



Harrow  
Safeguarding  
Partnership



HARROW  
SAFEGUARDING  
CHILDREN  
BOARD

***ANNUAL REPORT 2020 – 2021***  
***THINK WHOLE FAMILY***

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## 1. Foreword

This is the second annual report that we have produced as the Safeguarding Partners for Harrow. It explains how we have performed in relation to our safeguarding plan which you can see if you visit our website.<sup>1</sup>

In this report, you will be able to get a picture of Harrow as a place to live and you will see how most children here thrive in their homes, schools and communities. You will also be able to see the steps that we take to ensure that children are kept safe from harm and are allowed to develop happily and healthily.

The past year has been dominated by Covid-19 and the three partners to these arrangements have all had to adopt new ways of working, in order to ensure that the business of ensuring the welfare of children could continue. You will see some of that story in this report.

The tasks of safeguarding children and adults at risk share many common features and often involve people from the same families and communities. Our way of ensuring that these two safeguarding disciplines are as coordinated as possible is to adopt a “Think Whole Family” approach. Under this banner we have prioritised our work in the fields of domestic abuse, mental health and well-being and contextual safeguarding<sup>2</sup>, because they represent safeguarding cross over areas.

We believe that Harrow has a strong and effective safeguarding partnership. Recently an Ofsted review of the safeguarding and child protection arrangements in Harrow commented on the maturity and strength of our partnership work.

We want to thank the organisations that contribute to our work and to acknowledge the excellent partnership of the statutory and voluntary agencies.

We also want to pay tribute to the workforce who, in this most difficult of years, have worked hard to keep children safe, ensure their welfare and make Harrow a place where families can thrive.

Harrow Safeguarding Partnership



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<sup>1</sup> <https://www.harrowscb.co.uk/wp-content/uploads/2019/06/Harrow-Safeguarding-Children-Arrangements-May-2019.pdf>

<sup>2</sup> **Contextual Safeguarding** seeks to understand, and respond to people’s experiences of significant harm beyond their families. It recognises that the different relationships that young people form among their peers, in their neighbourhoods, in their schools and online can involve or lead to violence and abuse.

## 2. Evaluation of the effectiveness of the Harrow Safeguarding Partners' child safeguarding and welfare arrangements by Chris Miller

|             |                   |
|-------------|-------------------|
| <b>Key:</b> |                   |
| ✓           | = Good            |
| #           | = Some Work to Do |
| X           | = Much Work to Do |

### Introduction

The Harrow Safeguarding Partners<sup>3</sup> as part of their arrangements to safeguard children and promote their welfare are required to demonstrate that they are open to independent scrutiny<sup>4</sup>. I have been appointed to offer independent scrutiny of these local arrangements and this is my assessment of how those arrangements have performed over the past year.<sup>5</sup>

### Response to Covid-19

The year to which this report refers has been dominated by Covid-19. It caused the partners to re-evaluate how they were going to carry out their functions, with many staff absent, diverted to other priority activity or constrained by lockdown rules from having normal person to person contact. The partners demonstrated resilience and resourcefulness adapting operational, leadership and training systems to cope with a significant forced change to their normal processes. The steady progress towards more agile working was accelerated considerably and the children's workforce quickly adapted to new ways of doing business, using video and phone conferencing in a way considered inconceivable prior to 2020. Incorporating these new tools into their work in a way that benefits children and families will be a challenge for the next year or two. ✓

### The three core Safeguarding Partners<sup>6</sup> are actively involved in strategic planning and implementation

The three core Safeguarding Partners own the Harrow safeguarding arrangements together. They have devised a system for ensuring shared leadership of the strategic partnership group and they are reasonably well represented across the subgroup structure that is an important constituent part of the arrangements. They set the agenda for the partnership together and contribute fully in the development of the strategic plan. There has for some time been a deficit in the way in which the partners set about funding the arrangements. I have commented on this

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<sup>3</sup> These are Harrow Council, The Metropolitan Police and The Harrow Clinical Commissioning Group

<sup>4</sup> Section 16 G (3) Children Act 2004

<sup>5</sup> These safeguarding arrangements replaced the Harrow Safeguarding Children Board as of June 2019.

<sup>6</sup> These are Harrow Council, the NWL Clinical Commissioning Group and the Metropolitan Police

many times before. The arrangements are adequately funded because the Local Authority ensures that this is the case, but the way in which this occurs is inequitable. Involvement of Key Partners ✓ Funding Arrangements ✗

#### Involvement of Wider Safeguarding Partners ( Relevant Agencies)

The Safeguarding Partners must, not only make their own arrangements to coordinate their activities to safeguard children and protect them from harm, but also include other agencies in these arrangements<sup>7</sup>. These other agencies, called Relevant Agencies should then act in a mutually cooperative way to ensure the effectiveness of the local arrangements. The Harrow Safeguarding Partners have identified a significant range of relevant agencies<sup>8</sup>. These agencies have been effectively engaged in the arrangements since their inception. They have demonstrated this through their contribution across a range of meetings and activities and involvement both as attendees and leaders of various subgroups. The engagement of schools and colleges at all levels is particularly effective. ✓

#### Learning from reviews and incidents

It is a responsibility of the Safeguarding Partners<sup>9</sup> to identify serious child safeguarding incidents, to review them as appropriate so that improvements can be made. A developing strength of the Partnership is the way in which it has developed a flexible and cooperative approach to conducting reviews. This report includes the details of three different kinds of review, each of which is seeking to embed learning across the children workforce. The Harrow Safeguarding Partners have a good system for identifying incidents, a well organised group of multi-agency professionals that move these cases forward and a strong learning ethos which ensures that lessons learned go on to improve practice. Furthermore, the strong audit regime established by the Partners ensure that learning is revisited and embedded. ✓

#### Enquiry and Challenge

This is one of the key activities that Safeguarding Partners need to have in place. Harrow's arrangements are strong in this respect and the QA section of this report illustrates multi-agency energy that is put into ensuring that practice is scrutinised and improved. This area of work has been strengthened over the past twelve months by the inclusion of scrutiny of adult safeguarding information in the QA subgroup as part of the Think Whole Family ethos of the Partnership. ✓

#### Information Sharing

One particular issue that has arisen in the past twelve months is the uncertainty that the children's workforce demonstrate on the need to share information across organisational boundaries and the permission (and duty) that they have to do this. There remains

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<sup>7</sup> 16 E (2) Children Act 2004

<sup>8</sup> Accessed at Appendix 1; <http://www.harrowscb.co.uk/wp-content/uploads/2019/06/Harrow-Safeguarding-Children-Arrangements-May-2019.pdf>

<sup>9</sup> Section 16 F Children Act 2004

significant confusion among the workforce on the role that parental consent has in the sharing of a child's personal data, in circumstances where the safety or welfare of a child requires to be assessed. Given the frequency with which information sharing arises as an improvement issue in serious case reviews and child safeguarding partnership reviews, this is a matter that the Partnership needs to resolve , so that their staff can be confident in their knowledge about this aspect of their work **X**

#### Understanding performance information

This is an improving picture. We have a rich data set provided by Harrow Council. The Metropolitan Police following its restructure continues to work on its data provision to the partnership. Health provider data has improved and developed over the past 12 months. Compounding all the data that is available will further improve the picture of what is happening. There is though real determination among the partners to get this right **✓**

#### Working strategically with other partnership boards

Partnership work is a strength of these arrangements and there is a real commitment to work together with other partners and boards wherever there is mutual advantage to be had. The annual conference this year was conducted jointly with Harrow Safeguarding Adult Board (HSAB). I chair the HSAB as well as chairing and scrutinising the work of the children's safeguarding arrangements. I am also a member of the Health and Wellbeing Board and take part in the joint strategic need analysis working groups. Both the Safeguarding Boards work well alongside Safer Harrow **✓**

#### Children, young people and families are aware of and involved with plans for safeguarding children

Ensuring that children and their families play a part in setting the agenda for the Safeguarding Partners is a challenge for all Partnerships. Harrow has done some exciting and innovative work with Young Harrow Foundation in the past and recently with Harrow Public Health to capture a wide range of children's opinions and voices. The work with Voluntary Action Harrow sees that opinion seeking work carried out into Harrow's diverse communities. Finding a way to embed the child's voice into service planning still requires a further step up, but there is much to build on. The HSCB's Business Development Day for 2021 has been structured around the findings of the Children and Young Persons 'How Are You' survey to inform our future focus and activity **#**

*Chris Miller*

**Chris Miller**  
**Independent Chair and Scrutineer**  
**Harrow Safeguarding Partnership**



### 3. Harrow at a Glance (31<sup>st</sup> March 2021)



|  |  |
|--|--|
| Overall Population (ONS midyear estimate, 2020)  | 252,300                                |
| Deprivation (Where 1 is most deprived Local Authority Area in England). This index is updated every few years. In 2015 Harrow was more or less in the same place.  | 207/<br>317(England)<br>27/33 (London) |
| Deprivation Affecting Children (Where 1 is the Local Authority Area which has the most deprivation affecting children) This has improved markedly since 2015. That year Harrow was 140/326 <sup>10</sup> in England and 25/33 in London. | 199/317<br>(England)<br>30/33 (London) |
| Number of Primary Schools  | 41                                     |
| Through Schools (Ages 5-18)  | 1                                      |
| Independent Schools and Colleges   | 13                                     |
| Number of Secondary Schools / Sixth form colleges/ Tertiary Education Colleges   | 15                                     |
| Special Schools and Alternative Provision  | 6                                      |
| Children in Borough (up 3% in 12 months)   | 64,000                                 |
| Children from a Black, Asian or Multi and Mixed Ethnic Background  | (75%)                                  |
| Number of Contacts in MASH (1 <sup>st</sup> April 2020- 31 <sup>st</sup> March 2021) (+ 2% in 12 months)   | 9,971                                  |
| Number of social work assessments ( broadly the same as last year)   | 2600                                   |
| Number of Children on Child Protection Plans (31 <sup>st</sup> March 2021) (+12% in 12 months)   | 298                                    |
| Number of Children Looked After (LAC) (31 <sup>st</sup> March 2021) (broadly same as last year)  | 184                                    |
| Number of children fostered privately by someone who is not closely related to the child ( broadly same as last year)  | 5                                      |

#### **Commentary**

Harrow is on the whole a prosperous borough. Most of Harrow's resident children thrive in their families and achieve excellent educational results in our schools, which are among the best in the country. Harrow has one of London's most diverse populations and the communities in

<sup>10</sup> Since 2015 a number of England Local Authorities have merged.



which they live generally cooperate well. That helps to make Harrow an enriching place in which to live, learn, work and take leisure. Compared with London, the UK as a whole and other local areas which share our characteristics (our statistical neighbours) the number of children on child protection plans and being looked after by the Council is relatively low.

