

## Haringey Local Safeguarding Children Board Annual Report 2017-2018



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## **Haringey's Safeguarding Children's Board Introduction**

We are pleased to present the Haringey Safeguarding Children Board (HSCB) Annual Report 2017 - 2018.

This has been an eventful year due to the impending legislative changes impacting on the role of LSCBs nationally alongside the local challenges experienced. The report presents the work undertaken during this period and looks ahead to the challenges faced by the Board.

Haringey has an active and strong partnership, with all agencies committed to working together to protect vulnerable children and young people in the borough. We have seen progress against some of our most demanding priorities this year such as supporting partners to develop their joint response to the Joint Targeted Area Inspection (JTAI) of December 2017 which focussed on neglect, in response to the report issued by Ofsted in January 2018. We have outlined this and other activities within the report to demonstrate the key activities undertaken, to provide assurance that children and young people in Haringey are appropriately safeguarded. The year ahead will focus on strengthening our monitoring and scrutiny of key indicators and the quality of safeguarding work of local services. This will include undertaking significant work around the future structure and governance of the local safeguarding partnership.

We welcome this opportunity to ensure that the HSCB moves forward with the most effective and efficient evidence-based approach.



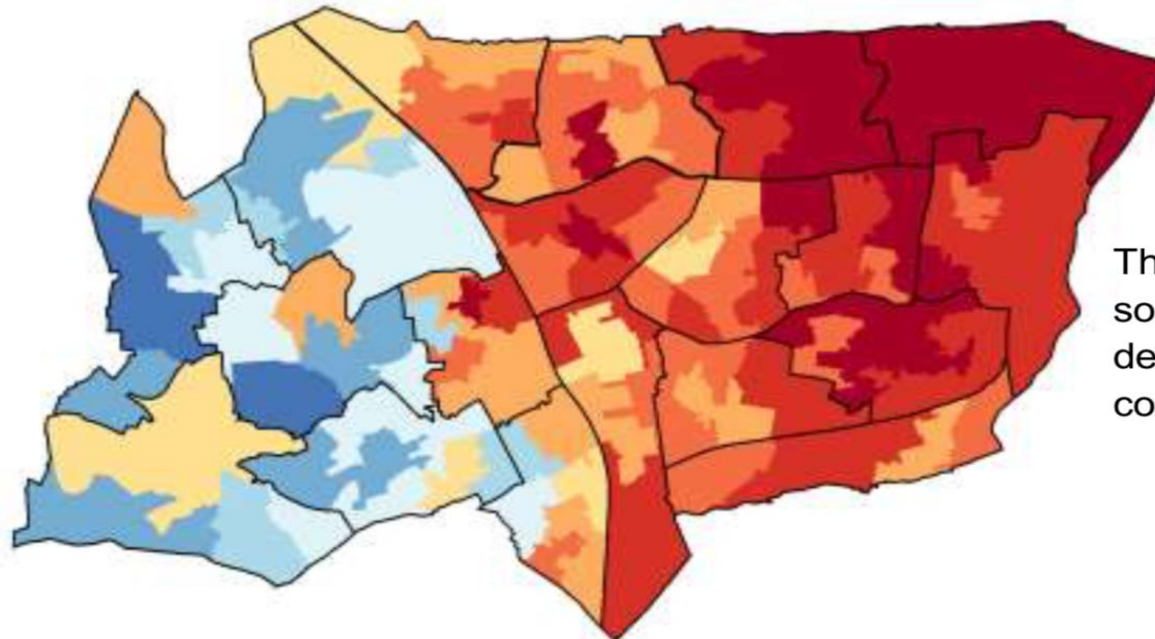
## **1. Haringey – Key data and safeguarding snapshot:**

Situated in the north of London, Haringey is an exceptionally diverse and fast changing borough. Within Haringey, there having some of the most deprived and the most prosperous wards in the country.

Of the approximately 278,000 residents of the borough (GLA estimate 2017), 62% of the total population, and over 70% of the children and young people living in the borough are from Black and Minority Ethnic groups (BAME) . Haringey's population is the seventh most ethnically diverse in the country, and at least 100 different languages are spoken in the borough. 48% of children in schools have another language rather than English as their first language (GLA 2015).

There are approximately 64,650 children (aged under 18) living in Haringey, making up 23% of the borough's population (Source GLA estimate). 16.9% of these are living in families where the adults are out of work.

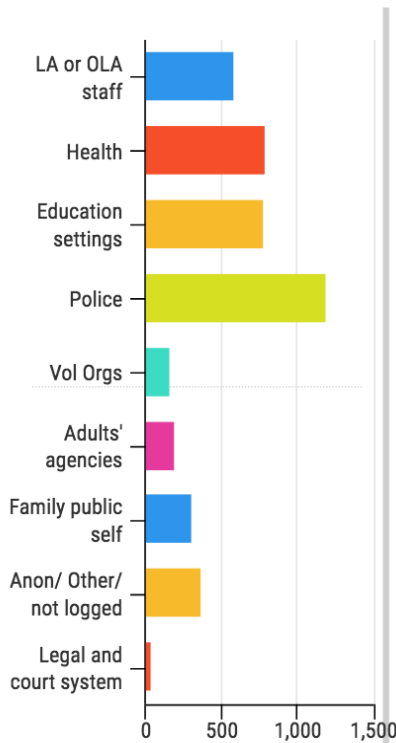
The wards with the largest number of people aged under 20 in Haringey are: Seven Sisters, Northumberland Park, White Hart Lane, and Tottenham Hale. Seven of Haringey's 19 wards are within the most deprived 10% nationally, and these are in the east of the borough. Haringey is the 6th most deprived borough in London with the 10th highest level of child poverty in London. There are more children in the east of Haringey, which has higher levels of deprivation than the west. (2015 MYE by ward (experimental statistics). The child population in Haringey continue to increase steadily.



The east contains some of the most deprived areas in the country.



## Safeguarding Snapshot 2017-8



These groups made the 4434 referrals regarding children accepted.



