Annual Report
April 2021 – March 2022

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Foreword from the statutory safeguarding partners

As delegated representatives of the three safeguarding partners – Solihull Metropolitan Borough Council, West Midlands Police, and Birmingham and Solihull Clinical Commissioning Group – who make up the Solihull Local Safeguarding Children Partnership, we commend to you this, our third annual report.

The Local Safeguarding Children Partnership is the statutory mechanism for making multi-agency arrangements to safeguard children and promote their welfare within the local area. As safeguarding partners, we are required to name other relevant partners agencies that we consider appropriate to work with us in exercising these functions, and those relevant partner agencies have a duty to co-operate. In Solihull we have good levels of strategic and operational engagement in our work to safeguarding children.

2021/22 has been a sad and challenging year for the partnership. The second year of the Coronavirus pandemic brought new lockdown restrictions, and with them, further difficulties in delivering local services. The previous year (in June 2020) six-year-old Arthur Labinjo-Hughes had been killed by his father's partner. Immediately this prompted a local review not only of Arthur's case, but of our system for safeguarding children in Solihull. Improvement work was started immediately following the notification of Arthur's death.

The national shock and concern expressed following the conviction of Arthur's father and his father's partner in December 2021, triggered additional scrutiny processes at a national level, such as the Joint Targeted Area Inspection, which is detailed later in this report. The recommendations from these processes are being embedded in practice to achieve the required improvements.

The partnership would like to register its' thanks for the positive and constructive way in which inspectorates and improvement partners have provided assistance and guidance at this crucial time for local services. We also acknowledge and appreciate the local front-line workers in all the relevant professions, who work day-in and day-out to help to keep children protected from harm.

Our main message to the children and families of children in Solihull is this: this partnership is committed to learning, especially from tragic cases, such as that of Arthur's. The improvement work required can't be a 'quick fix'. It requires careful consideration, and that can take time. The partnership understands the importance

of getting this right. We ask for your patience and for your involvement; children are harmed within our local communities. Wherever this happens (or is suspected), local communities have a duty to report any concerns they may have. You can be assured that we will treat such reports seriously and we will address them promptly. In doing this we will ensure that the voice or children and families is heard and forms a key part of partnership decision making.

Since our last report we have welcomed our new Independent Scrutineer, Steve Cullen. Steve has arrived at a demanding time, and his new outlook continues to provide support and challenge to the Partnership.

Tim Browne

Interim Director of Children's Services
Solihull Metropolitan Borough Council

Ian Parnell

Chief Superintendent
West Midlands Police

Diane Rhoden

Interim Deputy Director of Nursing and Quality
NHS Birmingham and Solihull Clinical Commissioning Group

Comments from Stephen Cullen, the Independent Scrutineer of the Local Safeguarding Children Partnership

My role as the Independent Scrutineer to is to support, challenge and hold to account Solihull Metropolitan Borough Council, West Midlands Police, and Birmingham and Solihull Clinical Commissioning Group for safeguarding and promoting the welfare of children and young people in Solihull.

I also recognise the important role that other partners including the Probation Service and Education play in protecting children and young people from harm.

The last year has been an extraordinary and particularly challenging year for the partnership.

We have faced the continuing challenge of dealing with the Coronavirus pandemic.

The partnership has also attracted significant national scrutiny and attention as a result of the tragic murder of Arthur Labinjo-Hughes in June 2020. I share the devastation felt by all professionals following his traumatic death.

The Solihull Local Safeguarding Children Partnership (Local Safeguarding Children Partnership) is absolutely committed to taking the learning from the Joint Targeted Area Inspection and the National Review to drive improvements in safeguarding children and young people.

There has been an extraordinary amount of improvement activity carried out since the turn of the year. Although there is some way to go, we are seeing some promising signs with enhanced multi-agency working resulting in a reduction in backlogs and increased consistency in approach.

Without being complacent, it is encouraging to hear first-hand from professionals that they have felt more supported and in a better position to support children and young people.

There can be nothing more important than protecting our most vulnerable. As Nelson Mandela said: “The true character of a society is revealed in how it treats its children”.

Section 2 – Comments from the Independent Scrutineer

Despite the challenges, I have witnessed first-hand the dedication, commitment, and resilience of professionals from a range of agencies who do an extraordinary job every day in the face of high levels of scrutiny and accountability.