During Covid-19 we experienced a small increase in the number of referrals into our multi agency safeguarding hub (MASH). The MASH is a collaborative group of professionals, who have access to a wide range of information who help ensure that the best intervention from a menu of possibilities is offered to the family. Mostly, whatever concerns there are can be helped through a range of support called universal services i.e. they are available to everyone and it's just a matter of the family accessing them. If, however, following a formal assessment the child or family is found to need additional help which goes beyond what universal services can provide then as a child in need, with the family's consent, we provide to them additional support and help.

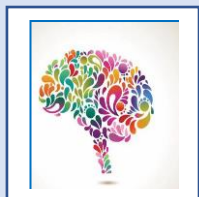
Sometimes the assessment of a family's circumstances and needs finds that a child is at risk of some harm. In those instances, we place the child on a child protection plan and we work with families to reduce the risk. Over the past 12 months although there has been little change to the number of assessments taking place there has been a noticeable increase in the number of children on such plans. We are not wholly sure what the cause for this is and we continue to analyse it closely and the numbers, which were higher in the latter part of 2020 are beginning to recede.

When the risk to a child 's safety or welfare is too high the child has to leave the family home (often temporarily) to live in an environment, where we know that the child's safety is assured. The number of cases in which the Harrow partners have taken this action has remained broadly the same in the past 12 months.





## 4. Progress on Priorities



### Preventing harmful behaviours

#### 1. MENTAL WELLBEING

- Promote an early intervention and prevention approach to mental ill health with a focus on harmful behaviours, including self-harm and suicide
- Promote collaboration between services and agencies at all stages of assessment and intervention
- Consider how multiple vulnerabilities impact mental ill health such as substance misuse and domestic abuse

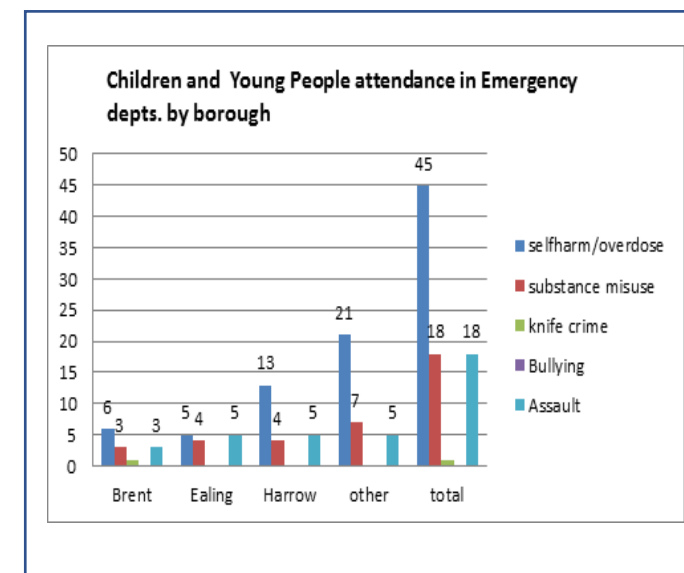
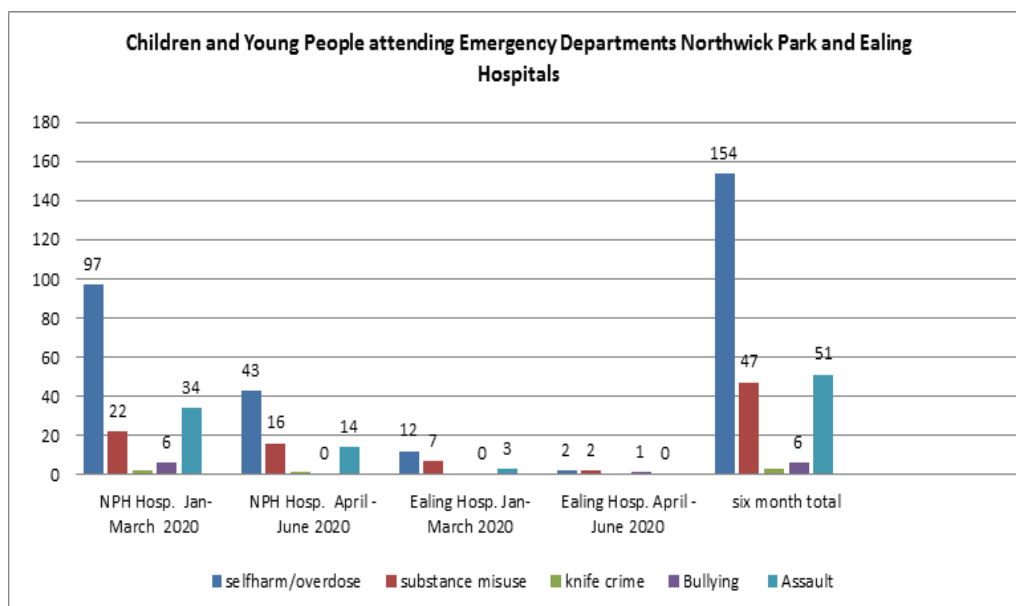
### What was achieved?

- **Impact of Covid-19 and Lockdown**

Mental Wellbeing was an existing priority for the HSP before the impact of the Pandemic, but it became even more relevant as the effects of the virus and the isolation took hold. With children and young people kept away from their normal school environment, local and national services began to see an increase in associated stress and anxiety. Local agencies' business continuity plans quickly responded by setting up a wide range of targeted support, including an enhanced offer from the Education Psychology Service and Central North West London NHS Trust. The HSP assisted with communications across the partnership and with schools, to ensure that the range of mental health support was clearly signposted.

- **Follow up from previous Safeguarding Annual Conference (2020) on Mental Health, Self-harm and Suicide Awareness - Scrutiny of A&E Attendances:**

The issue of children and young people's mental health was identified as a priority area by children and young people themselves in a survey undertaken in 2019 by the Young Harrow Foundation. The QA sub-group sought detailed knowledge and a breakdown of data from London Northwest University Healthcare Trust on children and young people seen at Northwick Park and Ealing hospitals for self-harm, overdose, substance misuse and bullying. There is an overlap with criminal exploitation and so data on those seen for knife wounds and other forms of assault were also examined. Data for the first six months showed the following picture for the region (including children seen at the two hospital from other areas):



In response to increasing demand the Child and Adolescent Mental Health Service (CAMHS) set up a new Adolescent Treatment Service in 2019 with the Urgent Care Team (UCT) for five boroughs including Harrow. Covid-19 had a significant impact on bed capacity for young people suffering acute mental illness. To prevent them from being assessed in unsuitable hospital settings an emergency assessment hub was set up

Throughout the Lockdowns, CAMHS UCT continued to provide face to face contact with their service users. Their aim was to prevent hospital admissions and to offer treatment in the community wherever safe to do so. However, should a child be hospitalised intensive work is undertaken to ensure the earliest but safe discharge possible. Robust follow-up from the UCT then takes place. Our review of the impact of Covid-19 over time on Mental Health activity shows:

- In March/April 2020 (lockdown begins) the demand for mental health services vanished for a while.
- In July 2020 the demand rose significantly and, in particular children were presenting with more acute conditions.
- In August 2020, there was a surge in referrals.
- In September 2020 there was the highest number of referrals ever seen. Presentations were even more severe, including self-harm and crisis presentations. Many issues had been hidden during Lockdown but were emerging and identified as children returned to school.

**Think Whole Family:** In a number of cases, when practitioners visited young people in their homes, it was found that other family members were suffering with Covid-19/Lockdown mental health issues, so referrals were also made for adult services.

ACT seeks to gain feedback on a regular basis from the young people it works with to help ensure services are responsive to them

... if you're actually outside, with all that extra support – it's easier, for like, kids to re-adapt...and just helped more....because when you're locked away, it's sort of like you're in prison...and it's just like really tough...

... when I think of the treatment workers, I think of someone who was there for me....and always there to help

... he like helped...put in more things ...so I would be safer to myself and other people like in school... and sorted other things in the home as well... and helped with my family...kind of helped my mum understand things as well...

### **Social Workers in Schools Project**

The Social Worker in Schools Project started in November 2020 and is funded by the Department for Education. Six social workers are working in six different secondary schools, with a manager overseeing the project. The social workers provide on-site support to schools to provide preventative help, early support and safeguarding expertise. This arrangement embraces collaborative working between schools and Children's Social Care and allows for early advice and intervention. The schools were selected on criteria set by the project's evaluation team from the University of Cardiff.

The team have worked hard to make themselves visible and accessible to staff and pupils in the schools and early indications are positive – to the point that the project has received funding for an extension.

Cases still go through the MASH for consistency of approach but are then allocated to the social worker attached to the school, so that they can work directly with the child and their family.

The Lockdown caused some initial problems of accessibility, but the project made good impact as soon as children returned to school. Feedback from staff, children and their parents has been very positive. In particular, the surge of associated stress and anxiety for children and their families has been responded to by a range of support provided directly by the social workers or by them quickly identifying specialist services. Drop-in sessions have been set up for parents and children and it is noticeable that parents have been comfortable in seeking advice from social workers about their relationship with their children. This is not likely to have been the case had the social workers not built up relationships within the schools.

The early work with children and young people is intended to reduce risk at a later stage. The University of Cardiff's final evaluation will be reported upon in the HSCB's next annual report.

The Team:



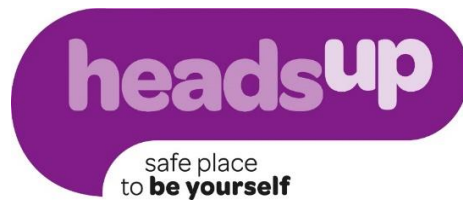
### **Schools – Designated Safeguarding Leads (DSL) Forum and Mental Health**

Each school is required to have a designated safeguarding lead (DSL). In Harrow the DSLs are supported by a council run forum which enables the discussion of innovation, good practice and concerns. They also support each other in their role.

Schools and Colleges in Harrow have had to work tirelessly to support children through the impact of Covid-19, the Lockdowns and the consequent home-schooling arrangements. They have remained alert to increased welfare and safeguarding issues brought about by the isolation such as domestic abuse, stress and anxiety – as well as families affected by unemployment and/or financial pressures. Schools and colleges were supported with the increasing welfare and safeguarding concerns by local statutory services and significantly the voluntary sector who made every effort to make their offers as visible and accessible as possible.

School and college staff also stepped up to the additional requirements for Covid-19 testing, managing the practical and emotional issues that entails for the children, their families and for staff.