There were 11,887 contacts with the SPA/MASH

4434 were accepted as referrals regarding children in Haringey



There were 1004 Early Help "Conversations 4 Change"

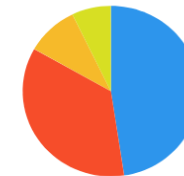
And 2670 Social Care Assessments of Children and Their Families



There were 1404 Child Protection Investigations



At the end of the year there were 327 Child Protection Plans



● Emotional   
 ● Neglect   
 ● Physical   
 ● Sexual Abuse



## **2. Haringey LSCB during 2017-18 – An Overview**

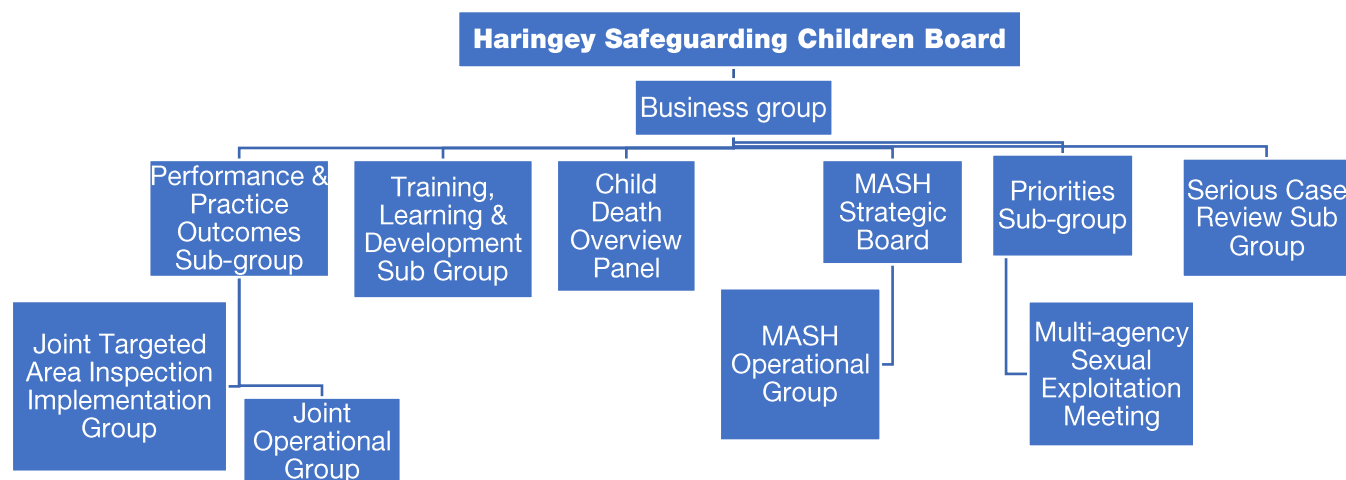
### **2.1 Practical Arrangements**

For Haringey's Local Safeguarding Children's Board (LSCB), 2017-18 was a year of challenge and opportunity. Despite the significant delay in the publication of the new draft of Working Together 2018, and the implementation of the Children and Social Work Act 2017, Haringey multi-agency partnership has ensured the effectiveness of fulfilling their statutory responsibilities to help, protect and care for children and young people.

A new independent chair (David Archibald) was recently appointed on an interim basis for one year until July 2019. Ann Graham was appointed as a permanent Director of Children's Services (DCS) in March 2018. A permanent Strategic Safeguarding Partnership Manager was appointed in May 2018. A Training and Development Project Officer was appointed on a fixed term basis in March 2018. The board's administrative tasks are supported by a full-time executive officer on a permanent basis.

## 2.2 The Structure of Haringey LSCB

During 2017-18 the structure of the Board remained largely unchanged from the previous year, as depicted below. Following the publication of Working Together 2018, restructuring and reviewing of the membership will now commence. The Executive group took a decision to become the LSCB Business group to ensure that all chairs of sub-groups, key senior operational managers and designated leads would be able to attend. Additionally the Performance and Practice Outcomes subgroup (PPO) and the JTAI group were merged and the Joint Operational Group (JOG) was initiated (see section 5 below).







### 2.3 LSCB Meetings and Attendance

At the LSCB in early 2017, it was decided that all meetings would take place on a quarterly basis. All meetings of the Board were quorate and attendance by agencies can be viewed at Appendix 1. Most of the sub-groups were held and were well-attended.

Whilst there were instances of some agencies bringing reports to the LSCB or its sub-groups, much of the business of the sub-groups moved to focusing either on the JTAI or on the new arrangements. However, key monitoring reports were heard at the Board e.g. the Allegations Management Report for 2016-7, and the Board and other sub-groups had the opportunity to review key research and reports, for example, a CAFCASS summary of key learning from SCRS where CAFCASS had been involved and the JTAI themed report ["The Multi-Agency Response to Children Living with Domestic Abuse: Prevent, Protect, Repair" \(2017\)](#).

The Board had stable attendance in terms of regular personnel and there was a sense that some sub-groups were challenged in identifying who should be in attendance from the key agencies in order to put the workplans in to effect or make key decisions. There were several agencies who relied upon the same staff member, due to their expertise in safeguarding, to attend several of the LSCB groups or sub-group meetings at both the more strategic and operational level.

Key changes to structure and function were made out of the need to drive the safeguarding agenda forward. The Executive sub-group was re-named the Business Group in November 2017 and membership changes included the Assistant Director



(AD) for Early Help. The Child Sexual Exploitation (CSE) group became the CSE and Vulnerabilities group. This was to ensure all work plans on specific vulnerabilities and risks were moving forward.

The Child Death Overview Panel and the Designated Doctor for Safeguarding made significant progress in clearing a backlog of cases and in establishing a robust process for the Practice Performance and Outcomes group, which had established a programme of multi-agency audits and had begun to prepare for inspection.

## **2.4 The LSCB Business Plan and Priorities 2017 – Achievements and Challenges:**

A 5-year strategy for Haringey LSCB was approved during 2016, with planned annual reviews and updates.

The priorities for action were as follows:

- **Priority One:** Overhaul the ways in which agencies tackle chronic neglect
- **Priority Two:** Improve outcomes for children with particular vulnerabilities and those subject to particular risks
- **Priority Three:** Strengthen cross-borough partnership
- **Priority Four:** Develop high quality partnership working at all levels between agencies

There were two further 'enabling' priorities with outcomes that would move the partnership toward best safeguarding practice.

- **Enabling Priority One:** Meaningfully engage children and young people in our work



- Enabling Priority Two: Promote and develop the children’s workforce to better safeguard children and promote their welfare

The following headlines were achieved under the priorities for action:

❖ **Priority One: Overhaul the ways in which agencies tackle chronic neglect**

This priority was superseded by the JTAI in December 2017. However, prior to this, there had been the following achievements:

- A multi-agency neglect workshop was conceived to consider what was needed to move this priority forward.
- A list of accessible neglect workshops was circulated to partners
- A plan for multi-agency learning was made

However, there were still some challenges:

- Consideration of a shared understanding and approach to neglect was in its early days
- The embedding of specific tools and models of intervention had been considered but not implemented
- The over-reliance on key senior safeguarding staff to deliver learning and development opportunities around neglect reflected the capacity issues in the system

❖ **Priority Two: Improve outcomes for children with particular vulnerabilities and those subject to particular risks**

The following achievements stand out:

- The multi-agency plan to tackle Child Sexual Exploitation was signed off as completed.
- The functioning of the Multi-agency Sexual Exploitation group (MASE) within the Missing/ CSE/ CCE/ Girls and Gangs group was reviewed by a senior Metropolitan policeman and who complimented the group on its effectiveness in analysing and responding to young people at risk of going missing and at risk of CSE.



