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NEWHAM
SAFEGUARDING CHILDREN
PARTNERSHIP

FIRST FRIDAY SAFEGUARDING PARTNERSHIP FORUM

For all in Education, Health, Children's Social Care, Police, Adult and other public services who are members of the Newham Safeguarding Children Partnership

Time	Item	Presenter Mentimeter
10.00	Welcome and Introduction Recap from January;	Natalie Newton NSPC Service Manager
10:05	• Produced 7 min briefings; overview of views and partnership interest • Live sign up to confidential area	Natalie Newton
10:15	Annual Report 2022/23 Patterns in practice, key messages and 2023/24 work programme; National Panel Mentimeter Q & A	Elena Nicolaou Safeguarding Children Workforce Development Lead, Professional Practice
10:40	Permissions to share information/data and local Privacy Notice Mentimeter Q&A	Mahfuzul Khan Head of Service (Multi-Agency Safeguarding Hub & Ass)
10:50	Child Q – Update report – Newham's Response Mentimeter Q&A	Annabel Bates Director of Education, Inclusion & Achievement, Education, Inclusion & Achievement
11:15	Training Available	Elena Nicolaou
	Feedback and closing comments	
11:25	Closing Remarks	Julia Stephens – Row NSCP Independent Chair

Dates of Future Meetings: 3rd May, 5th July

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WWW.MENTI.COM CODE 5320 5578

Recap from last Forum

Extra Familial Harm 7 Minute Briefing Video; This briefing particularly focuses on the additional learning from three adolescent rapid reviews that have been completed in the last 6 months

Testing out; Safeguarding Adolescents from Extra-Familial Harm. An aide-memoire tool developed in response to the learning from rapid reviews 2022/23

SUDI Prevent and Protect Model; Sudden Unexpected Death in Infancy.

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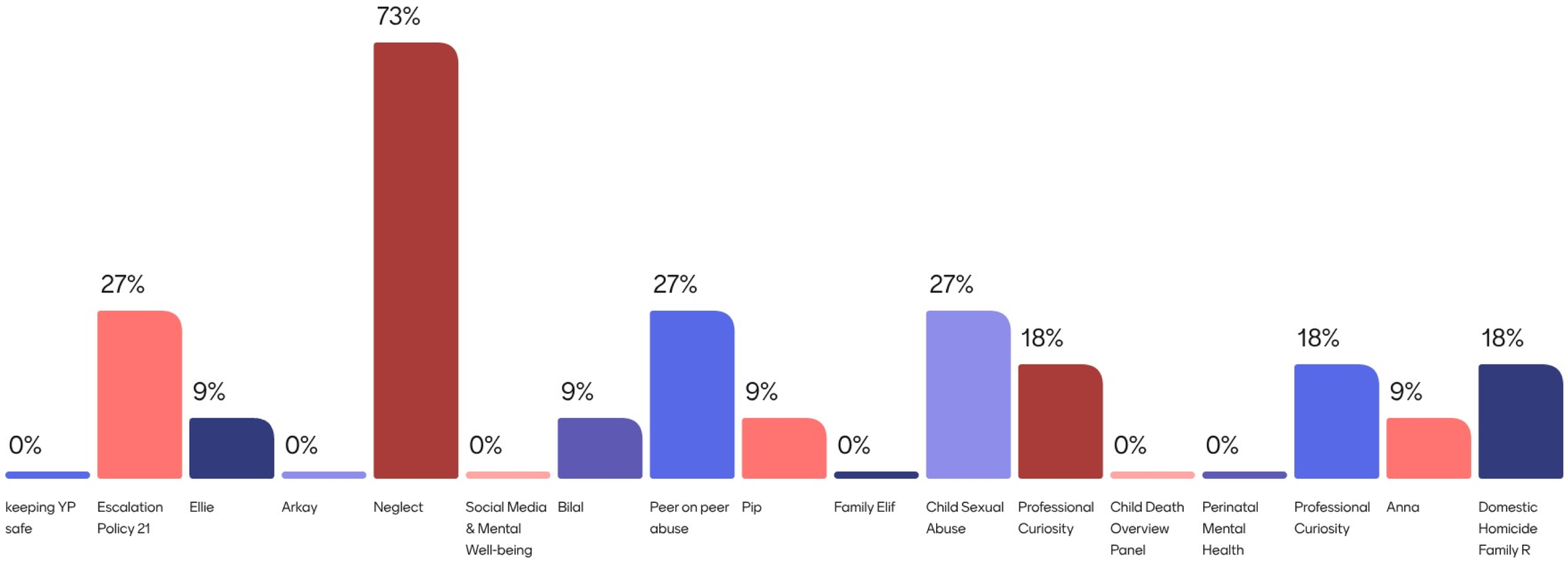
What 7 minute briefings have you used ?