The DSL Forum was used to highlight the mental health and wellbeing support available across Harrow and allow for discussion about issues emerging for schools during and post Lockdowns. Specialists from a wide of services attended the HSCB's DSL Forum throughout the year, including



**youngharrow**  
foundation

Clinical Psychology in  
Harrow Virtual School

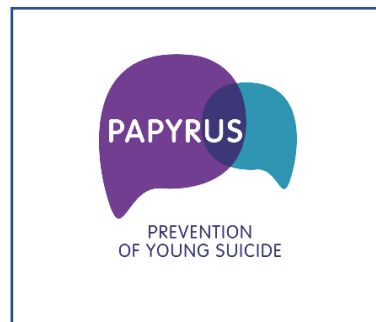


**Early Support**  
Small Steps – Lasting Change

Compass  
Young People's Substance  
Misuse Service  
Harrow  
*Building a Better Life*  
Compass

The Central and North West London  
NHS Foundation Trust  
**The Harrow Children  
Looked After Health team**

Virtual School for Looked After Children-  
Hampshire  
Attachment Awareness in Schools  
Harrow  
**kca.**  
KATE CAIRNS ASSOCIATES



Free training and workshops –  
Young People and Problem  
Gambling  
GamCare - bigdeal.org.uk





Through a welfare lens



## 2. CONTEXTUAL SAFEGUARDING

- Target the contexts in which that abuse occurs, from assessment through to intervention
- Develop partnerships with agencies who have a reach into extra-familial contexts e.g. transport providers, retailers, residents' associations, parks and recreation services
- Monitor outcomes of success in relation to contextual, as well as individual, change

- **The Violence, Vulnerability and Exploitation Operational Group (VVE):** The introduction of this multi-agency operational group which meets daily has significantly strengthened the flow and timely sharing of intelligence regarding young people affected by sexual and criminal exploitation – both in relation to individuals at risk or those posing risks - and in terms of local and cross border developments such as gang activity, county lines and the exploitation of vulnerable adults.

The VVE Group and the MASH (Multi-agency Safeguarding Hub), MACE (Multi-agency Child Exploitation Panel) and the Community Safety Unit work in partnership to ensure that early intervention to support individuals and local communities is prioritised. The work is supported by a secure information sharing system - ECINS<sup>11</sup>, which enables those in key practitioner roles to deliver effective case management.

- **Dedicated Team:** Harrow's commitment to address the growing concerns of exploitation and youth violence (local and national) has led to the establishment of a dedicated case work team. It comprises specialists in various aspects of exploitation, on-line abuse, children who go missing, children who are trafficked – and social workers attached to the Rescue and Response Project that identifies and provides intervention for young people affected by county lines.
- **Serious Incident Group (SIG):** For several years schools and community policing across Harrow have led on an initiative to identify pupils at risk of youth violence and exploitation – and to help divert those from anti-social and criminal behaviour. This group works in close collaboration with the town's business community to identify young people who need diversionary and preventative support. It engages parents in this activity to ensure programmes are supported on the home-front too. Every effort is made to encourage young

<sup>11</sup> Empowering Communities with Integrated Networks

people to understand the impact of their behaviour on other young people, their communities and local businesses, so that they are steered away from prosecution and a life of crime.

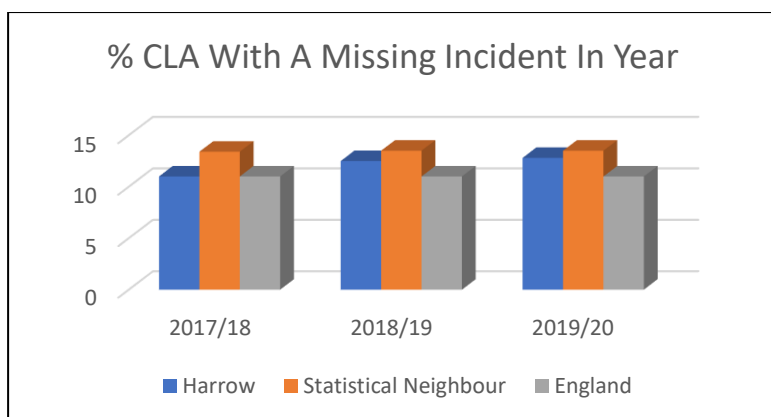


- **Training:** The members of the VVE team continue to support the HSCB's training programme by helping to raise awareness of the signs and indicators of VVE and the procedures to follow. They also highlight to the wider partnership the range of local support services available. Schools have also been active in raising awareness of their pupils about the different forms of peer on peer abuse, with particular emphasis on what constitutes appropriate sexual behaviour.
- **Children who go missing:** When children go missing from home or care that can be an indicator of risk in the home or contextually in the form of, extra familial harm. Harrow treats missing children as a priority. This is a complex area and in Harrow we have devised an effective multi agency response.

Harrow holds a weekly Missing Persons Meeting jointly involving key partners to discuss any high-risk children and young people. A new London wide scheme 'Operation Philomena' seeks to strengthen communications between the police and Children's Residential Homes. This includes keeping an up to date 'Grab-Pack' of information about the child/young person to help with quick identification and provide knowledge of their needs, behaviours, likely contacts etc. A review of Operation Philomena's London wide effectiveness found some weaknesses in the quality and availability of up to date Grab-Packs when needed. In Harrow the HSCB conducted its own local review and found that practice in Harrow was good. The MPS have now adopted Harrow's procedures across the rest of the NWL Basic Command Unit.



In recent years, Harrow has seen a slow but steady increase in the number of children who go missing – mostly in the 14-17-year-old age bracket. In the period 2019 to 2020 a total number of 83 children went missing for a period (50 from their family homes and 33 from Local Authority Care). Some went missing on more than one occasion bringing the total number of missing episodes for the same period to 198<sup>12</sup>.



The table indicates that over a three-year period the percentage of our looked after children who go missing has increased and for the past two years we have exceeded the England average. We are lower than our statistical neighbours, but the margin is slightly less than it was previously.

In the majority of cases children and young people are provided with a return home interview within 72 hours of a missing episode, however, there will be occasions where this is declined or avoided by the young person. Efforts are made to determine why they went missing in order to address any problems or risks. The reasons for young people going missing include, not feeling cared for at home, wanting to stay out with peers, being at risk of child sexual and criminal exploitation through county lines or gang affiliation, not being in employment or education. Our increased understanding of child trafficking for county lines has also alerted us to be curious regarding frequent absences in addition to actual missing episodes. Exploiters may encourage young people to stay under the radar of concern by appearing compliant, e.g. attending school and returning late, but not so late that it would cause undue alarm. With the cooperation of schools, absences are therefore also scrutinised, particularly when there is a pattern of high frequency.

<sup>12</sup> Covid 19 and the associated Lockdowns saw an initial decrease in the number of missing episodes during 2020 but rates are being seen to rise again (confirmed post the reporting period for this annual report).

| <b>Ethnicity</b>        | <b>2019/20 Missing Children</b> | <b>2019/20 %</b> |
|-------------------------|---------------------------------|------------------|
| Asian or Asian British  | 12                              | 14.5%            |
| Black or Black British  | 30                              | 36.1%            |
| Mixed background        | 12                              | 14.5%            |
| Other Ethnic background | 8                               | 9.6%             |
| White or White British  | 21                              | 25.3%            |
| Total                   | 83                              |                  |

Black or black British Harrow children are over-represented in the data on missing episodes. They and other minority ethnic children are also overrepresented in our records of those at risk of coming to harm outside their families. This data has led us to increase our scrutiny of the education and social care outcomes for black and minority ethnic children

### **Research informed strategy and practice:**

Harrow has been working with the **University of Bedfordshire** to improve our response to risks to children and young people that arise outside the family home<sup>13</sup>. The strategic direction of this work relies heavily on the work of Dr Carlene Firmin, (**The International Centre for Researching Child Sexual Exploitation, Violence and Trafficking**) and our approach is informed by the views and experiences of young people, their families and communities.

When multiple children are associated with the same context or locations of risk, we now adopt a neighbourhood and community safeguarding approach – both at a strategic planning and operational level which explores and makes use of the following:

- Safeguarding assessment of the area identified –with resident engagement, mapping, and business surveys
- Assessments considered at a safeguarding meeting
- Estate based parental support groups
- Community guardianship, property re-design and detached youth work planned





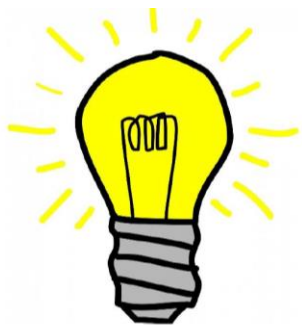
For more information and resources visit  
[www.contextualsafeguarding.org.uk](http://www.contextualsafeguarding.org.uk)

carlene.firmin@beds.ac.uk

 @ContextualSafeguard



<sup>13</sup> Known as contextual safeguarding



Mapping application in  
light of the work  
delivered and reflections  
from the session



Peer led safety mapping and surveying by  
the WISH Centre

### **Annual Safeguarding Conference:**

Contextual Safeguarding remains one of the HSP's three priorities and so its annual Safeguarding Conference 2021 focussed on this topic – please see pages 37 and 38 for more details.



### Early identification of risk

## 3. DOMESTIC ABUSE

- Ensure all relevant sectors have access to training and awareness training
- Promote vigilance to the fact that age, gender, ethnicity and ability do not discriminate in term of who can become a victim or perpetrator of domestic abuse
- Ensure early intervention and appropriate support for victims
- Promote access to specialist intervention programmes for perpetrators

### Impact of the Pandemic

Along with the impact on mental health, domestic abuse became an even greater priority for Harrow as it did for the rest of the country. MASH and Police data became key in understanding what was happening during the periods of lockdown and how this was being reflected in the emerging safeguarding concerns. Increased isolation for victims meant greater risk and difficulty in accessing support. Stress and anxiety about the virus/lockdown, associated financial and unemployment worries undoubtedly led to increased tension behind closed doors.

Initially in Harrow, we saw a drop in domestic abuse related referrals into the police and MASH, but our partners across the voluntary sector reported a surge in contacts. Steps were taken to promote existing and new lines of support and by April/May 2020 'hidden harms' started to emerge, and referrals began to spike. The spike repeated itself in September and this was associated with children returning to school where they were more able to share their concerns.

Police data showed that Harrow's figures were lower than neighbouring areas in the Basic Command Unit, but they did follow the same trend in the timing of the peak referral periods.

Perhaps surprisingly, police reported that males made up 40% of victims. Suspects were 75% male and 25% female. These figures will include same sex relationships, but Harrow Safeguarding Partnership also responds to previous case review learning to ensure that gender bias does not influence decision-making in relation to thresholds for safeguarding.

Despite the increase in referrals and the pressure on courts, local Police were able to maintain their normal arrest rate of 45% and its attrition rate. Following the autumn increase, figures started to drop down to pre-covid-19 levels.