- A mapping exercise regarding the multi-agency strategic oversight regarding key vulnerabilities and risk was carried out, which resulted in realignments of some work in order to avoid duplication and the identification of some risks which required increased attention and planning, for example, the response to Harmful Sexual Behaviour.

There were some challenges identified in terms of what the priorities might be for focus by the partnership.

❖ **Priority 3 : Strengthen cross-borough partnership**

Key or relevant to this priority were several changes:

- The completion of mapping work across Enfield and Haringey regarding CSE
- The appointment of the LSCB Chair of Enfield to the post of Interim Independent chair of Haringey LSCB
- Strategic and Operational restructuring within the Metropolitan Police, such as the merging of the London Boroughs of Haringey and Enfield under a single Metropolitan borough commander
- The advancement of the Strategic Transformation plan across five North London Clinical Commissioning Groups
- The joining together of Haringey and Islington Clinical Commissioning Groups
- Some cross-border issues within cases under review leading to cross-border reviewing activity

❖ **Priority 4: Develop high quality partnership working at all levels between our agencies**

Evidence of this, in terms of the LSCB partnership, was shown via the time commitment to the JTAI and the involvement of all agencies in inspection activity. It is also evidenced in the commitment of partnership agencies in terms of their attendance at the Board Meetings. There was excellent turnout from the agencies at specific events such as the Threshold and MASH workshops and the Neglect Workshop.



However, the nature of the LSCB 5-year strategy and business plan chimed with the findings of the Wood Review in that it was overwhelmingly bureaucratic and cumbersome. A briefer statement of priorities was approved at the LSCB in December 2017.

### **3. Haringey LSCB and the Joint Targeted Area Inspection regarding Children Living with Neglect December 2017**

The Haringey Children's Safeguarding Partnership was subject to a joint inspection between 4<sup>th</sup> and 8<sup>th</sup> December 2017. The inspection included an evaluation of the multi-agency 'front door' arrangements and an evaluation of practice with children that were neglected. There was a specific focus on the experience of children between the ages of 7-15, using a 'deep dive' case analysis methodology.

This methodology was effective in drawing out the 'lived experience of these children'. The overall picture showed a variability in practice with children that were being neglected. A robust system-wide multi-agency approach was required as was a coherent joint commissioning strategy. The findings of the JTAI will inform the business of the safeguarding partnership during 2018-19 and the priorities going into the new multi-agency arrangements from September 19 onwards.

Ofsted report highlighted strengths and areas for improvement in practice and outcomes for Haringey's children and young people. The JTAI focused on the activity and actions for the partnership. A combined partnership action plan was submitted to Ofsted in May 2018 as required. The Haringey Safeguarding Children's Board (HSCB) is responsible for driving forward change required in response to JTAI findings.



Haringey Children's Services and our partners, including health and the police, are committed on getting the very best outcomes for our children and young people. The combined action plan aims to achieve greater consistency in good practice. Individual agencies like Social Care, Health and Police have also developed single agency plans in order to improve the practice of their individual agencies which complement the combined multi-agency action plan.

The Head of School Standards, is currently updating the schools' section 11 safeguarding audit to reflect the changes and additions to Keeping Children Safe in Education 2018 and Working Together 2018. The 2018 changes include expectations around Neglect and the audit includes these.

### **3.1 Examples of key strengths**

- The MASH has good multi-agency representation and is supported by good performance management data.
- Auditing led to the LSCB and local authority having a good understanding of the deficits at the front door and in relation to the response to children living with neglect.
- There is co-location of police and a social worker out of hours.
- There was praise for staff in individual agencies including health, police, social care, youth offending, around their engagement with families, children and young people, and regarding understanding their role and responsibilities in safeguarding.
- There was an initial LSCB neglect action plan in place.



### **3.2 Examples of areas for improvement**

- The MASH multi-agency practice was inconsistent in terms of the contribution by all agencies to risk assessment and decision making.
- Thresholds were not consistently applied; neglect was not being identified as an underlying cause of harm to children and young people and pathways out of the MASH were not clear
- There are challenges to multi-agency work both strategically and operationally
- Capacity and stability in recruitment and retention was identified as needing attention.

### **3.3 The key areas going forward as a partnership in response to the JTAI are as follows:**

- A Partnership Response – Early Help, Developing the MASH
- A Partnership Approach to the MASH
- A Partnership Response – understanding and applying thresholds and decision-making
- Working together to support families at risk of / experiencing neglect
- Understanding the child's lived experience in Haringey
- Supporting and developing the workforce

Each agency also has single agency actions in a combined Neglect Action plan and there are clear governance arrangements which will support achieving of the outcomes during 2018.



## **4. Haringey's Subgroups – a summary of their activity**

### **4.1 Priorities sub-group – strategy**

During 2017-18, the CSE group changed chairs and the group reviewed its terms of reference to respond to some of the different priorities in safeguarding in the borough.

#### **Achievements:**

- The CSE group supported work to map the strategic oversight and operational response to all vulnerabilities to streamline business across the partnership and identify areas of duplication and gaps.
- The CSE group reviewed its TOR to initiate work-streams arising from the vulnerabilities work or other drivers.
- The CSE group continued to support the learning from a joint project across Haringey and Enfield to understand the needs of children and young people in both boroughs.
- The signing-off of the CSE action plan represented a recognition of responding to CSE as 'business as usual' in the borough.

#### **Challenges**

- Changes in chair and in some challenges in attendance led to slow progress.





- The complexity of governance arrangements around many vulnerabilities and safeguarding risks faced by children remained in place for much of this period, influenced by the uncertainty regarding what future arrangements would be in place after Working Together 2018

### Missing Children, Exploitation, Girls and Gangs – the Haringey Multi-Agency Operational Response

There has been some significant progress in developing a highly effective operational response to young people at risk in their communities in what is increasingly becoming known as contextual safeguarding. This has been driven by key operational managers in several agencies. Whilst the CSE and vulnerabilities sub-group has had some oversight of this work, the drivers for this progress come from the very real operational challenges that have emerged for children and young people in Haringey. In the forthcoming year, the new partnership arrangements must develop clarity and purpose in how the strategic work can challenge and support the operational response.