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Name of section and team …….. Contact details ……..
Please ensure you keep a copy of this discussion and plan for your records

Action Plan

What actions have been agreed to improve practice?
Please ensure you keep a copy of this discussion and plan for your records

Identify the learning or recommendations that are relevant to your team and your team's discussion on those points

1 ……

2 ……

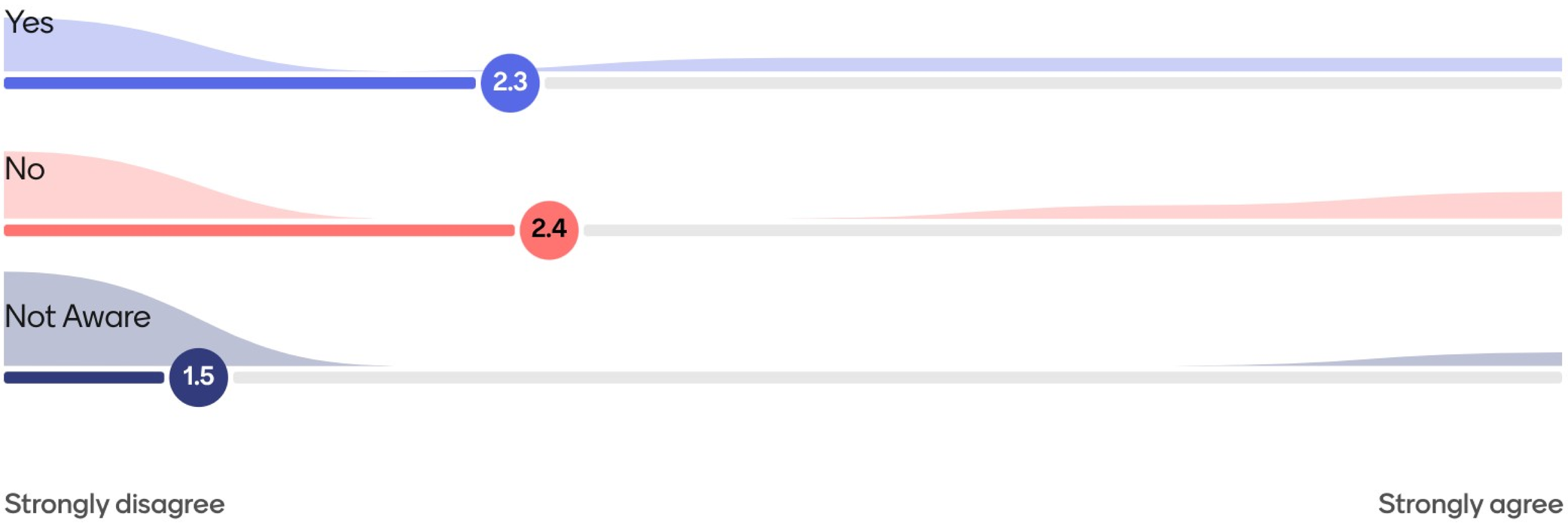
3 ……

7 Minute Briefing - Action Plan

Title of 7 Minute briefing ……
Name of organisation …….. Team manager ……

What need to happen?	Who will do it?	By when?	How will you know when this has been done?	How will you know if it has worked?

