the FGM Task and Finish Working Group.</td>
</tr>
<tr>
<td>To review the current programme of online Training and to possibly expand on the existing materials to cover new areas that has not been included.</td>
<td>To discuss this matter at the Training &amp; Workforce Sub-Committee.</td>
<td>WSCB Business to raise with the Chair of the Training &amp; Taskforce Sub-Committee by October 2018.</td>
</tr>
<tr>
<td>To further improve the understanding of the LADO role across staff in all agencies.</td>
<td>To publish a new leaflet and circulate it widely. All agencies to ensure that key staff attend the Multi-Agency Safeguarding Training around the role of the LADO.</td>
<td>To re-send the LADO Leaflet by the end of October 2018. LADO to deliver Training on her role and further Training sessions will be delivered: 4 times per year.</td>
</tr>
</tbody>
</table>
To promote the role of the LADO within the WSCB Newsletter

To disseminate the finding of the Section 11 Multi Agency Self Assessment Audit to all agencies.

To share the Final Section 11 Audit Report with all agencies, to publish a summary of the report in the WSCB Newsletter and to publish it on the WSCB website as appropriate.

WSCB Business Manager to promote the role of the LADO within the WSCB Newsletter.

WSCB to email it out to all agencies upon approval at the Monitoring Sub-Committee on 15th August 2018.

<table>
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<tr>
<th>Case Reviews</th>
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**Serious Case Reviews**

In 2017-2018 the WSCB continue to finish off the improvement work arising for the Kingston SCR Action Plan, for example, see [Children with disabilities and special educational needs](#) above.

**Learning Lessons from Baby Eliza Serious Case Review:**

In July 2016 the WSCB SCIL Sub-Committee met and recommended to the Independent Chair of the WSCB that a Serious Case Review should be initiated into the case of a young child (Baby Eliza) seriously harmed. This Serious Case review concluded in May 2017, although the report could not be published for ongoing legal reasons. The focus of the SCR was always on identifying learning and this has already been applied to aspects of the Board’s work and multi-agency practice, subject to the restrictions identified above. It is expected that the Board will be able to fully report on the SCR and publish it during 2018-2019.

All Local Safeguarding Children Boards follow the statutory guidance in Working Together to Safeguard Children 2015 when considering the threshold for conducting a serious case review (SCR), This should take place if a child abuse or neglect is known, or suspected in a case and a child has died or a child has been seriously harmed and there is cause for concern about how the authority or other organisations or

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5 Working Together 2015, Chapter 5, P75 outlines the responsibilities of LSCBs to undertake SCRs.

professionals worked together to safeguard the child. The WSCB has undertaken a Serious Case Review on Baby Eliza* in 2016-17. The SCR was about baby Eliza who received serious injuries whilst living at home with her mother. Eliza’s mother was recognized as a young parent who suffered from gendered abuse across her childhood and into adulthood; from child sexual abuse to child sexual exploitation then domestic abuse. The mother experienced separation and disrupted attachments from her family as child who moved between care arrangements in her family and was in public care as a teenager; she experienced harm/abuse and was a missing child. In light of child protection concerns about neglect and harm to animals her first child was removed.

Her own history impacted upon her parenting capacity. Professionals worked with the family recognized their sympathy for her as a child who had been looked after and was also a vulnerable care leaver. The SCR highlighted the potential to identify with the abused child within the adult who was a parent. The possibility that practitioners may have over identified and whether this unconsciously impacted on decision making and response to concerns was noted. Professionals initiative to ask questions and show curiosity about the role of men and fathers; their history of parenting and relationships was also raised.

**What was learnt from the SCR? The WSCB recognised the learning highlighted in this SCR as listed below:**

- Pre-Birth Assessment Guidance was revised and reissued to ensure that pre-birth procedures are understood & followed.
- Information sharing should be prioritised by all agencies to ensure the welfare of the baby.
- Importance of detailed safeguarding information being included in referrals for services to help identify the child needs.
- A recognition that mental ill-health, substance misuse and domestic abuse have an impact on capacity to parent to inform a risk assessment for a vulnerable child and not diminished in consequence of sympathy for a vulnerable parent.
- The benefit of precision in professional exchanges e.g. status of a service user’s given address and commonality of terms (core group v team around the child). The WSCB has now changed the terminology and asked professionals to use the term Core Group in line with the Child Protection Procedures.
• The WSCB will need to continue to hold professionals and organisations to account to support them to challenge perceived errors of professional judgments.

• Professionals will need to continue to encourage full involvement of GPs.

**Learning Lessons from E Children Learning Review:**

In September 2016, the SCIL Sub-Committee recommended an independent learning review about E Children to be commissioned into serious concerns about the care of children from a Wandsworth family. This review did not commence until May 2017 following issues with contracting an appropriate independent reviewer. The report in the Autumn of 2017 and learning picked up by the relevant agencies. While this review does not meet the criteria in Working Together 21-5 for an SCR, it is still receiving a full and robust independent review on behalf of the WSCB. The multi-agency learning review was carried out by WSCB in partnership with a neighbouring Borough’s LSCB. This review considered the permanence planning, decision making and protection of two Black British children now aged 10 and 13 who have been adopted by their former Foster Carers. The review considered the period between 2004 and 2015.

When the children were placed together in what was their foster home, they had no previous relationship as one of them a baby joining her older brother. The adoptive parents were originally Independent Fostering Agency (IFA) carers who then moved across to become Wandsworth Foster Carers. The adoptive parents had an older birth child and were a suitable match in terms of identity and culture. During the placement a number of child protection concerns arose particularly in relation to sexualised behaviour and how this was understood.