### **Achievements this year include**

- The establishment of a multi-agency, cross-borough, monthly Missing/CSE/CCE/Girls and Gangs Panel where all high risk children and young people are discussed and safety plans put in place.
- The panel has been highly effective in safeguarding through a joined-up family and community approach and supports service developments such as Single Point of Contact for CSE who works with our Missing and Child Criminal Exploited children and young people. There has been an increase in the use of Disruption Orders.



- The Missing/CSE/CCE, Girl and Gangs Panel has representation from the relevant Police departments (CSE, Missing, SET, and Operation Harkime), Health (Sexual, LAC and School Nurses), Education, Prevent, Youth Justice, Early Help and Enfield/Islington SPOCS.
- Safer London Young People's Advocates work closely with the CSE SPOC. High-risk cases are discussed weekly with Safer London, and The Gangs Unit, with safety plans realigned when and if needed. Safer London and the Gangs Unit provide crucial information, intelligence and data that underpins our CSE Service. Professionals are as 'Champions' to provide future team and individual consultations and learning.

#### **Areas for development over the next year:**

- The safeguarding partnership will agree the governance arrangements for this vitally important work.
- Whilst young people who are affected by CSE are routinely identified and supported, there is currently no means of collecting multi-agency data on the number of young people at risk. This sits within a wider workstream led by the PPO to develop a comprehensive approach to strategic data analysis across the partnership. A Business Analyst Job Description is currently being developed to gather the increasing information, intelligence and data collated through partnerships.
- The quality of referrals made to the panel and to strategy meetings will be further developed. This is being addressed through the use of the CSE toolkit and mapping meetings including Signs of Safety.



- In response to recognised patterns and trends in the cases of Haringey young people who are at risk of CSE/CCE, the Local Authority and the Safer London Harmful Sexual Behaviour Manager have made an application for funding to the Home Office for a HSB service for young male victims in the borough.

What different has the multi-agency approach to Missing/ CSE/ Criminal Exploitation and Girls and Gangs made to young people in Haringey?

Raising awareness of CSE with our multi professional partners and social work professionals has resulted in a major increase in our knowledge and identification of CSE. This supported:

- Effective management of the most high-risk cases
- An increase in mobilising emergency responses in 'threats to life' e.g. six young people have been moved out of Haringey with their families to safeguard them from future harm.
- Where we have not been able to safeguard our high risk CSE, we have increased our court activity and sought Interim Care Orders, placing our young people in areas outside of London.

## **4.2 Policies Performance and Outcomes subgroup**

In Haringey the LSCB's Policy, Performance and Outcomes subgroup lead on ensuring policies and protocols are up to date as well as carrying out audits and other way of learning from practice. During 2017-18, the following summary outlined the work done in terms of reviewing and relaunching policies. This was against a backdrop of a level of uncertainty regarding



the new Working Together to Safeguarding Children and the possible impact of changes to local safeguarding arrangements. The group also extended its remit to prepare for any possible forthcoming Joint Targeted Area Inspection.

### **Key achievements**

- The group supported the production of a draft neglect strategy in September 2017.
- The LSCB Escalation policy was revised and relaunched in January 2018 to ensure that it was more accessible and user friendly in practice and, towards the end of the year, the PPO began to consider how to evidence the implementation of the Escalation approach and its impact on safeguarding practice.
- A new Pre-Birth Assessment protocol was developed by a multi-agency task and finish group of professional and launched in March 2018. The emphasis is on the importance of ensuring that pre-birth assessments should be triggered by different factors in a timely way to ensure the best outcome for the child at birth.
- Gave a detailed response to the draft proposed Working Together 2018

The PPO group also established an annual programme of multi-agency audits which focussed on the following areas:

- The response to Child Sexual Exploitation
- Neglect (before the inspection that was positively commented on during the inspection)
- Children who present to A and E who have been assaulted



- The Lived Experience of the Child – building upon the huge amount of learning from the JTAI audit activity, the PPO challenges its agencies to review how the lived experience of the child was gathered by practitioners; what skills, knowledge and tools were utilised to build this picture?

The PPO group also focused on preparation for a possible Joint Targeted Area Inspection (JTAI). The PPO group, which was well attended by all agencies and their representatives, was involved in auditing for mobilisation and thus delivered on all the required inspection activity. The group looked at specific subject areas that the JTAI would cover and supported self-assessment against the JTAI evaluation criteria around domestic abuse and against the findings from other JTAI inspections. Haringey was subject to a JTAI in November-December 2017.

There were other exercises which took place which supported developing the partnership's understanding of specific concerns. There was a useful discussion which took place in January 2018 with representatives from health and social care regarding the differing responses to Female Genital Mutilation in the borough of Haringey. This discussion supported a development of how statutory guidance regarding the response to, and the reporting of, FGM had been implemented in different agencies and how this might affect the level of reporting in Haringey. There was an identified need arising to develop a multi-agency pathway to ensure that girls at risk of FGM are identified early.

The PPO group also supported the development of a multi-agency Joint Operational Group. This group offers the monthly opportunity for professionals and safeguarding leads to come together and hold reflective discussions in order to develop



a shared understanding of safeguarding practice in individual cases, but also more broadly to understand what the safeguarding risks to children and young people in Haringey are and what the effective ways of working with risk are. During this year there were several conversations about very 'live' cases where the various risks included gang-involvement, physical abuse and parental mental health. In some cases, agencies escalated concern regarding professional decisions which led to further action in the case. Participants have reported useful learning arising from the conversations.

**Ongoing challenges in the work of the PPO include:**

- Ensuring change and learning is implemented throughout the partnership from audits.
- Developing a truly multi-agency data-set to inform strategic thinking.
- Agreeing and implementing tool kits such as the neglect tool kit.
- Developing a shared understanding of what good quality practice in safeguarding is.
- Developing relationships within which professionals challenge each other in a way that brings about change.

**Going forward:**

The PPO recognised that, in order to make a difference to children through effective practice, their work needed to focus on embedding impact frameworks that support an understanding of different types of abuse and how safeguarding practice in those areas can be demonstrated to identify the difference to improve outcomes.



### 4.3 Training Learning and Development sub-group

During 2017-18, Haringey Training, Learning and Development Sub-group met three times.