Have you used an action plan



How to access the secure 7 minute briefings

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Email the LSCB.administrator@newham.gov.uk using the subject title: *Access to secure 7 minute briefings*

Please send your *feedback* to the same email address with details of who the briefing has been shared with and how the learning is being used to improve safeguarding practice.

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Confidential Area

Home | Children & Young People | Parents & Carers | Professionals | Community | Early Help | Learning Zone | About

7 Minute Briefings – Confidential Area

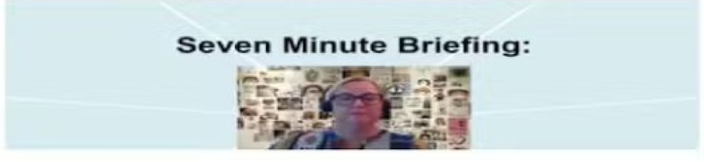
This password protected area contains learning related to Newham specific cases. To document your learning you can access this tool, which can evidence and track the learning with in your agency. This area should be used to share good practice and learning within Newham.

Please add in the same the provided log-in password to watch all videos.

Anna

Ellie

Keeping Young People Safe



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Live Sign up

- Take this opportunity to request access to the confidential site.
- This comes with responsibilities –
  - That you disseminate the information within your establishment
  - Complete action plan to document and evidence change and outcomes
  - Share your action plan with the NSCP

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Annual Report 2022/23 Patterns in practice, key messages and 2023/24 work programme; National Panel

Elena Nicolaou
Safeguarding Children Workforce Development Lead, Professional

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The Child Safeguarding Practice Review Panel Annual Report 2022/23

Patterns in practice, key messages and 2023/24 work programme

(Published January 2024)

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Background and Aim

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- Fourth annual report (1 January 2022 to 31 March 2023, bringing it in line with financial year reporting)
- Its aim is to disseminate evidence and learning originating from the unique national oversight of rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs) and of undertaking reviews about issues of national significance.
- This report presents the collective understanding of how best we can help keep children safe through effective multi-agency practice.
- The updated analysis shows that the practice themes from last year's report remain relevant, despite some good practice being identified. The report have looked at how learning can inform practice of senior leaders and middle managers as well as for those involved in direct practice. The role of strategic leaders has been considered and the organisational conditions that will best enable and sustain embedding recommendations that will drive long-term change.

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Evidence base

- Serious Incident Notifications (SINs), rapid reviews, a sample of LCSPRs, letters to safeguarding partnerships from the Panel used to assess the quality of rapid reviews, evidence from national and thematic reviews
- Safeguarding panel reviews from Child protection, Domestic Abuse, Bruising in non-mobile infants, and safeguarding children with disabilities in residential settings.

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The current operating context, change and challenges

- Issues such as: lost education, poor housing, poverty, adverse mental and emotional health can trigger, intensify or be the backdrop to affect a family's ability to cope, which can affect their parenting and heighten risks for children.
- Challenges: workforce recruitment and retention, preventative and early help services, and in provision for children with mental health needs.
- Consider the 'why' question from reviews
- New Working Together guidance and new National Practice Framework for children's social care have also been published. (Multi-agency working)