Cases referred to the MARAC (Multi-agency Risk Assessment Conference) in Harrow have also seen a steady rise, including those with children in the household. Domestic abuse related referrals into the MASH increased by 9% on the previous year and Children Social Care reports indicate that the nature of these cases has been made more complex by the pandemic.

## **Impact of the Domestic Abuse Bill**

Harrow Council in collaboration with relevant partners are planning new domestic abuse services to complement existing provision. Final arrangements will need to consider the new requirements being introduced by the Domestic Abuse Act, which passes some responsibility to the Greater London Council for assessing, coordinating and providing oversight for certain domestic abuse services. It remains possible that future commissioning of some services such as domestic abuse refuges will be led centrally for all London boroughs. Local research has identified the need for increased safe accommodation, a complex needs project for high risk victims, both male and female – and an increase number of Independent Domestic Violence Advisors. The HSP and Safer Harrow will maintain its focus on domestic abuse and collaborate in the monitoring of new arrangements introduced in the new business year.

## **Operation Encompass**

The HSCB continues to monitor the impact of Operation Encompass led by the BCU– an information sharing system that allows the police to notify schools of their call outs to domestic abuse incidents where a child is associated with the household (and specifically in Harrow - whether present at the time of the incident or not). The vast majority of schools have signed up to the arrangement as this helps them to respond more effectively and sensitively to the impact on the child's wellbeing.

During the lockdown the number of notifications dropped, but a challenge was brought to the HSP by the schools to ensure that they be notified even when the child is being schooled at home. This was helpfully addressed by the BCU.

## **Operation Dauntless**

The MPS has recognised that there are areas for improvement in its approaches to tackling domestic abuse and has established a continuous improvement initiative, known as Operation Dauntless, through which it has developed an action plan for improved services. This includes action to better identify and target serial domestic abuse offenders, and better manage the risk to victims when their abusers are released from prison after serving their sentence. The HSP's Quality Assurance Subgroup has built in monitoring of the Operation's local impact into its forward scrutiny programme.

## **Mayor's Tagging Project**

Towards the end of the year London's mayor announced that he was committing £230,000 on a project to tag domestic abusers on their release from prison. GPS tags offer the opportunity for the Police and Probation Service to monitor the extent to which released offenders are complying with their release conditions which will usually forbid contact with their victims and other family members. Harrow were one of the first boroughs to benefit from this programme and next year we will be able to report on whether victims and families benefited from this innovation.

## Probation Service Conducting Polygraph Tests on Domestic Abusers

The Domestic Abuse Act requires Prison Governors to impose on certain high-risk offenders, when they leave prison a licence condition that they submit to polygraph testing. Polygraph testing has been used since 2014 on certain sex offenders on release from prison as a means of ensuring that they obey their licence conditions. This programme extends the what is now a well-established tactic to another group of offenders, who pose a risk to vulnerable victims. This is a new programme and next year we will be able to report on how this new tactic has helped partners manage offenders and protect the vulnerable.

## Multi-agency Training

The HSCB's Domestic Abuse training programme has been significantly refreshed during the pandemic – with its core course updated. Access to specialists in the field has been increased due to the use of virtual delivery of the courses. A new course on culture and domestic abuse was piloted to help embed an understanding of “honour-based” violence and forced marriage. The voice of a survivor has been included to strengthen the impact on learning. In addition, the link between domestic abuse and eating disorders has also been included in our training programme to help recognise the signs – with Alpha Vesta providing specialist training. This too includes the voice of a survivor. Going forward our programme will be responsive to changes introduced by the new Domestic Abuse Act.

## Support for Black and Multi-Ethnic Communities

The HSCB collaborates with the Safer Harrow partnership to ensure that a range of local domestic abuse support services are promoted; also including training for practitioners, parents and young people. Going forward our programme will be responsive to changes introduced by the new Domestic Abuse Act.

As part of our collaboration, we help to promote new services specifically designed to support those affected by domestic abuse who come from Black and Multi-Ethnic Communities. Harrow is one of the most diverse communities across the country and the Partnerships (HSCB, HSAB and Safer Harrow) are committed to developing their statutory provision as well as promoting the voluntary sector's response to ensure a more informed and relevant response to individual communities.



## 5. Covid-19 Business Continuity Planning





## 6. Learning from Case Reviews

This year we undertook an increase in case review activity. Covid-19 delayed early progress as partners adjusted to virtual communications and many were understandably diverted to respond to the crisis and subsequent vaccination programme. It is to their credit that all of the review activity resumed throughout the year, enabling crucial learning to be extracted from these processes. The following provides examples of key learning:

### Child Safeguarding Practice Review – Child M

Harrow's Case Review Group led a Child Safeguarding Practice Review into the sad death of a young boy with complex medical needs and learning difficulties. He died of natural causes linked to his medical condition, but the Partnership felt there was learning to be identified because of:

- M's low school attendance
- M's non-attendance for a number of medical appointments
- Lack of follow up for M's ongoing dental pain
- Use of mechanical restraints on M



The review sought to understand why these matters had not been addressed in a timely or consistent way. The Review process established a series of key learning points which were discussed with those practitioners who had been directly involved in the case. This process enabled the Case Review Panel to test its findings against the experience and views of those who worked most closely with the child and family: <http://www.harrowscb.co.uk/wp-content/uploads/2021/08/Overview-Child-M-Publication-Version-24.06.21.docx> A Quick Learning Sheet can be seen in Appendix (iiv).

#### Key findings from the review:

- The need for a coordinated approach to support parents with multiple commitments/appointments
- The need to apply 'Was not Brought' procedures robustly when relating to children with disabilities
- The need to challenge where there are different expectations and thresholds applied to children with disabilities (in this case regarding low school attendance and safeguarding concerns)
- The need for robust follow-through and escalation in dealing with dental care needs
- The need to better understand the child's lived experience at home and his family's coping mechanisms
- The need for guidance regarding parental use of mechanical restraint

## Learned Lessons Review – Child H – Ongoing Impact

In the previous HSP's Annual Report, we described the circumstances and learning from a Learned Lessons Review. This review examined the multi-agency response to a case involving sexual abuse of a child – which also involved the making of indecent images. A Quick Reference Learning Sheet was produced to share the key learning points and this included links to specific guidance on responding to indecent images – one document for schools and another for non-school environments:

<https://www.harrowscb.co.uk/wp-content/uploads/2021/02/QUICK-REFERENCE-LEARNING-POINTS-FROM-HARROW-SAFEUGARDING-PARTNERSHIP-002-in-relation-to-Child-H-7.pdf>

To ensure that the learning was embedded effectively, the HSP's new Impact Analysis approach was introduced for this case into the 2021-22 auditing programme and will be reported on in the next annual report. At the time of producing this report, the activity is showing areas of good practice and areas for development, allowing the HSP to challenge where needed.

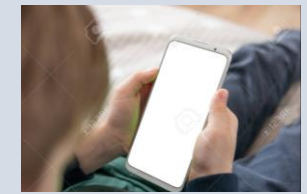
## Safeguarding Adult Review – Family A

As part of Harrow's **Think Whole Family** approach to safeguarding, the HSCB has collaborated with the Safeguarding Adult Board in conducting Safeguarding Adult Reviews (SARs). These are required in some cases when an adult with Care and Support needs dies or is seriously harmed. In the case of Family A, where a middle aged woman died of self-neglect, the HSCB was interested in the experience of her two children who lived with her. There had been child protection concerns about them when young, some non-school attendance and a subsequent period of home-schooling for one of them. In more recent years, the mother began hoarding to an extreme degree causing concern about unhygienic and unsafe living conditions for herself and one of her daughters.

Non-engagement with all agencies was a long-standing feature of this case – and the review examined the obstacles faced by the agencies trying to assess and help, whilst trying to respect the adult's own wishes.

### Key findings:

- The need to track children who become home-schooled where there have been safeguarding concerns
- The need for practitioners and their managers across the partnership to understand the purpose of the Risk Enablement Panel for complex cases especially where there are resistant service users – and powers of entry are limited
- The need for training across the partnership on the link between self-neglect and hoarding
- The need for practitioners to access the training available for cases of Perplexing Presentations (formerly referred to as Fabricated or Induced Illness) – and to understand the referral pathway



| <h2>HOARDING</h2> <p>Hoarding is the compulsive need to find and keep objects, animals or trash regardless of their value. Items commonly hoarded include newspapers, photographs, boxes, clothes, food, furniture, paper and plastic bags, appliances or electronics.</p> |         |         |         |         |         |
|--|---------|---------|---------|---------|---------|
|  | LEVEL 1 | LEVEL 2 | LEVEL 3 | LEVEL 4 | LEVEL 5 |
| Light amounts of clutter and no noticeable odors   | ✓       | ✓       | ✓       | ✓       | ✓       |
| All doors and stairways are accessible   | ✓       | ✓       | ✓       | ✓       | ✓       |
| Pet waste on the floor   |         | ✓       | ✓       | ✓       | ✓       |
| Evidence of household rodents  |         | ✓       | ✓       | ✓       | ✓       |
| Overflowing garbage cans   |         | ✓       | ✓       | ✓       | ✓       |
| Dirty food preparation surfaces  |         | ✓       | ✓       | ✓       | ✓       |
| At least one unusable bathroom or bedroom  |         |         | ✓       | ✓       | ✓       |
| Overflowing garbage cans   |         |         | ✓       | ✓       | ✓       |
| Odors throughout the house   |         |         | ✓       | ✓       | ✓       |
| No clean dishes or utensils  |         |         |         | ✓       | ✓       |
| Bugs   |         |         |         | ✓       | ✓       |
| More than one blocked exit   |         |         |         | ✓       | ✓       |
| At least four too many pets, per local regulations   |         |         |         | ✓       | ✓       |
| Noticeable human feces   |         |         |         | ✓       | ✓       |
| Rotting food on surfaces and inside a non-working refrigerator   |         |         |         | ✓       | ✓       |

- The need for strengthened collaboration between adults and children's services when identifying and assessing the needs of young carers

## Ongoing Reviews

### Learned Lessons Review: Young Person J

This review was instigated to examine the multi-agency response to a teenage girl with a long history of self-harming behaviour which escalated to a serious incident. The review is ongoing but initial findings show that:

- More professional curiosity about early Childhood Adverse Events would have helped inform the assessment of current risk and need
- Assessing the suitability of a placement for a child should also consider the risks that child might present to other children in the placement
- Consultation with adult services should take place when there are indications that a parent might have learning needs to see if assessment and advocacy are required. (NB. This is repeated learning from Harrow's Case Reviews)
- Better coordination of the multi-agency response was required to avoid assumptions about which agency was doing what.

The full findings from this review will be disseminated later in 2021.