#### Key achievements:

- In November 2017, the draft training plan for the next six months was developed collectively by participants. The group had conducted a basic training needs analysis and had agreed appropriate training levels and the audience for the required learning opportunities.
- Following discussions at the March 2017 board around thresholds and feedback from the recent Director Children Service (DCS), there was a review highlighting concerns about an increase in contacts/referrals Single Point of Access (SPA). In November, a total of 4 half day partnership threshold workshops were held for over 200 staff. A similar workshop was held for approximately 30 Designated Safeguarding Leads in Schools in March 2018. The sessions were well attended with significant contributions from several agencies as facilitators and received positive evaluations.
- Neglect Learning for Health Visitors was developed and delivered by the LSCB Business Manager and Haringey CCG Designated Nurse and Doctor for Safeguarding Children in November 2017. The event discussed the national and local guidance around neglect and informed the draft LSCB neglect strategy. There was good interaction and attendance. Live cases were presented, and themes considered around early recognition and responding to children and young people experiencing neglect. The aim is to roll out further neglect workshops including the themes for practice improvements from the Haringey Joint Targeted Area Inspection with the focus on Neglect (2017).



- Child Protection Training for Designated Leads. Training received very positive feedback; training/trainer considered to be excellent; clear and up to date.
- Safer Recruitment. This was the first training of this course provided by Helen Elliott/Wardell Associates was well evaluated by attendees. The aim is to continue as part of the LSCB core training offer.
- Signs of Safety. The SoS Project Lead delivered briefing sessions across the partnership as part of the required work underway to improve the quality of referrals using the framework.
- In March there was a new appointment to the team of a part-time project officer to take forward the arrangements for the delivery of the training programme, the embedding of the new London Safeguarding Children Safeguarding Board Training Competence and for the measurement of impact.
- The Training Learning and Development subgroup expanded its role to 'own' the Board Bulletin and communications. The aim of the board bulletin is to focus on developing skills safeguarding behaviours in frontline practice. The TLD group own the responsibility for the bulletin. The bulletin also includes a summary of discussions from each board meeting. Messages go out in the Bulletin every 4-6 months.

### **Challenges for the Training, Learning and Development subgroup**

- There is an outstanding need to identify Deputy Chairs. At the meeting held on the 31<sup>st</sup> January 2018, the chair asked group members to consider the use of time-limited task and finish groups to drive the pace of work going forward, however this requires support and time resource.





- Two out of three meetings were not quorate and this led to delays in decision making and actions being signed off at the meetings. Progress had been made since June 2017, however there remains much to do to ensure that the work already achieved has a positive impact on children and young people. It was agreed the T&D group will consider use of task and finish groups with distinct time limits to take forward pieces of work as required. The work going forward needs to be sustainable post 2018-19 to ensure it reflects the needs of local safeguarding arrangements in the future.
- The online booking system used by LB of Haringey, FUSE, which hosts the Haringey LSCB training booking system is regarded as a challenge for the individual user in terms of access, especially for users external to the local authority. Additionally, the Fuse system does not offer the capacity to measure attendance and evaluation of training or support an analysis of the impact of multi-agency safeguarding training

### **Going forward in 2018/19:**

- Revision of the HLSCB training plan informed by updated Strategic business plan and JTAI partnership action plan 2018.
- To present proposal to LSCB regarding future sustainable Learning and Development (L&D) multi-agency offer under new safeguarding partnership arrangements. This will include partnership communication approach, core L&D offer, and key focus of future partnership safeguarding L&D.



- To review the membership and format of the TLD group in line with the JTAI recommendations 2018 and Alan Wood review 2016.
- To develop training plan priorities that are focused and realistic – identifying core multi-agency learning and development (L&D) offer and identify where it is aligned and can be co-delivered across other Strategic Boards.
- To identify core multi-agency L&D offer across all training levels. Using a range of delivery mechanisms that include use of a training pool but also partners and Board members.
- To review and monitor effectiveness of the external users' registration document/information currently held on the LSCB website
- Review the resource for supporting the delivery of LSCB training offer.
- LSCB members are asked to nominate member to act as Deputy Chair.
- Development of partnership communication plan agree as to how to connect strategic activity to operational practice.
- Take forward recommendations from London Safeguarding Board Training Evaluation and Impact Analysis Framework and the London Competency Framework documents to ensure robust process in Haringey for evaluating quality effectiveness and impact of training on practice and outcomes for children.
- Consider use of good practice case studies celebrating good practice (all members could contribute) and use what is currently available.
- Consider giving staff a platform to speak at seminars and share good practice. Speak at events outside Haringey and how we fit into the London picture. Development; opportunities for people to share.



#### 4.4 The MASH Strategic Board

During the year 2017-18 the MASH strategic group met four times, chaired on a temporary basis by the Assistant Director of Children's Social Care. The chair of this group should have been held by a Police DCI, but due to the demand on resources arising from the Grenfell Tower investigation, the temporary arrangement was made and remained until early 2018. Significant to the work of the group was the review of the 'front door' arrangements led by a Head of Service within Children's Social Care, to move from the Social Care Single Point of Access (SPA) to a multi-agency MASH (Multi-Agency Safeguarding Hub). A report regarding the review and the plan for improvement was heard at the LSCB in September 2017.

##### **Key achievements:**

- Reviewed the Information Sharing Agreement.
- Agreed the Terms of Reference and governance for a MASH Operational group meeting.
- Developed an improvement plan arising from the review report.
- Established effective daily MASH data reporting and analysis.
- Review of cases through the system against thresholds and EH approach.

##### **Challenges:**

- There were concerns regarding the attendance at the MASH strategic group.



- There were challenges to the implementation of the plan to establish the MASH arrangements in terms of establishing personnel from different agencies and delays in bringing the multi-agency operational partners together.
- Progress was sometimes slow in embedding the required changes for improvement which led to further review – for example the daily MASH meeting and the MASH operational group’s purpose and functioning were reviewed again in February 2018.
- The JTAI during December 2017 led to some clear findings to be incorporated in to the action plan to embed effective arrangements at the front door

### **Going forward:**

The MASH group is now being chaired by an operational police officer and will be working to implement the findings of the JTAI and the Haringey JTAI action plan.

### **4.5 Child Death Overview Panel**

The CDOP is chaired by the Assistant Director of Public Health and the deputy is the Designated Doctor for Safeguarding. The remit of the group is to provide a review of all deaths of children who are under 18 and resident in the borough and to use the information gathered to develop interventions and recommendations to improve the health and safety of children in order to prevent future deaths.

Key data:



- During 2017/18, there were 19 deaths of children resident in Haringey.
- During the year, there were 5 rapid response meetings in relation to unexpected deaths of children.

There were 5 meetings of the CDOP panel itself. During 2017/18 the CDOP group made great progress in clearing a backlog of old cases – reviewing them effectively, identifying any learning from the modifiable factors and ensuring that those messages were fed back in to practice. For example, this resulted in a meeting to consider best practice in multi-agency preventative work where child or young people were managing life-long illnesses such as diabetes or severe allergy, after co-ordination of key personnel by the Designated Doctor.