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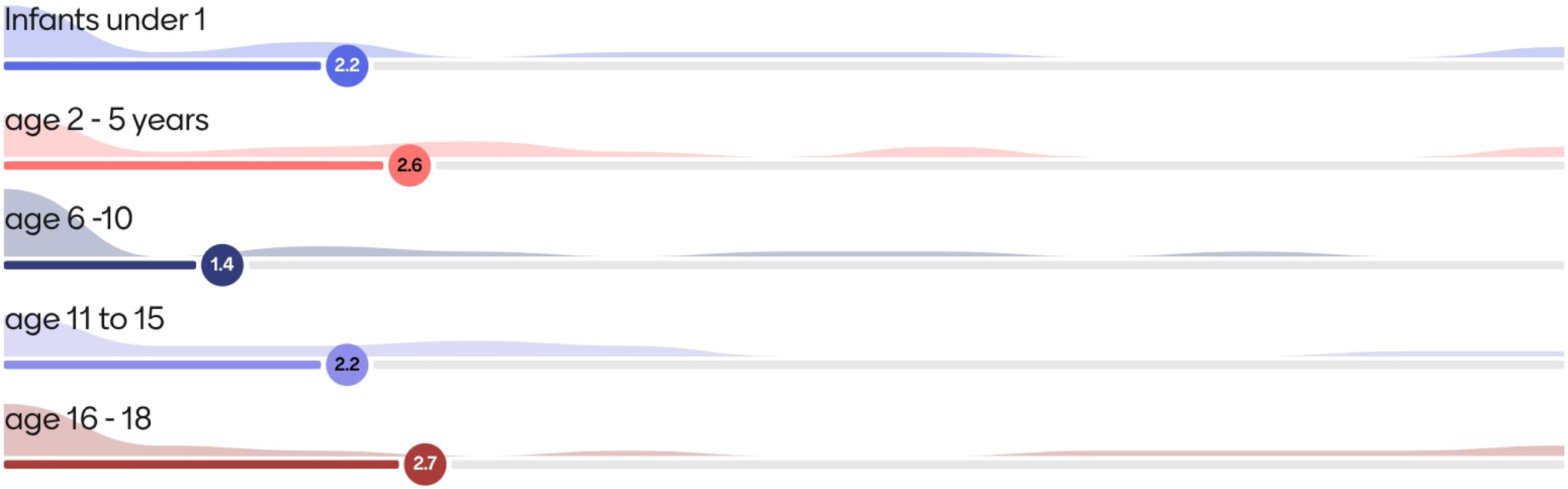
‘A window on the system’ – ‘who’ and ‘what’ is featuring within SINs and rapid reviews

- There were 393 SINs and rapid reviews submitted for serious incidents where abuse and/or neglect is known or suspected that occurred between April 2022 and March 2023.
- Around two-fifths of these due to the death of a child and around three-fifths due to serious harm, which is similar to the 2021 figures.
- In over three-quarters of cases the family of the child was known to children’s social care either as an open case or previously, and a third of children were either on, or had previously been on, a child protection plan.
- In addition, nearly a fifth of children were classed as ‘looked after’ either at the time of the incident or previously.
- A range of factors were present in the lives of these children, e.g. mental health needs, especially among teenagers, ongoing neglect, and absence from school.

what age range distribution was the most reported?



A 'Window on the System' (2)

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- Age distribution: a predominance of infants under the age of 1 (36%) with a second peak in the 11 to 15 age group (21%) (similar to 2021).
- In comparison to the 2021 census figures for 0 to 17-year-olds, children from mixed/multiple ethnic groups and Black/African/Caribbean/Black British ethnicities were overrepresented in the rapid reviews. Conversely, children from Asian/Asian British ethnicities or other ethnic groups were underrepresented in the rapid reviews.
- Reasons for death showed some variation by sex, with girls (20%) experiencing higher rates of suicide than boys (6%) and boys showing higher rates of both extrafamilial child-homicide and extrafamilial fatal assaults combined than girls (17% versus 3%).
- Reasons for serious harm also showed some variation by sex, with females (38%) more likely to suffer child sexual abuse than males (8%) while males experienced higher rates of both intrafamilial non-fatal assaults (39% versus 20% for female children) and extrafamilial non-fatal assaults (14% versus 3% for female children).

What percentage of children experienced neglect prior to the rapid review?

75%

30

75

90%

60%

80%

30%

80%

16

What percentage of children experienced neglect prior to the rapid review?