### Action plans to make a difference

The Partnership is overseeing the multi-agency action plans linked to the findings of its reviews and supporting the dissemination of learning to wide audiences through its learning and development programme. How well the learning has been embedded is being tested through the HSP's new Impact Analysis activity and will be reported on in its 2021-22 Annual Report. Lunchtime Forums are accompanied by Quick Reference Learning Sheets to be embedded across all organisations. The HSCB's Learning and Development Officer then carries out enquiries through focus groups and individual interviews to check the understanding of

practitioners and their managers. Reports on the strengths and weaknesses of agencies processes for embedding the learning are then scrutinised by the Learning and Development and Quality Assurance Subgroups.

## New Reviews

The Case Review Subgroup has recently embarked on new safeguarding reviews for both adults and children. A new Safeguarding Adult Review (SAR) is exploring the long-term impact of Adverse Childhood Experiences expressed in adulthood. A new Learned Lessons Review has also begun to look at the multi-agency response to a case involving a shaken baby. The amount of review activity undertaken by the Case Review Subgroup in such challenging times confirms the partnership's commitment to its cycle of Improvement and Learning.



## 7. Scrutiny – Monitoring and Evaluation

The HSP's Quality Assurance Subgroup meets every 6 weeks to meet its full monitoring and evaluation programme. In 2020 the group built on its commitment to Harrow's Think Whole Family approach to safeguarding and began scrutinising relevant Adult safeguarding data alongside Children's data. The overlap of themes and findings has reinforced the relevance of this collaboration across the two safeguarding boards.

### Young Carers

The Partnership became curious about the impact of Covid-19 on young carers who were having difficulty in attending school because their parents were shielding. Schools expressed concern about these being the children in need who were becoming even more isolated because of their home circumstances. The impact on their access to schooling and the lack of respite available because of the pandemic needed to be understood and addressed.

Data reports were sought so that we could check whether young carers remained at home following the opening of schools. A total of 83 children were on the LA's system as young carers. Of these, 35 were registered to Harrow schools. 11 had Special Educational Needs support and 5 had an Education and Healthcare Plan. The impact of Covid-19 saw attendance:

- Remain the same for 4 young carers
- Improve for 11 young carers
- Worsen for 18 young carers
- Not confirmed: 2



#### Actions:

- The HSP to routinely gather data for scrutiny on young carers in Harrow
- Information between Adult and Children's Services needed to be cross referenced for parents who were shielding
- The voice of young carers needed to reach strategic planning
- Learning from a local Safeguarding Adult Review relevant to young carers was to be embedded across the partnership

### Female Genital Mutilation (FGM)



The HSCB has continued to monitor the improvements introduced since audits found weaknesses in the application of risk assessments for FGM. To assist with the improvements London North West University Healthcare Trust (LNWUHT) had introduced a new risk assessment in March 2020 and had set up their own internal scrutiny arrangements. Analysis of data by the Quality Assurance subgroup has shown that the changes were making positive impact for girls and woman at risk of FGM in Harrow.

### Waiting Times for Mental Health Services

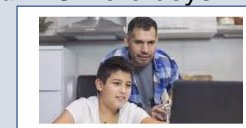
The HSCB has continued to monitor the waiting times for children and young people needing assessment and treatment for their mental health. Regular reports are provided from Central and Northwest London NHS Trust (CNWL) for the Partnership to review.

Good progress has been evidenced on waiting times for initial assessment and interim support arrangements have been put in place for children and young people where there have been delays for treatment. Progress will be monitored throughout 2021.

### Children Educated at Home

Whilst there is not a requirement to keep a list of children educated at home - only those children not getting an education, Harrow attempts to gather information where possible and this has become more important as the impact of the lockdown led to many more parents choosing to educate their children at home.

From the 1<sup>st</sup> of September 2020 to 31<sup>st</sup> of March 2021 299 children are known to have been electively home educated. Of these 154 were girls and 145 were boys.



Figures used to be low in Harrow for EHE but there has been a big increase during and following the pandemic restrictions. There was a higher than expected number of children who did not return to school after the restrictions were lifted. Where children who are educated at home also have child protection or child in need plans, there is a specialist officer in post to ensure good communication between all agencies involved.

In addition, alternative education providers are required to meet local safeguarding arrangements and the Council confirmed good compliance both in this respect and in providing details on children on their registers. Parents are also provided with an online safeguarding checklist when using such providers.



## Local Data Analysis and comparisons with London (ISOS) Data

The QA subgroup scrutinises our multi-agency dataset to keep an overview of trends and to identify areas for further scrutiny. During 2020 we were able to compare our data with the ISOS data (albeit for the previous year) to see how Harrow compared with London as a whole.

This activity prompted the QA subgroup to make enquiries in the following areas:

- Harrow has the 12<sup>th</sup> highest number of Child Protection Plans per 10,000 population. This was put down to Harrow's strategy to manage risk at home wherever possible, as opposed to placing children in Local Authority Care. This leads to a lower number of children in care, something considered a success in a recent Ofsted Inspection.
- Referrals for sexual abuse across London were low compared to other parts of the country – and Harrow's figures were low compared to London (this had been identified in our child protection registrations in recent years which has directed the topic of some of our audits)
- Referrals related to faith-based abuse were low for Harrow and London. Our work with Voluntary Action Harrow has led to an expansion of training activity with the faith sector and we expect our referrals in this area to rise.
- A lower referral rate for specialist services in Harrow was thought to be related to the effectiveness of early support services – and so further evidence would be sought

The QA group continues to monitor these variations and seeks evidence to support or challenge the interpretations and actions listed above.

## Section 11 Audits

As part of the HSCB's monitoring of safeguarding arrangements, agencies are asked to present evidence of their compliance with s11 of the Children Act which outlines what they should have in place e.g. safeguarding policies and procedures; staff training; safer recruitment arrangements; and internal monitoring. This year we have received robust evidence of compliance from a number of agencies including the commissioned services for children and adult substance misuse services and CNWL.

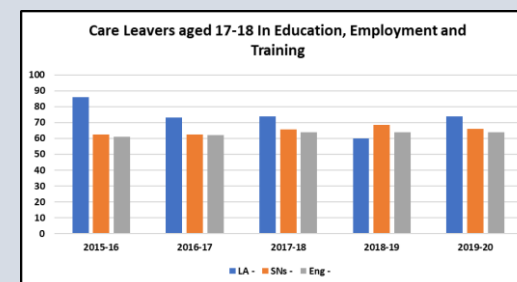
In addition, the HSCB has revived its pre-Covid-19 plan to carry out a survey of front-line staff's knowledge of their safeguarding responsibilities – a way of checking how well the agencies have embedded their arrangements. Outcome will be reported in the next Annual Report.

## Allegations Against Staff and Volunteers

Each year the HSCB requires the Local Authority Designated Officer (LADO) to report on activity around the management of allegations (data for the previous year). This showed a slight decline in the number of referrals of around 14% on the year before – and it is anticipated that this will fall again during the lockdown periods due to less direct access with children. We remain mindful however of the risks presented by on-line contact. The overall decline is thought to be related to better training on safe practice and robust safer recruitment arrangements. As found in recent years, the majority of cases are concluded in a timely way, aiming to limit any stress to the parties involved.

## Not in Education, Employment or Training (NEET)

As part of the HSP's focus on the quality of transition into adulthood for our young people, information on those who are NEET is scrutinised. Compared to statistical neighbours and England averages there is little difference for Harrow care leavers aged 17 and 18 but for those aged 19-21 Harrow has noticeably fewer who are NEET.



During 2018-19 there was no significant difference by gender of those who were NEET. However, this changed in 2019-20 where 43% of females were NEET compared to 16% of males. This may be due to a drop in the number of females in the cohort.

**Ethnicity:** In both age groups of care leavers, a higher proportion from mixed ethnic backgrounds and from white backgrounds tend to be NEET. The Partnership is prioritising its focus on identifying any disproportionality identified through the scrutiny of data to inform both individual and multi-agency service development.

## Children Excluded from School/College

The HSP wants to know why children are excluded from education and to establish if there is a connection with contextual safeguarding concerns. Too many excluded children were recorded as 'Other' as a reason for exclusion. This undermined our ability to understand the circumstances for these children.

Our analysis found that in 2018-2019 there were 45 permanent exclusion of which 23 were categorised as "other":

Further analysis found the precise reasons for exclusion very relevant to our understanding of contextual safeguarding and so schools are now being encouraged to use more precise descriptions.

### **Ethnic breakdown of children excluded:**

In the past three years there have been no exclusions in the India/Asian group - which makes up a significant proportion of the population in Harrow. In contrast, black Caribbean young people (mainly boys) make up a disproportionate number despite their lower population in Harrow schools.

The Partnership has prioritised the need to explore solutions to reduce the number of Black Caribbean boys being permanently excluded is and working closely with schools and early support to approach the disproportionality at the earliest possible stage.

Although overall numbers in Harrow are small, we are exploring the learning from inner London Boroughs that have been successful in addressing a similar disparity.



## Black Lives Matter (BLM)

Following the distressing death of George Floyd in the USA, the implications were felt worldwide. The Partnership has strengthened its commitment to identify and address disproportionality for our local communities - and in particular, for the children and young people we serve.

Our activity includes a refreshed and constructively challenging approach. There is much more for us to do, but all members of the partnership are required and committed to include ethnicity data in their reporting for external scrutiny by the Quality Assurance Group.

### **Early Support - Integrated Early engagement – with a focus on ethnicity and disproportionality**

A new project led by the Metropolitan Police Service in collaboration with Multi Agency Safeguarding Hub & Youth Offending Team was launched to promote early engagement with young people who demonstrate behaviour which could later lead to antisocial behaviour or criminal activity. It also involves working with sibling groups as there were strong indication that they required support too. There are 2 strands - one for primary school ages and the other for high school children.

There is a focus on BLM, as black Caribbean young males are disproportionately represented in this cohort of young people.

The disproportionality is mirrored in YOT referrals where there are often links to exploitation. Our ongoing analysis of data and agency reviews is steered to understand how best to engage with different ethnic groups – finding out what works in helping young people engage.