Haringey CDOP members continued to access the excellent workshops and seminars organised by The Healthy London Partnership CDOP work stream including tackling asthma deaths, understanding and tackling neonatal deaths, bereavement support in the London CDOP system, process mapping workshops and understanding youth knife crime. Learning from the events have been shared with all panel members.

For 2018/19 the Healthy London Partnership will fund the roll out of the E-CDOP system to all London boroughs. Arrangements for 2019/20 will need to be considered as part of the new arrangements. A representative from the Healthy London Partnership CDOP work stream attended the Haringey CDOP meeting held in March 2018 and described the changes and the support available to local CDOPs in light of the LSCB partnership arrangements changing. No decisions have been made as the Chair will be having various discussions with other London CDOP Chairs and other stakeholders to



look at what arrangements would be best for Haringey. The latest the new arrangements will need to be in place is the end of July 2019

## **5. Learning from Practice**

### **Haringey Serious Case Review – A summary of activity and learning**

Haringey LSCB has a Serious Case Review (SCR) sub-group and all SCR decisions have followed the requirements in Working Together (2015). The Independent Chair of the LSCB also chairs the SCR sub-group so is party to the discussion around any referred case and understands the sub-group's recommendations regarding the decision of to initiate a serious case review. As there have been two Independent Chairs of the LSCB in Haringey this year there have been two chairs of the sub-group and two decision-makers. The current (interim) chair of the LSCB took over for her first meeting in July 2017 (the second of 4 meetings during 2017-18).

In Chapter 4 of Working Together 2015 it sets out the requirement for LSCBs to undertake reviews of serious cases in specified circumstances stated as:

"undertaking reviews of serious cases and advising the authority and their board partners on lessons to be learned."

A serious case is one where:



- abuse or neglect of a child is known or suspected and
- either the child has died, or the child has been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child.

During 2017-18 there were two cases where an SCR was initiated. One was complete due for sign off, the other is underway.

There were also two cases which did not reach the threshold but which the SCR sub-group had some oversight of as they were being dealt with through other agency reviewing mechanism. The SCR sub-group worked to identify the key learning to take forward from these cases.

One of these case reviews resulted in a learning event planned by NHS England to which the LSCB contributed. This event allowed professionals from different agencies to better understand different agency powers with respect to the use of secure placements or secure hospital admission where children and young people have complex mental health needs and attachment disorders arising from the impact of abuse and neglect.

In the autumn of 2017, the SCR sub-group worked to sign off outstanding SCR action plans regarding three SCRS; older actions were assessed for ongoing relevance or linked to the current LSCB workstreams. Some of the older recommendations did not lend themselves to a SMART approach, rather the outcomes arising from the were deemed more appropriate to be met through reflective learning processes.



Therefore, a Learning from Practice Bulletin was draft and published on the LSCB website in Autumn 2017 to support practitioners in considering best practice and they might do differently in practice around these themes. This was published on the LSCB website.

- Cultural Competence in Safeguarding Practice.
- The application of thresholds.
- Participation in multi-agency meetings (Child in need; strategy meetings; child protection conferences) and plans.
- Escalation of practice concerns.
- Multi-agency communications
- Disguised compliance/non - compliance of parents and carers: working with resistance, hostility and non-engagement.

There was a planned session in January to support key safeguarding leads in organisations to consider these themes and how to cascade them through their agencies and workforce. Despite good sign-up there was poor turn-out for this session, suggesting lack of capacity to prioritise safeguarding in agencies where other statutory responsibilities are also priorities.

However, this thematic approach is now established as a learning component in the activity of the LSCB, and the themes and how to embed them are part of training and learning development activities.





## **6. The Management of Allegations regarding professionals: The Haringey LADO service - activity and impact**

The Local Authority Designated Officer (LADO) is a well-established role in Haringey. The LADO is based within the Safeguarding & Quality Improvement Service and provides oversight of allegations against people who work with children as well as advice and guidance to agencies. An annual report is produced and presented to the LSCB. London LADOs conducted a peer audit exercise and the LADO from a neighbouring borough gave very positive feedback regarding the work of the LADO in Haringey evidencing sound work and appropriate outcomes.

The role of the LADO is to manage allegations where a professional who works with children may have:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- behaved towards a child or children in a way that indicates he or she would pose a risk of harm if they work regularly or closely with children.

This applies to allegations both in the work place and in the adult's personal life which may cause concern.

The LADO is involved from the initial phase of the allegation through to the conclusion of the case. They will provide advice, guidance and help to determine whether the allegation sits within the scope of the procedures. The LADO helps co-ordinate

information-sharing with the right people and will also monitor and track any investigation with the aim to resolve it as quickly as possible. Key data over the past three years shows that there was a fall in the number of contacts made to the LADO; this year, however, not a significant fall. Some of these contacts simply required a telephone consultation to agree actions and the matter was closed but some contacts led to a year or more of complex investigation and resulted in a criminal charge or conviction.

Year	Number of contacts to the service	Average per week
2015/2016	276	5.3
2016/2017	301	5.7
2017/2018	271	5.2

Who makes contact with the LADO?

- 79 (29%) were from the education sector, usually from Head Teachers or Designated Safeguarding Leads.
- 97 (36%) were contacts for advice, consultation or referral from social workers either within the London Borough of Haringey, or in other neighbouring authorities.
- There were 27 (10%) contacts from OFSTED. Most of them were parental complaints direct to Ofsted regarding schools and early years settings.

Which professionals are the subject of initial allegations in Haringey?

- 271, 124 (46%) were about staff working in the education sector. This total is the about same proportion as last year. This included allegations about teachers and school support staff. The allegations refer to current and historical situations where a concern has arisen in a person's home life as well as allegations that the staff member has behaved in a harmful way towards a child. Contacts were evenly split between primary and secondary schools, with slightly more calls about teachers than about school support staff.
- 35 (13%) were regarding Early Years which includes nurseries, pre-school settings, and childminders.
- 30 (11%) were contacts about the care sector i.e. including foster carers, both in-house and from the PVI sector, and residential care workers.
- 20 (7%) were contacts regarding health professionals. It is interesting to note that this year there has been a higher than usual of these situations. As there is no large general hospital in the boundaries of Haringey, allegations about staff go to the borough in which the hospital is based. The majority of contacts to the LADO in Haringey concerning those in the health sector are about incidents in the professional or volunteer's personal life, most of these were child protection investigations in the home life of those working in the health sector.
- The rest of the consultations concerned professionals or volunteers involved in sports and leisure clubs, health professionals, transport providers, the charitable sector and the faith sector.