30

80%

80

50%

30

85 percent or more

70

80%

16

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What percentage of children experienced neglect prior to the rapid review?

65

75%

90%

75-100

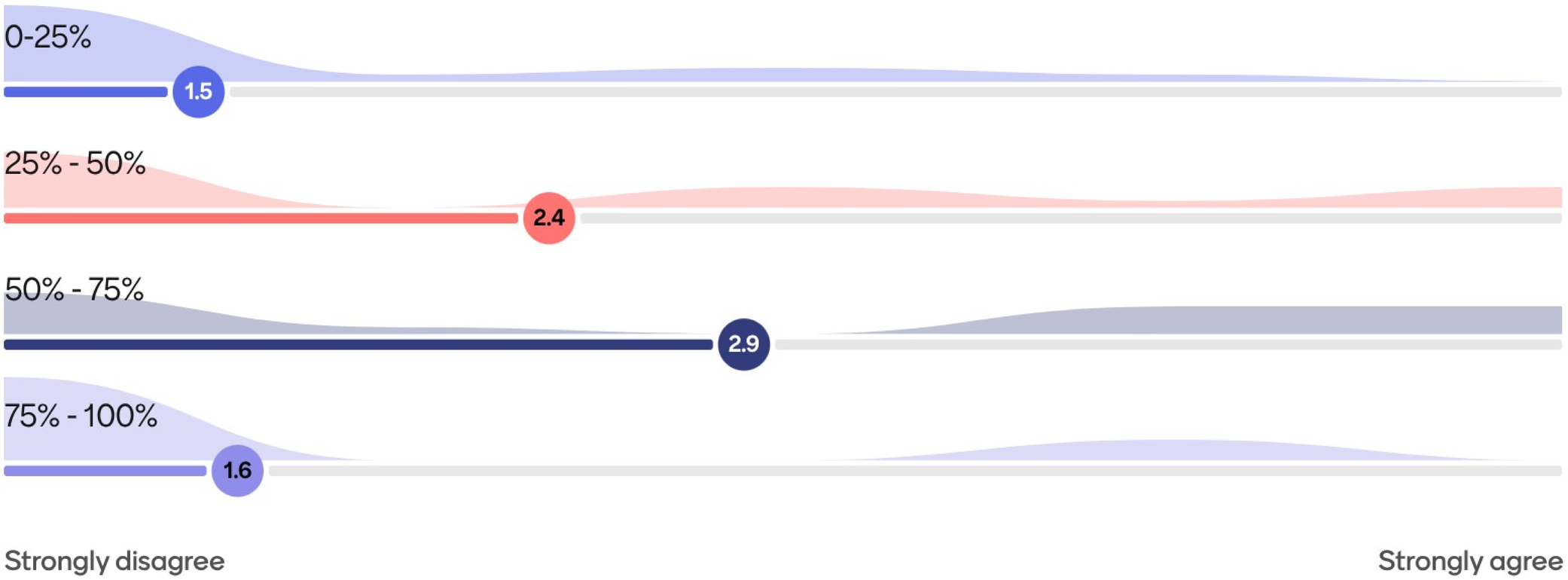
50

30%

80%

16

What percentage of children were reported to have one or more mental health conditions, either diagnosed or undiagnosed?



A ‘Window on the System’ (3)

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- Over half of rapid reviews (53%) noted that the child had experienced neglect prior to the incident. This was the same proportion for those incidents where the child had died (53%) or had suffered serious harm (52%).
- Of the 133 children of school age (aged between 4 and 15 years old) and subject to a rapid review for an incident that occurred between April 2022 and March 2023, the majority (64%) were enrolled at a mainstream school at the time of the incident, with a further 18% enrolled either at a special educational needs establishment or in alternative provision.
- Overall, a fifth (21%) of children who were the subject of a rapid review were reported to have one or more mental health conditions, either diagnosed or undiagnosed

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Practice themes from 2021 annual report

- Effective leadership and culture supporting critical thinking and professional challenge.
- Giving central consideration to racial, ethnic, and cultural identity and impact on the lived experience of children and families.
- The importance of a whole family approach to risk assessment and support.
- Recognising and responding to the vulnerability of babies.
- Domestic abuse and harm to children – working across services.
- Keeping a focus on risks outside the family.