## MONITORING AND SCRUTINY - CHILD PROTECTION CONFERENCES

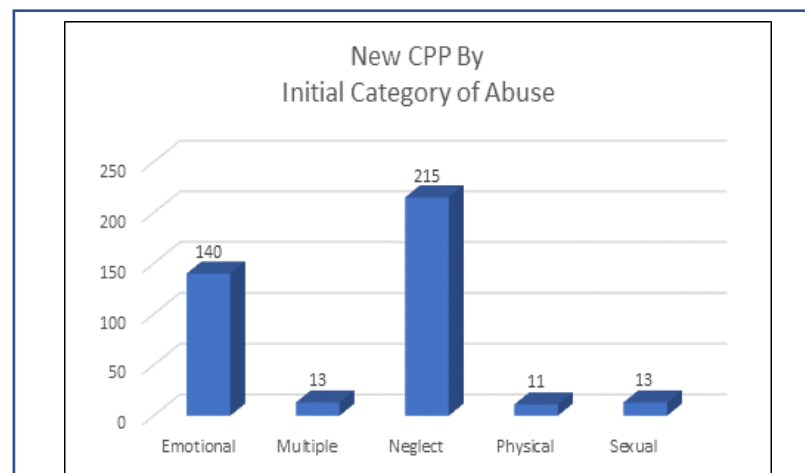
Child Protection Conferences (CPC) are held by the partnership of agencies involved with a child and family to consider whether the children have suffered or likely to suffer significant harm and to decide what action is required to safeguard and promote their welfare. Our performance and activity data for 2019 to 2020<sup>14</sup> tell us how many cases we have dealt with, why children are placed on a plan, whether the plan is a repeat case and how long the plans last. The Strengthening Families model continues to be used in Harrow, with 'Signs of Safety' being the key tool.

In April 2019, there were **281** children with Child Protection Plans (CP Plans) in Harrow. A further **291** initial CPCs took place during the following 11 months which resulted in CP Plans in respect of **275** children in March 2020.

There were **789** CPCs in Harrow in 2019-20 (including **498** Review Conferences).

Of the initial conferences, 80.3% had an outcome of a CP Plan; 16% of conferences had a Child in Need plan.

### The breakdown of categories of harm:.



### Performance

- 88 children were subject to a repeat CP plan during 2019-2020, having previously had CP Plans.
- 6 children had a CP Plan lasting for two years or more (2.2% of the total) placing Harrow below the statistical neighbour (4.35%) and above the England (2.1%) average.

A multi-agency Practice Panel scrutinises the duration of child protection plans to provide challenge to prevent drift in case management. This panel also highlights good practice and Learning Outcomes to disseminate through HSP learning and development opportunities.

- The majority of ICPCs have taken place within the target timescale of 15 days (62.7%)
- Only a minority of transfer-in conferences were held within timescales. This is when a child with a plan moves from another borough into Harrow. Difficulties have been faced by all receiving areas in responding to the impact of welfare reform and housing shortages which

<sup>14</sup> It takes some time for the data for these cases to be ratified by the Department for Education so the data are always published in the following year's annual report.

forced many families to move. This is a focus area for improvement, but is currently being compensated by regular contact with the originating boroughs and duty visits by Harrow social workers in all cases

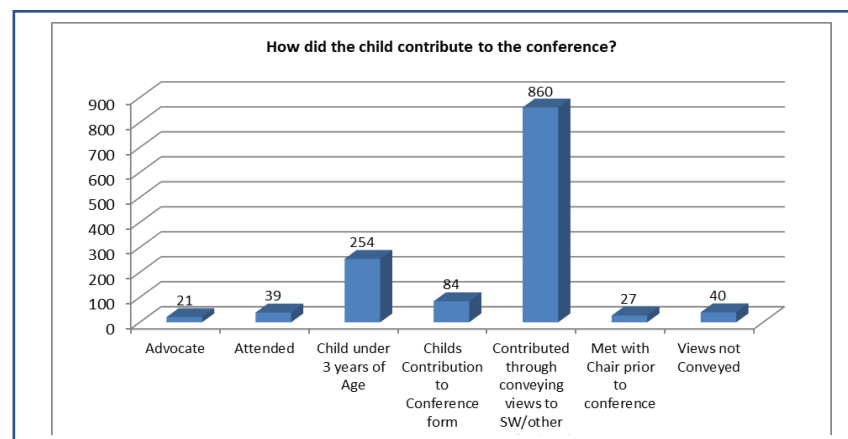
- 75% of parents received social worker reports within the agreed timescale for the conferences – and 100% received the report in time for the conference itself
- 95% of conferences were quorate (having the relevant professionals participating)
- 93% of social worker visits took place within the agreed timescale
- 96% of social worker reports were assessed as satisfactory, good or excellent. Where standards were not met, Conference Chairs address this with managers to support practice improvement
- Since the pandemic and during lock down chairs have streamlined the process for reporting outcomes of the conference to become effective in meeting timescales – current practice is to provide the decision letter in 24 hours; the child protection plan and Record of Conference (notes) within 5 working days
- On a scale of 0 to 10 (with 10 being the most positive), parents were asked if the Child Protection Plan had helped their families achieve positive changes. 83% of parents gave a rating of 10 and 17% gave a rating of 8.
- Concerns or disagreements that were escalated for resolution were all resolved in a timely manner at stage 1 or 2 (31 and 19 respectively).

#### **Developments throughout 2019 to 2020 and adapting to the Pandemic:**

- A dedicated conference room on the ground floor to support easy access
- A separate waiting space to support preparation and meet social distancing requirements
- Using Signs of Safety as a visual tool at every conference – translated or adapted to meet the language or learning needs of parents
- Using 'Next Steps' as a planning tool, working toward producing SMART decisions
- Overall Telephone Conference (video calling) has worked well and enabled families to engage in the conference and agency attendance is reported to have been very good

#### **Involving Children & Young People through:**

- support by an independent advocacy service
- the use of children's consultation forms
- feedback from professionals relaying the child/young person's views and other contributions



## Highlighting good practice:

*Excellent focus on the child's views and experiences*

*Very good understanding of the family's cultural issues*

*...has managed to tread a line where parents feel confident in 'X's' commitment to the children but without compromising the approach to risk*

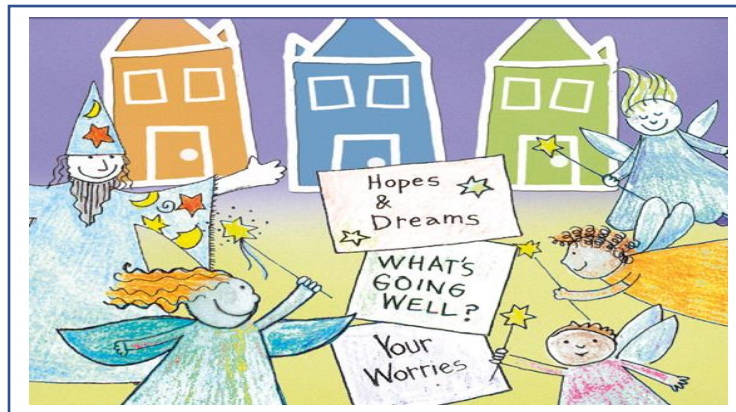
*Both Mr and Mrs 'X' were very complimentary about the social worker....feeling her arrival was the beginning of real progress.*

*'X' has clearly completed a lot of work on this very complex case – there were no gaps or drift (in progress)*

*...ensured that the father was actively involved*

## PRIORITIES FOR 2020 – 2021

- To pilot a hybrid model for conference using Microsoft Teams along with having face to face contact with Children, Young People, Parents and Carers
- To consider Children's Centres as the venue for conferences
- To revise the social workers' report template to promote reports that use more accessible language for parents and carers
- To further promote the gathering of fathers' views, and increase their contribution to conferences
- Based on learning from a previous Case Review: to review the 'Signs of Safety' methodology to help maximise the engagement of and support to, parents with a Learning Disability in the conference process - and further develop the links with CYADS (Children, Young Person and Disability Team)



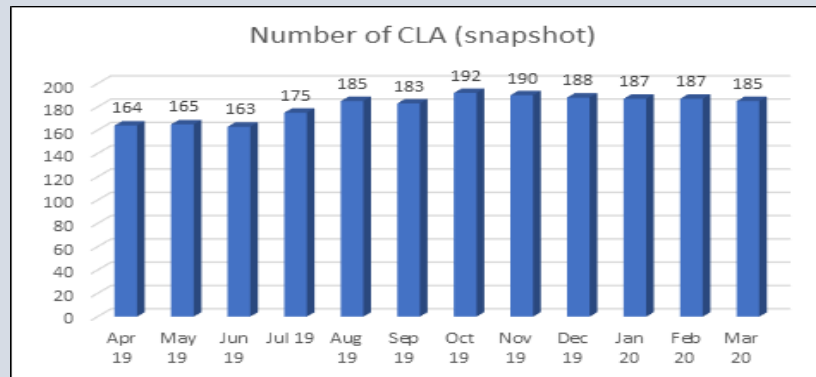
## INDEPENDENT REVIEWING OFFICERS FOR CHILDREN LOOKED AFTER

The Independent Reviewing Officers (IRO) have a key role in overseeing and improving the care planning for Children Looked After and for challenging drift and delay. The IRO Service also has a role in monitoring the Local Authority in respect of its corporate parenting and safeguarding responsibilities. What we know:

- The Looked After population for 2019/20 ranged from **170** to **186** and IRO caseloads have been around 75 per full-time equivalent – slightly higher than the recommended caseload of 50-70
- A total of **547** Reviews were chaired by IROs in the year ending 31<sup>st</sup> March 2020 – showing an increase of 4%
- 52 Reviews concerned children and young people with a disability – extra time is built in to ensure that wishes and feelings are incorporated
- As a result of Covid-19 pandemic as of 23 March 2020 Child Looked After reviews have been delivered by telephone conference. Overall telephone reviews (and video calling) have worked well and enabled young people, parents and other agencies to engage in the review. This has meant that there has been the potential to consider the venue for the Child Looked After review.
- Having such experienced, established and longstanding IROs has been very beneficial in providing more consistency for looked after children and has assisted with the process of challenge where it has been appropriate.
- All CLA Reviews were held within timescale.
- All disputes were resolved in a timely manner – the majority at Stage 1 and the remainder at Stage 2.

### The Number of Looked After Children and Young People:

The number of Looked After children rose during the year with a slight dip towards the end – ranging between 175 and 193



### Age Profile of Children Looked After year ending 31.03.20:

- **13.8% under 1 year**
- **15.9% 1 to 4 years**
- **8.7% 5 to 9 years**
- **30.4% 10 to 15 years**
- **31.2% 16 years and above**

### Permanency Outcomes

During the period 2019/20, the most common way children have achieved permanency is through a return home to live with parents: The profile in terms of children leaving care as at 31st March 2020:

- 35.4% Returned home to live with parents/relatives.
- 31.5% Moved into Independent Living.
- 15.4% Special Guardianship Order granted.
- 3.8% Age assessment determined child is aged 18 or over
- 3.1% Adopted
- 3.1% Sentenced to Custody.
- 2.3% Left care to live with relative/person with no parental responsibility
- 1.5% Accommodation on remand ended
- 0.8% Care taken over by another Local Authority
- 0.8% Transferred to Adult Social Care
- 0.8% Child moved abroad

**Entitlements and Advocacy** All children on becoming looked after receive information about a series of entitlements that they have. How their case will be reviewed, how to access their records, how to get advocacy help and much other besides. In addition, Harrow has the Harrow Children's Pledge for children who are looked after<sup>15</sup> The Independent Reviewing Officers check within the Review whether a child or young person has received all this information and whether they understand it

**100%** of Children Looked After of an appropriate age in Harrow, had information about their entitlements.

Advocacy and Independent Visitors service provision in Harrow are currently provided by Community Solutions (Harrow Mencap). Young people detained in young offender institutions (YOIs) and secure training centres (STCs) are also entitled to specially provided advocacy services. IROs routinely check that children and young people know about advocacy and how it can support them in having **a real say** in decisions affecting their lives.