Of the 271 contacts 39 cases resulted in the application of thresholds and of the management of allegations procedures.



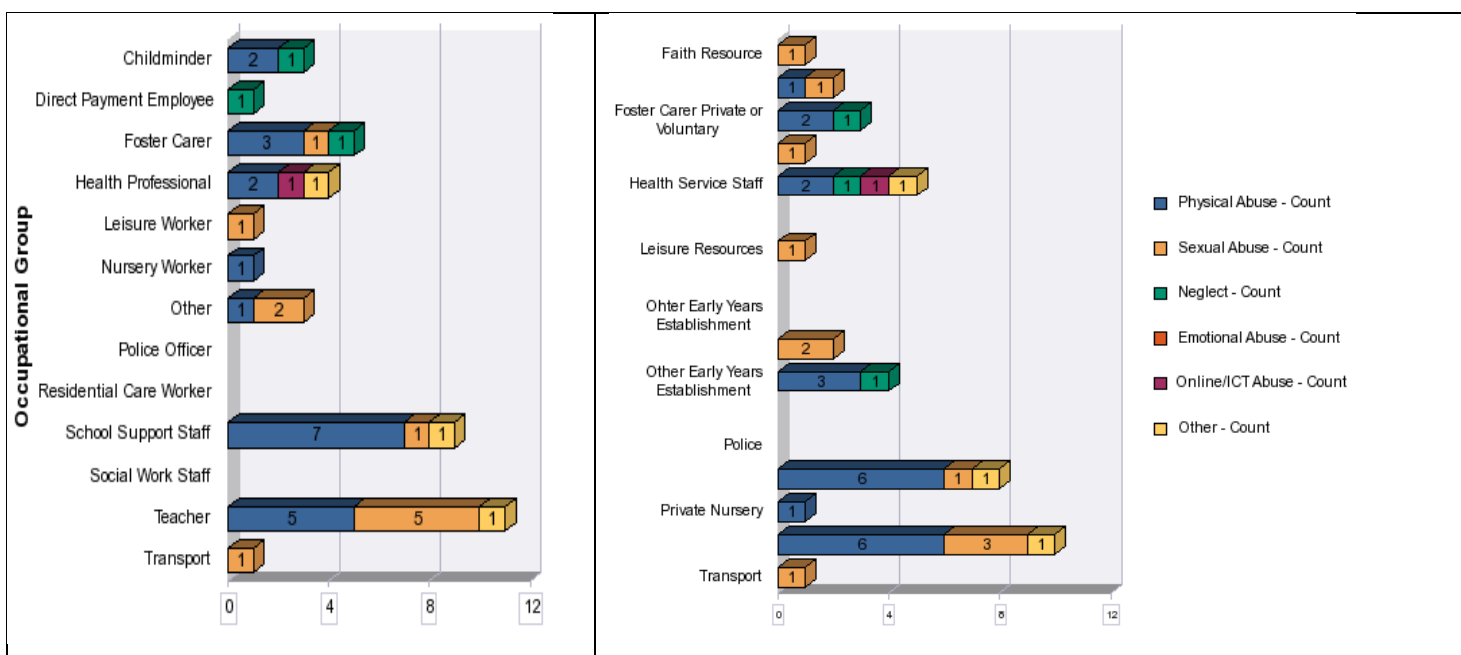
What are these more serious investigations regarding professionals about?

The data below shows the category of abuse or concern that was the presenting feature when the referral was received. The categories used in Haringey are wider than those in the London Child Protection Procedures as referrals do not always fit neatly into a category. For example, sometimes a professional or volunteer is arrested for accessing indecent images of children when there have been no presenting concerns in the workplace; this may be classed as 'online or ICT abuse' rather than sexual abuse. There may be an arrest resulting from a serious criminal issue in the home life of a professional or volunteer which does not involve a child and there are no concerns about them at work. This could fall in to the 'other' category, and lead to a risk assessment being necessary to establish if there were any safeguarding concerns in the workplace. An example would be a parent whose son living at home is arrested for possession of illegal drugs. Such cases would require assessment under the Disqualification By Association guidance.

The chart below shows the categories of suspected abuse or neglect by agency:

- Allegations of physical abuse are by far the highest category at 21 of the 39 cases, which is 54%. This is in line with previous years' data. It does not mean that large numbers of professionals within the borough are physically abusing children, but that the presenting issue when the referral was made was of some sort of inappropriate physical contact. Referrals range from allegations that children were hit or slapped to allegations of shoving or pushing and incidents that may be a misinterpretation or a misunderstanding.

- The second largest category is sexual abuse at 11 which is 28% of the total. The majority of these were serious allegations of sexual abuse against children by people who were in a position of trust and led to a police investigation.





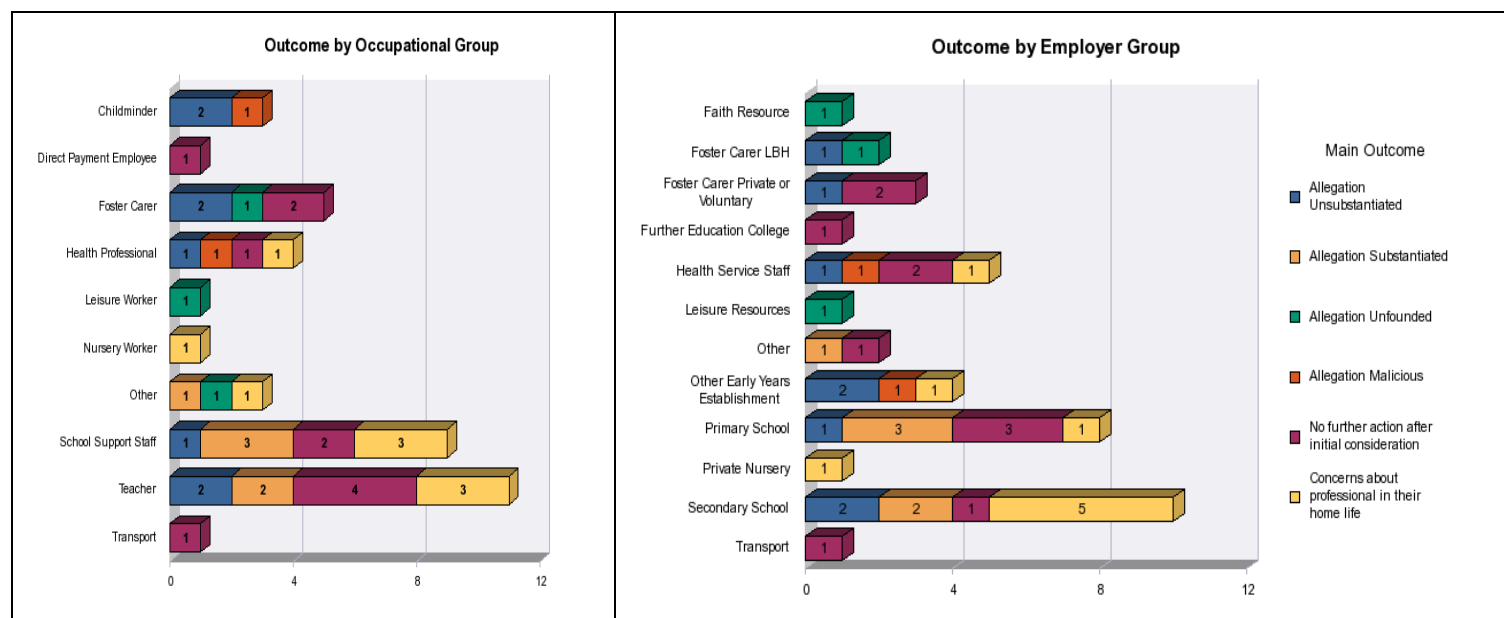
What are the outcomes for these allegations?