There were also challenges in addressing safe care, requests for financial support and structural changes to the family home.

**Key learning**

• The review identified failings in the protection of the children. There were missed opportunities to assess the children’s safety by carrying out Section 47 child protection enquiries in 2011, 2014 and March 2015.

• Statutory guidance within London Child Protection Procedures and National Fostering Standards was not followed.
• Need to ensure that standards of approval for foster carers are high that Fostering and Adoption panels fulfil their role in scrutiny and challenge.

• The need to review the permanence plan for the children when concerns arise including the question of whether siblings should be placed together or apart.

• To understand the role that complaints and requests for finance may have when addressing safeguarding.

• Dynamics of disguised compliance need to be understood and recognised.

• Understanding the importance of internal escalation of concerns and across the partnership within Wandsworth and the neighbouring Borough led to questions about professionals understanding of their responsibility and process for LSCB escalation.

Learning from the review will be presented at the WSCB Learning from Experience events on 24th April 2018 at Wandsworth Professional Development Centre (WPDC) based at Burntwood Academy.

**Child L Learning Review:**

In 2017-18, a further Learning Review was commissioned by the SCIL Sub-Committee with regards to Child L due to professionals at a local hospital not being able to recognise the neglect of a child’s health. The Learning review is expected to progress during the year 2018-19.

**WSCB dataset and performance management**

**Revised Dataset for 2017-2018:**

A new dataset for 2017-2018 has also been under construction and will be reported in future WSCB annual reports. This will involve a number of important principles:

• Good demographic data, including from the Health & Wellbeing Board Joint Strategic Needs Assessment (JSNA)
• More narrative/commentary
• Outcomes data – measuring impact of services by surveying methodologies
• Working with neighbouring boroughs to coordinate data collection, particularly as many partner agencies are combining or plan to combine during 2017-2018, e.g. health agencies, police.
• Simplifying data collection for partner agencies by use and combination of existing agencies datasets:
  • Improvement Board dataset. The WSCB or its successor will be expected to pick up this dataset, which has been revised for 2017-2018, at the stage when the Improvement Board hand over full responsibility for safeguarding. It presents a smaller and more focused set of indicators for Wandsworth Children’s Services.
  • Housing data – this has been revised.
  • Health indicators – These are likely to undergo thorough review with the changes happening in the Clinical Commissioning Group
  • Police and community safety data – Most data is collected centrally by the Metropolitan Police Service, and there have been problems since 2015 with provision of data to LSCBs. A new MOPAC Police & Crime Plan dashboard is being constructed which will include
  • A range of indicators covering areas which the Board is required to mentor statutorily, including:
    – Private fostering – numbers are low, so this is an indicator that requires more challenge, and is not in the Improvement Board dataset.
    – Young people Not in Education, Employment or Training (NEET).
    – Child Sexual Exploitation data
    – Female Genital Mutilation
    – Young Carers data – number engaging with commissioned services?
    – Children Missing from Education
    – Youth Offending data
    – Early Help – particularly the number of children ‘stepped down’ to Team Around the Child services which has proved hard to retrieve previously. A new IT system in Children’s Services may provide more detailed data.
Team Around the Child - The WSCB will be looking to find a way to assess some information by proxy, e.g. how many children on GP lists are regarded as safeguarding risks or vulnerable families.

The WSCB needs to get beyond data and audit to performance assessment and scrutiny, which requires an holistic approach viewing and quality assuring outcomes for: the experience of the child, the experience of families and the experience/ effectiveness of multi-agency practice. The aim will be to draw upon the learning and encourage/ broker practice development.

With the support of the Board chair, a complete rethink of the data needs of the Board has begun. This has meant looking at the current data set as well as the set currently provided to the Improvement Board. A view has also been taken of what the Board should be provided with to demonstrate, (with regard to all children in the borough), that it is monitoring:

1. The child safeguarding, (as well as the child protection) needs of the Borough
2. The interventions that are in place to improve wellbeing and protection
3. That the right outcomes are being achieved for all

Derived from these questions there are a number of secondary inquiries that fill out the context of each main question. Behind this process is the expectation that the work of the Board will be to challenge and influence partners to build and maintain positive relationships with their charges. And where it is apparent that such relationships are not being developed, challenge will follow based on the premise that no safeguarding work is effective without the development and maintenance of durable positive relationships.

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With the support of the Board chair, a complete rethink of the data needs of the Board has been undertaken. We looked at current data set and data provided to Children’s Services Improvement Board. A recommendation for the Board to be provided data about all children in the borough that is monitoring:

1. The child safeguarding, (as well as the child protection) needs of the Borough
2. The interventions that are in place to improve wellbeing and protection
3. That the right outcomes are being achieved for all

Behind this process is the expectation that the work of the Board will be to challenge and influence partners to build and maintain positive relationships with their charges. And where it is apparent that such relationships are not being developed, challenge will follow based on the premise that no safeguarding work is effective without the development and maintenance of durable positive relationships.

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**Partner Agencies Reports**

As part of the process to produce the WSCB’s annual report, each statutory partner agency was asked to complete a report, using a template provided by the WSCB. The report therefore includes not only the work of the safeguarding board itself, but a summary of the work undertaken by all partners to promote safeguarding children during the past year. Each agency was asked to provide a rigorous and transparent assessment of the performance and effectiveness of their service; and to identify areas of weakness, the causes of the weakness and actions being taken to address them as well as proposals for action. All key statutory partner agencies reports are included in this report and are within the appendices (published separately).