#### **Children's Views about their IRO and their review process**

Harrow's Participation Officer encourages feedback from children and young people to allows them to comment about their experience of their IRO. 98.1% participated in their Reviews. Participation includes attending and/or contributing to their Review – for some this includes part-chairing their Review.

#### **Care leavers**

When children leave care, they may continue to need support for some time and the IROs provide an essential service in ensuring that those young people receive what they need. On 31/03/2020 there were 194 young people who had recently left Harrow's care.

1. Young care leavers need information about their entitlements. These are described in the "The Leaving Care Charter" and include

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<sup>15</sup> Accessed at <https://www.harrow.gov.uk/childrens-social-care/harrows-pledge-children-care/2>

- An ILG grant of £2,000 for setting up home.
  - Finance to cover the costs of being in education or training up until the age of 21 (or 25 if the young person is still in education)
2. They also need a Pathway Plan and they should have a personal advisor (PA) or qualified social worker. The Pathway Plan is a holistic assessment and every young person completed should complete their own action plan which is part of the Pathway Plan. There are mechanisms which enable young people to challenge their Pathway Plan.
- 100% received information about their entitlements
  - 100% had a pathway plan. 100% had contributed to their plan and none challenged its effectiveness
  - Of those in Higher Education only two requested vacation accommodation (or money towards it) and paid for the period requested.





## 8. Learning and Development

### Adjusting to Virtual Delivery

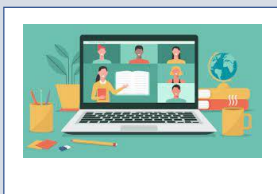
The Covid-19 Pandemic has had a significant impact on training, and we saw a shift from face to face to on-line learning. We had to adapt the scheduled training programme and our annual safeguarding conference, as we worked to find digital solutions for delivery of training events.

There were various platforms being used across the partnership, but it was agreed that TEAMS would be used for the majority of the HSCB training. There was considerable generosity expressed across the partnership as colleagues helped each other learn new technical skills as trainers and as delegates.

The Learning and Development multi-agency group have begun exploring the possibility of a blended approach to delivering training and other Learning event, so that we largely continue with virtual delivery, but build in some face to face learning with the removal of restrictions.

Having no venue costs is significant when budgets are tight. In addition, we have found that because they do not have to travel, many colleagues find attendance easier. At the same time, we have recognised the impact of practitioners not having down time with each other – to get to know each other and support each other when in the same room.

Consequently, the HSP is planning to use a blended approach to delivering virtual events (virtual and face to face).



### Learning Events

The HSCB can run its courses because of a very committed pool of multi-agency trainers who share their knowledge and skills in their specialist area of work. This helps to ensure that our courses are aligned to local issues and needs – as well as embedding a clear understanding of how local services can be accessed by local service users.

The HSCB from time to time commissions external trainers to ensure that practitioners understand the national perspective.

#### Core Courses

It has been essential to maintain the delivery of our introductory and advanced courses in safeguarding to help equip new staff to take appropriate action when they have child protection or child welfare concerns. The HSCB delivered most of these courses virtually, but with the generous assistance of Norbury School, two courses were delivered face to face in Covid-19 compliant facilities.

#### Specialist Courses

We have prioritised the need to provide training relating to the Partnership's priorities of Domestic Abuse, Contextual Safeguarding and Mental Wellbeing in our course programme and Designated Safeguarding Leads Forums – with emphasis on:

The Domestic Abuse  
Bill

Grooming

Honour Based  
Violence

Missing Children

Substance misuse awareness

Keeping safe on-line

Faith & Safeguarding

Parenting and  
mental health

Learning from  
Case Reviews

Understanding  
mental health

Safer Recruitment

Managing Allegations

**Examples of External/Collaborative courses:** Child Death Review; Domestic abuse and Eating Disorders; Child Exploitation in Sport; and Every Mind Matters



## 9. JOINT ANNUAL SAFEGUARDING CONFERENCE 2021 – CONTEXTUAL SAFEGUARDING

Contextual Safeguarding was chosen for this year's Conference as it remains one of our shared top three priorities in Harrow.

### Our First Virtual Conference!

We conducted our joint Safeguarding Boards' conference through MTeams because of the pandemic restrictions. The format followed previous arrangements as closely as possible to ensure delegates had access to the key-note presentations as well as a good range of workshops.

The usual partnership networking that takes place at our annual conferences was limited but we learned much about how we can succeed in delivering such learning events through new ways of working. 185 delegates attended. Feedback has been very positive with many saying it was the best conference we had run so far – **Well done to the Conference Planning Team!**



### Nazir Afzal OBE

We were delighted to have Nazir as one of our key-note speakers. Nazir previously held the position of Chief Crown Prosecutor for the Northwest and shared with us his legal perspective on exploitation.

During his 24-year legal career, Nazir prosecuted some of the most high-profile cases in the country, including the Rochdale grooming gangs. His work has been ground-breaking, and he has campaigned tirelessly on a range of issues including Violence against women and girls, and honour-based violence – helping to change the landscape of safeguarding.

Nazir's passion and commitment inspired the audience, with many delegates reporting a new energy and vision for addressing contextual safeguarding. Nazir makes protecting the vulnerable his business and everyone's business – both on a professional and personal basis: Listening to what children and vulnerable adults tell us whether by verbal means or through their behaviour is key and we must all be receptive to the signs – and acting on

### Dez Holmes



Another much respected and high-profile lead in contextual safeguarding, Dez Holmes joined us to share her vision for supporting young people into adulthood. Dez is the Director of Research in Practice, a not-for-profit organisation that since 1996 has been supporting those who work with children, families and adults to use evidence in their practice and leadership. She has a vast knowledge and expertise in early intervention, adolescent risk and transitional safeguarding.

Dez challenged existing arrangements and presented thought provoking approaches which focussed on systems and not a service approach to the needs of young people. Much of her thinking has been influential with national bodies, policy makers and with our local arrangements for responding to victims of exploitation and youth offending.

### 'Rhiannon' Voice of a survivor Marie Collins Foundation -

'Rhiannon' courageously shared her experience of being groomed as a teenager. She told us of the impact this had had on her into adulthood and on family relationships. Her perspective strengthened our understanding of the complexity and confusion faced by young people in managing normal transitions into adulthood - alongside risks, threats and actual harm presented by skilled perpetrators.

'Rhiannon' continues to use her experiences to provide valuable insight into the dilemmas faced by young people who feel isolated in such circumstances and manipulated to feel guilt and that they are responsible for their situation – acting as a powerful obstacle to them seeking help.

The HSP is collaborating with the Marie Collins Foundation to enhance the contextual safeguarding training offer across Harrow.



### Conference Workshops

The event was supported by an excellent range of specialist workshops – drawing upon both national and local knowledge and skills:

**Rescue & Response** – an intelligence led service for exploited young people run by St Giles in collaboration with statutory and voluntary services

**Red Thread** – Trauma informed support for young people affected by violence

**National Referral Mechanism** – intelligence network to respond to exploitation by trafficking

**Community Safety** – a local response to 'Cuckooing' and 'County Lines'

**Ignite** – Substance misuse and 'County Lines'

**NWG** – Exploitation in Sport – prevention and response

**VVE Team** – The role of film, music and social media in exploitation



## 2021 Annual Conference on “Contextual Safeguarding & County Lines”

We want to ensure that our safeguarding learning events lead to better professional practice – and to improve the lives, wellbeing and outcomes of children, adults with support needs and their families in Harrow. Our 2021 joint conference with the Harrow Safeguarding Adults Board led to the following feedback and actions taken by a selection of those people who attended

*I feel more able to recognise and respond to risk of significant harm from peer on peer in neighbourhoods, schools, online and not just safeguarding issues in the family. Discussing and sharing in team and group meetings.*

*Increased my awareness of legal and contextual issues (e.g. how society/ institutions view YP in different contexts), how online abusers operate and the impact on YP - so helpful to hear this from a victim's perspective.*

*I am more aware of contextual safeguarding and county lines, and so more vigilant during my home visits with families. I give advice and support around contextual safeguarding more confidently, signpost and refer when required.*

*Understanding how the child safeguarding structure focuses on the family unit and that children are vulnerable to exploitation outside of the family and often in sport venues. This has helped me to be more aware of the situations in which adults and children may be vulnerable to abuse as it may not be so obvious at first.*

*I am adapting Safeguarding Training for September 2021, with significant emphasis on contextual safeguarding, to ensure all staff have a deep understanding of what it entails.*

*As the DSL at my school, the learning from this conference has been immeasurable. For instance, understanding the deep rooted signs and issues that YP face as regards to sexual/peer on peer abuse etc, and being able to ensure EVERY effort is made in a TIMELY MANNER to safeguard and share information with partner agencies remains a critical part of my role at the school. This learning has also been shared with the wider staff at the school, whilst we continue to have an overarching culture of vigilance on the welfare of each child.*

*I took forward the learning at our first Adults and Children's Safeguarding Forum at the Trust. We looked at the impact on vulnerable adults, children & young people.*

*However significant the abuse is, there is always help available - we as professionals should not just work at the surface structure but have professional curiosity and dig deeper so that we can recognise abuse as only then we can carry out intervention strategies*

*The Conference was excellent, it was truly worth a day of my time. There were such inspiring speakers who are very passionate for getting justice for others and for ensuring the protection of children and adults. It is important to have caring, passionate and driven people in health and social care professions and although tough, it is worth the efforts and you can truly make a difference.*

*I've learned more about asking appropriate questions*

*I have improved my understanding of how young people can be groomed and blackmailed*

*I linked up with someone from the conference and they delivered a training session for Harrow foster carers on Internet awareness/social media safety.*

## 10. Working with the Voluntary Sector – HSP’s Commission of Voluntary Action Harrow (VAH)



The success of Voluntary Action Harrow in reaching and supporting the private, voluntary and faith sector across Harrow led to its recommission up to 2022 by the Safeguarding Partnership. Their small Safeguarding Outreach Team have demonstrated again throughout this year the difference made by having knowledge and expertise of the voluntary sector supporting our local priorities for children and young people.