Emerging themes

Six emerging themes are also introduced. These relate primarily to specific groups of children and families:

- **Parenting capacity and children with disabilities and health needs.** We observed themes relating to parenting capacity of children with these types of needs, and how these can be compromised by ecological factors. We also saw that, where practitioners' primary focus is on the child's health condition or needs, there is a risk that abuse and neglect go unnoticed.
- **Children with complex mental health needs.** We saw a high prevalence of mental health conditions for teenagers identifying as being LGBTQ+ and those recorded as having a gender identity different to the sex registered at birth or being non-binary. A significant proportion of teenagers with reported mental health conditions were also recorded as experiencing alcohol and/or substance misuse. Suicide was also notable as cause of death for nearly half of those teenagers with mental health conditions who had died, and all of whom were known at the time or previously to Child and Adolescent Mental Health Services.
- **Parental mental health and parenting capacity.** We noted that this could be overlooked, highlighting a need for practitioners to assess parents' awareness of their child's needs. When parental mental health is not fully considered services can also overlook the viability and practicality of parenting arrangements and safety plans. Parents struggling to meet the expectations within plans can then be framed as neglectful rather than as evidence of parents feeling that the demands of them from some agencies are overwhelming.

Emerging themes (2)

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- – **Children not in school.** The latest analysis demonstrated difficulties with a lack of suitable placements and support for children with complex needs and stretched resources within special educational needs services. Case reviews continue to show that too many children spend long periods of time outside of formal education as a result. It is during these periods that some children have died or experience serious harm.
- – **Young carers.** We saw how agencies are not always recognising this role for children and the impact this has upon them. These children can be providing crucial support for their parents or other adults, sometimes where they have substance misuse problems, mental health needs or where domestic abuse is present, all which impact on their own capacity to support their children.
- – **Working with Gypsy, Roma and Traveller communities.** This theme highlights the importance of exploring the impact of cultural identity and community factors on individual children and families. We saw how cultural barriers could mean that traditions and parenting approaches of Gypsies, Roma and Travellers, as well as those of other ethnic and cultural groups, were not always understood by services and their impact rarely assessed or analysed.

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National reviews and thematic analysis

The Panel considered three important cross-cutting themes that have surfaced from their own national and thematic reviews undertaken in 2022 and continue to be observed in rapid review and LCSPR data presented in this annual report.

These themes are:

- **Knowing what life is like for children**, highlighting the centrality of children's voices and experience, and those of their parents, carers, and wider family members, but also the knowledge, skill and confidence required to build a full picture of children's lives to enable the best safeguarding, support and protection.
- **Information sharing and seeking** which is a perennial issue in child protection and safeguarding work. Issues in this area undermine the ability of practitioners and agencies to have a full and accurate understanding of what is happening in children and families' lives, including any risks of harm. 14 Annual Report 2022/23
- **Working across agency boundaries**, on which information sharing is reliant and which is essential for building holistic pictures of children's lives.

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Conclusion

The report concludes with a series of reflective questions for safeguarding leaders to support them in promoting the very high standards of safeguarding practice and making sure that learning reviews drive longer term change to help children and families.

These questions are organised around 6 key strategic themes:

- **Culture**: creating an inclusive culture where professional challenge is promoted.
- **Clear partnership intent**: ensuring clear and balanced partnership working.
- **Strategy to delivery**: ensuring strategy is carried through to frontline practice.
- **Assessing effectiveness**: evaluating impact of the safeguarding system.
- **Getting upstream**: ensuring learning feeds into prevention, early intervention and the commissioning of services.
- **Workforce**: working together effectively across agencies and promoting development

Any Questions

1 question
0 upvotes

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Mahfuzul Khan
Head of Service (Multi-Agency Safeguarding Hub & Ass)

Any Questions?