Once an allegation reaches the threshold for an investigation there are a range of outcomes drawn to a conclusion in line with procedures. The outcomes available within the London Child Protection Procedures (2017), and Keeping Children Safe In Education (2015) are 'Substantiated', 'Unsubstantiated', 'Unfounded', 'Malicious' and 'False'.

In Haringey there is also the option of an outcome which is 'Concerns about a Professional in their Home Life'. This last category is used to draw out the situations where there is an incident or event in the home life of the professional or volunteer. Such cases usually come to the attention of the LADO where a child is the subject of child protection enquiry under Section 47 of the Children Act, and it is identified that a parent is employed working with children and young people. Sometimes cases are referred directly by police to the LADO, for example, if a professional is arrested outside their work life or accepts a caution following an incident. This is the largest category in Haringey and is the outcome recorded if the employer is satisfied that any risk can be managed in the workplace with safeguards in place, so the concern does not lead to suspension or dismissal.

'Substantiated' allegations result in either a criminal charge or caution, disciplinary action arising directly from the safeguarding incident, or a balance of probability decision that there is enough evidence to support the allegation. The Allegations against Staff and Volunteers (ASV) meeting attended by those directly involved in the allegation investigation makes this decision. There were 12 substantiated allegations during 2017-8 and 4 which were subsequently referred to the Disclosure and Barring Service.

The LADO management of allegations outcomes are shown below in the tables below by the different professional groupings:



Other data regarding ethnicity, gender and age of those subject to allegations is reported to the LSCB on a regular basis as well as timescales for managing cases as per Keeping Children Safe in Education.

This year, the London Safeguarding Board has significantly updated the chapter on Allegations (Chapter 7). Changes include:



- LADO meetings are now referred to as 'ASV meetings' meaning, 'Allegations Against Staff or Volunteers' not Strategy Meetings; this is to prevent confusion with Section 47 Strategy Meetings.
- There is new guidance on the difference between an 'allegation' and a 'concern'. This is to clarify thresholds for a formal referral and ensure that referrals are regarding incidents that are sufficiently serious to indicate that the behaviour of the adult presents a risk of harm.
- There is a new section clarifying reasonable timescales in line with those in Keeping Children Safe in Education.

There is a local Haringey LADO Threshold Document has been shared with other Local Authorities through the new National LADO Network. The document was well received. A small working group of LADOs from different parts of the country, as part of the National LADO Network, are now developing a threshold document which it is hoped can be shared with the Department of Education and possibly added as an addendum to future statutory guidance.

The Haringey LADO works closely with colleagues in order to consider learning from cases which have had a significant impact on a setting. There have been opportunities to link with peers in other boroughs and the Haringey LADO has offered supports and training to other new LADOs. The LADO also offers training on safe recruitment via the LSCB training programme. It is key that all agencies are familiar with the LADO and how allegations are responded to in Haringey – it is hoped that this section of the Annual report can be circulated as a useful summary for all employees.



## Appendix 1: Attendance LSCB Board 2017 – 2018

\* Denotes representative attended on behalf of the member

× Denotes membership ceased

• Post name changed

Organisation	Job Title	No of Meetings attended			
		14 June 2017	20 Sept 2017	13 Dec 2017 – Development session	March 2018
Independent	Chair	✓	✓	✓	✓
Independent	Lay Member (none apt)	n/a	n/a	n/a	n/a

CAFCASS	Senior Service Manager	✓	✓	✓	-
Local Authority	Deputy CEO	-	-	✓	
	Director of Children's Services	✓	✓	✓	✓
	Director of Early Help Targeted Support	*	*	✓	✓
	Assistant Director, Safeguarding & Social Care	✓	*	✓	✓
	Assistant Director (Public Health	✓	✓	✓	✓
	Strategic Violence Against Women and Girls Lead (FD)	✓	✓	✓	✓

Health	Director of Quality & Nursing (Haringey CCG)	*	*	*	*
	Designated Nurse for Safeguarding (Haringey CCG)	✓	✓	✓	✓
	Designated Doctor Consultant Paediatrician (Haringey CCG)	✓	✓	✓	✓
	Named GP (Haringey CCG)	✓	-	✓	-
	Dep Director of Nursing (NMUH)	-	✓	-	-
	Dep Director of Nursing & Patient	-	-	-	-

Experience, Whittington				
Head of Safeguarding (Whittington)	✓ *	✓ -	✓ -	✓ -
Executive Director of Nursing Quality & Governance (CAMHS/BEH-MHS)	✓	✓	✓	✓
Executive Director of Nursing Quality & Governance (CAMHS/BEH-MHS)	* ✓	- ✓	- ✓	- *
Borough Commander				

Police	Borough Commander	✓	✓	✓	*
	DI, CAIT	✓	✓	*	✓
	DCI, CAIT	*	✓	✓	-
Probation	ACO (Haringey Probation Service)	*	*	✓	✓
	ACO (Probation Community Rehabilitation Company)	-	-	-	-
Voluntary	HAVCO	-	-	-	-
	The Bridge Renewal Trust	-	-	-	-
Lead Member	Councillor	✓	✓	✓	✓
Primary School	Head Teacher	✓	✓	✓	✓

Secondary School	Head Teacher	✓	-	-	-
London Ambulance Service	Quality, Governance & Assurance Manager	-	-	-	✓
Homes for Haringey	Deputy Director	-	-	-	-
LSCB	Business Manager	-	✓	✓	✓
LA legal service in attendance	Solicitor	✓	✓	✓	✓