VAH provide training, advice and the production of up-to-date guidance. In addition, VAH support organisations with their safer recruitment processes, including helping to process DBS checks. The impact of the pandemic has been immense on the voluntary sector and VAH have shown ongoing commitment and flexibility in supporting the sector and the HSP through such challenging times:

### Key Achievements

1. Despite the Lockdowns, VAH managed to continue to deliver a fair amount of face-to-face training – and then quickly adapted to on-lines sessions in June 2020.
2. During the pandemic VAH increased the support they were able to offer in providing safeguarding guidance and signposting professionals and service users to the services that remained available.
3. The outreach team continued to support the Learning & Development Subgroup in both the planning and delivery of multi-agency training. This included supporting a bespoke police training course on Adverse Childhood Experiences.
4. The outreach team is an integral part of the Safeguarding Conference Planning Group. This year, in addition to help organise the event, VAH delivered a workshop on how Contextual Safeguarding impacts faith organisations and how to access mental health/suicide prevention support.
5. The Team sent out and regularly promoted best safeguarding practices, key contacts and areas of safeguarding concerns through training, newsletters & promoting national awareness days.
6. The [safeguarding Green Book](#) was been updated for 2020 in PDF format and is now available on the HSCB and Harrow Council website. It was launched by the VAH and HSP first online forum event.

#### Training and events delivered:

- 13 Level 2 Children & Young People Safeguarding Training Sessions
- 3 Level 3 Nominated Safeguarding Person Training Sessions
- 3 Safeguarding Children, Young People & Families Support Forums

#### Specific Support:

- 103 Organisations
- 249 Individuals

#### Additional support in response to the impact of Covid-19

- The Pandemic led voluntary organisations to divert their resources to providing emergency food parcels, undertaking food shopping, delivering medication and medical equipment to people who were shielding. This led to a call for more volunteers and when they were recruited an increased need for advice on how to introduce lots of new people safely. VAH supported organisations in ensuring that they met their safeguarding responsibilities with regard to safer recruitment practice.
- VAH also supported organisations with funding applications for programmes that addressed food poverty

#### Impact of Safeguarding Training



#### Appendix (i) HSCB MEMBERSHIP AND ATTENDANCE 2020-21

| REPRESENTATIVE/ROLE                      | ATTENDANCE OUT OF 4 MEETINGS |
|--|------------------------------|
| Independent Chair                        | 4                            |
| Vice Chair/Lay Member                    | 4                            |
| Elected Member                           | 4                            |
| CCG                                      | 2                            |
| Metropolitan Police                      | 4                            |
| Local Authority                          | 4                            |
| Designated Nurse                         | 4                            |
| CNWL                                     | 4                            |
| LNWUHT                                   | 4                            |
| RNOH                                     | 2                            |
| Education Service                        | 4                            |
| Primary Schools                          | 2                            |
| Secondary Schools                        | 3                            |
| Special Schools                          | 3                            |
| Independent Schools                      | 3                            |
| Colleges                                 | 4                            |
| WDP                                      | 4                            |
| Compass                                  | 3                            |
| Voluntary Sector Rep                     | 0*                           |
| Public Health                            | 3                            |
| Housing                                  | 3                            |
| Probation                                | 0                            |
| CRC                                      | 2                            |
| London Ambulance Service                 | 1**                          |
| London Fire Brigade                      | 1**                          |
| Cafcass                                  | 3                            |
| Adult Social Care/Disability             | 2                            |
| Chair of Case Review Subgroup            | 4                            |
| Chair of Quality Assurance Subgroup      | 4                            |
| Chair of Learning & Development Subgroup | 3                            |
| Legal Advisor                            | 2                            |
| Business Intelligence                    | 4                            |
| Business Manager                         | 4                            |
| Training Manager                         | 2*                           |

Above also includes HSCB Development Day

\*new voluntary sector representatives have been identified for 2021 \*\* joined later in year


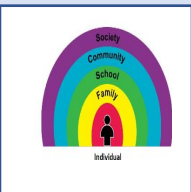


#### HSSP MEMBERSHIP & ATTENDANCE 2020-21

| REPRESENTATIVE/ROLE   | ATTENDANCE OUT OF 7 MEETINGS |
|---|------------------------------|
| Independent Chair   | 7                            |
| Elected Member  | 7                            |
| CCG   | 7                            |
| Metropolitan Police Service   | 7                            |
| Local Authority   | 7                            |
| Schools - Primary   | 4/6*                         |
| Schools - Secondary   | 4/6*                         |
| Designated Nurse - Children   | 7                            |
| Designated Nurse - Adults   | 7                            |
| London Fire Brigade   | 2/3*                         |
| Business Manager - HSCB   | 7                            |
| Safeguarding Manager - HSAB   | 7                            |
| Above also includes additional Business Continuity Meetings in response to Covid-19<br>*joined membership later in year |                              |

## Appendix (ii) HSCB Budget 2020 to 2021

| <b>HSCB Budget &amp; Expenditure 2020-21</b>                        |  | <b>Outturn</b>  |
|---|--|-----------------|
| Harrow Council including Business Support                           |  | -162,417        |
| Police / MOPAC  |  | -5,000          |
| National Probation Service and CRC                                  |  | -1,000          |
| Harrow Clinical Commissioning Group                                 |  | -20,000         |
| London Ambulance  |  | -500            |
| Training Income   |  | -3,540          |
| <b>Total Income</b>   |  | <b>-192,457</b> |
| LSCB Chair  |  | 20,250          |
| Professional Support<br>(full time BM & part time L&D co-ordinator) |  | 88,715          |
| Training Admin (0.8 FTE)  |  | 35,636          |
| SCRs and Independent Auditing                                       |  | 4,875           |
| Recruitment expenses  |  | 554             |
| Voluntary Outreach work   |  | 14,000          |
| <b>Staffing &amp; consultancy expenditure Total:</b>                |  | <b>164,030</b>  |
| Council charges   |  | 21,020          |
| Annual Conference   |  | 750             |
| Training Providers  |  | 3,955           |
| Venue Hire  |  | 0               |
| LSCB Website & 3-year Chronolator™ Licence                          |  | 1,017           |
| TASP Membership   |  | 1,500           |
| Publications, Printing, USB Production                              |  | 16              |
| Catering & Misc   |  | 168             |
| <b>Delivery Costs Total:</b>  |  | <b>28,427</b>   |
| <b>Total Expenditure:</b>   |  | <b>192,457</b>  |

## Appendix (iii) Harrow Safeguarding Partnership Priorities

|   |  |
|---|--|
|  <p><b>Preventing harmful behaviours</b></p> | <p><b>1. MENTAL WELLBEING</b></p> <ul style="list-style-type: none"> <li>• Promote an early intervention and prevention approach to mental ill health with a focus on harmful behaviours, including self-harm and suicide</li> <li>• Promote collaboration between services and agencies at all stages of assessment and intervention</li> <li>• Consider how multiple vulnerabilities impact mental ill health such as substance misuse and domestic abuse</li> </ul>   |
|  <p><b>Through a welfare lens</b></p>        |  <p><b>2. CONTEXTUAL SAFEGUARDING</b></p> <ul style="list-style-type: none"> <li>• Target the contexts in which that abuse occurs, from assessment through to intervention</li> <li>• Develop partnerships with agencies who have a reach into extra-familial contexts e.g. transport providers, retailers, residents' associations, parks and recreation services</li> <li>• Monitor outcomes of success in relation to contextual, as well as individual, change</li> </ul> |
|  <p><b>Early identification of risk</b></p>  | <p><b>3. DOMESTIC ABUSE</b></p> <ul style="list-style-type: none"> <li>• Ensure all relevant sectors have access to training and awareness training</li> <li>• Promote vigilance to the fact that age, gender, ethnicity and ability do not discriminate in terms of who can become a victim or perpetrator of domestic abuse</li> <li>• Ensure early intervention and appropriate support for victims</li> <li>• Promote access to specialist intervention programmes for perpetrators</li> </ul>   |
| <p><i>Considering the voice of children and those with care and support needs in everything we do</i></p>                     | <p><b>Safeguarding Guidance:</b><br/> <b>Adults:</b> <a href="http://www.harrow.gov.uk/safeguardingadults">http://www.harrow.gov.uk/safeguardingadults</a><br/> <b>Children:</b> <a href="http://www.harrowlscb.co.uk">www.harrowlscb.co.uk</a></p>  |



## Appendix (iv) Quick Reference Learning Sheets from HSCB Case Reviews

### CHILD SAFEGUARDING PRACTICE REVIEW: CHILD 'M'

#### Learning about managing complex needs and practice regarding thresholds for children with disabilities

##### Background

Child 'M' was a 12-year-old boy from a Pakistani family who had complex medical needs and a significant learning disability. He lived at home with his parents and two younger siblings - both of whom had additional needs.

'M' sadly died due to natural causes, but this was slightly earlier in his life than expected, so an initial review took place (Rapid Review) to see if there was anything to learn about the care and support he was given.

There were indications that services for this child and his family may not have been coordinated as well as they could have been and that thresholds for intervention and services did not appear to have been applied in the same way that they would have been had 'M' not been a child with disabilities.

It was agreed that a **Child Safeguarding Practice Review** would be undertaken to explore these issues further.

##### Multiple and uncoordinated appointments

Agencies were concerned about the high number of appointments missed by the parents for Child M. As with many families with multiple needs, the multitude of appointments (sometimes overlapping), became overwhelming for the parents.

**The need for oversight and coordination of services is essential for families with complex needs.**



##### Use of Mechanical Restraint

The use of soft materials to restrain Child M had become accepted over time by most of the professionals who worked with him. Whilst applied by his parents and others with good intention, only one professional explored this as a potential safeguarding issue.

A referral on the matter was not met with timely or rigorous response – either as a Child Protection or Child in Need matter.

**The review concluded that any such arrangement should be carefully considered, and any safeguarding issues referred. Final decisions should form part of the formally agreed multi-agency Care Plan for the child.**

##### Low School Attendance

The transition from primary to secondary school was followed by a significant decrease in school attendance for Child M, largely due to the complexity of his medical needs combined with the associated high number of health-related appointments. This is a recognised challenge when working with children with multiple medical needs and an unintended acceptance of the situation can mean that unlike for able bodied children, there is no formal or robust scrutiny of any prolonged period or multiple periods of absence.

**All future 'Attendance Panels' to include a representative of the Children & Young Persons' Disability Service to ensure equal attention to the absence of children with disabilities**

##### Voice of the Child and Family

Some **excellent** examples of good practice were found where practitioners had been creative in reaching and responding to Child M's wishes and feelings – which could only be expressed non-verbally by him.

However:

- Child M suffered intermittent dental pain. Dental assessment and treatment were delayed and lacked consideration of the child's experience
- There were some services that relied too heavily on one parent for communication (the other may have benefitted from the assistance of an **interpreter**) and the **experience of Child M's siblings** were not adequately explored.