1 question
0 upvotes

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Child Q – Update report – Newham's Response

Annabel Bates
Director of Education, Inclusion & Achievement, Education, Inclusion & Achievement

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Newham London

Child Q - Why was it me?

- Actions from the updated report
- Newham Education team response to second round of recommendations
- Broader partnership development to support our next steps

Annabel Bates
Director of Education, Inclusion and Achievement

Child Q Update report, June 2023

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Newham London

Review of initial recommendations

- Building trust in the police
- Tackling racism
- Tackling adultification
- Recognising importance of local context
- Partnership with safer schools officers
- Culture and practices in schools

Child Q Update report, June 2023

Additional recommendations

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1. Comprehensive council-wide strategic mechanism for tackling racism
2. **Headteachers agree the list of items prohibited in our schools**
3. **Surveys into schools to ask children and young people whether they feel safe, respected, safeguarded**
4. **Involve children and young people in self-assessment processes**
5. DfE to reword guidance in relation to strip searching
6. DfE to reword guidance in relation to searching, screening & confiscation
7. Ofsted to incorporate review of 5&6 into inspection framework to form part of routine school inspections

Child Q Update report, June 2023

Additional recommendations

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Newham London

8. MTIP should be carried out at a police station
9. Acknowledgement of institutional racism by the Metropolitan police
10. Local representatives involved in recruitment of new commanders
11. London policing board test how well police being held to account
12. Safer schools officers should have a proven ability to engage and work with children and young people
13. Independent people play a much stronger role in deciding when a review is needed

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Newham London

Challenges which cut across services

Safeguarding

Racism

Disproportionality

Child Q - Gaining Insights

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Newham London

- Understand confidence, clarity and concerns of all colleagues working in schools
- Gaining insights into the Newham narrative of safe feelings in school, adultification, and bias is crucial.
- As the report highlights, it is necessary to collect children's voices where they feel comfortable, which is why working with partners and stakeholders is vital to gather meaningful information. Review across all teams, and seek input from partners.
- Partnering with other local authorities via LASOB, SELL and VRU.

Child Q - Addressing Attitudes

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- Look at language used to describe children.
- Promoting best practice around bias, adultification and trauma for staff working in schools.
- Working across partnerships (EPB, Headteacher groups, DSL network) to create safe spaces to explore change. Learn lessons from cross-council response to conflict.
- Viewing anonymous samples of referrals for support and protection as a dip test.

Child Q - Providing Support

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- Provide support to review Screening, Searching and Behaviour policies.
- Learn from the voices of children in Hackney where screening / searching / confiscation and behaviour polices remain confusing.
- Discuss anonymised sample policies from schools in Newham at the Education Partnership Board, and relevant steering groups, through the DSL network as well as at the Education KIT meeting to promote best practices.
- Identify areas of intersectionality within TRID and programmes to tackle disproportionality.

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Newham London

Education Partnership Board

NSCP

Equity for learners with SEND

Meaningful pathways & destinations

Resources & finance

Equity for vulnerable learners

Equity for vulnerable learners

Child Q Update Report recommendations:

- Survey of all young people into how safe, respected and safeguarded they feel
- Discussion group to look at banned items and work towards an agreement
- Review involvement of children and young people in our analysis of where we are in relation to 'Working together'

Any Questions?

1 question
0 upvotes

Training Available

Elena Nicolaou

Feedback & Closing Comments

Julia Stephens – Row
NSCP Independent Chair

What are your 2 takeaways from today's session?

Share information rather than not Importance of promoting 7min briefings

=The practice themes highlighted in the child safeguarding practice review annual report. =Child Q - reference to Adultification Bias echos the recent report on the Met's handling of child exp

Really useful to hear about information sharing

All of the content was really useful

3