We have a lot to build upon, but a lot to do. Every day, we have the privilege and the challenge to make a difference to people's lives.

My appreciation and thanks go to each and every one of you working so hard to keep children and young people in Solihull safe.

Stephen Cullen
Independent Scrutineer

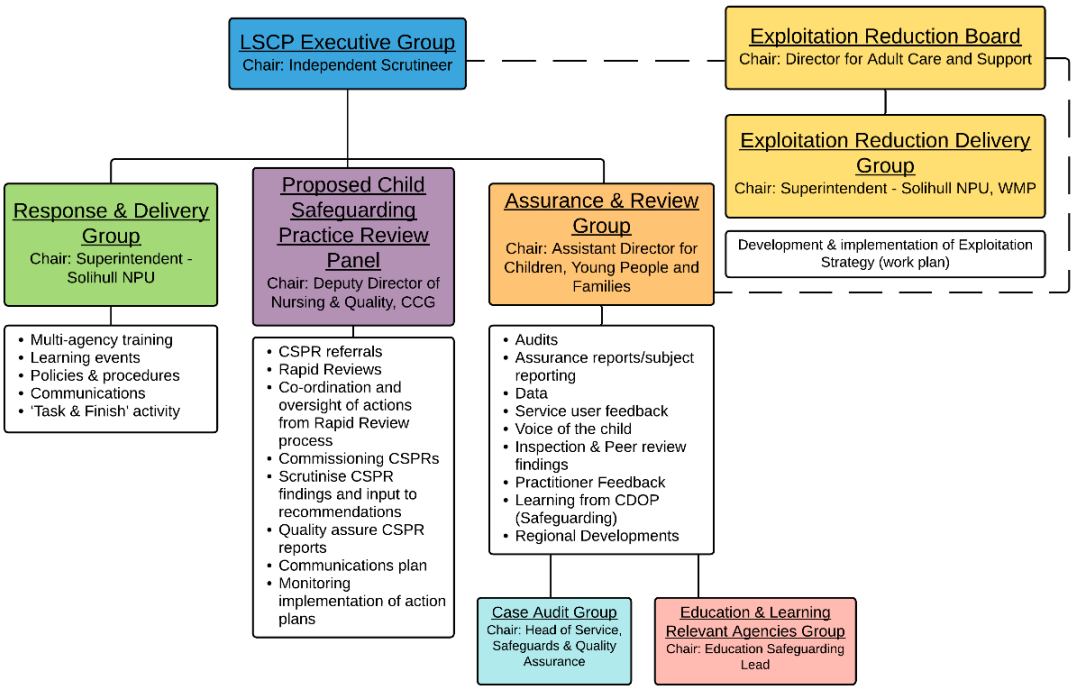
About the Local Safeguarding Children Partnership

3.1 Solihull's Local Safeguarding Children Partnership

3.1.1 Although there are 3 key agencies ('safeguarding partners') at the core of the Local Safeguarding Children Partnership, the wider partnership is made up of:

- 1 local authority
- Probation Service
- Third Sector organisations
- 1 NHS Clinical Commissioning Group
- Solihull Community Housing
- UK Visa and Immigration
- West Midlands Fire Service
- West Midlands Police/Solihull Neighbourhood Policing Unit
- 3 NHS Foundation Trusts (and we also commission services from Coventry and Warwickshire NHS Partnership Trust)
- Children and Families Court Advisory and Support Service (CAFCASS)
- 5 schools collaboratives involving 76 primary, secondary and special schools
- 6 Primary Care Networks made up of 24 GP practices

3.2 Local Safeguarding Children Partnership Structure Chart 2021-2022



3.3 Local Safeguarding Children Partnership Vision and values

3.3.1 All children, whether living in Solihull or visiting, will have equality of opportunity and be protected from harm when necessary

3.3.2 In working to safeguard children and young people the Partnership will strive to ensure all children:

- are safe from abuse, neglect or exploitation both at home and in the community
- are enabled to live healthy lives
- receive an education suited to their needs which enables them to meet their potential
- are supported into adulthood where they have specific needs

3.3.3 Our 'Working Together' as a Partnership is underpinned by:

- Always asking 'so what' is the impact?
- Honesty and respectful challenge of one another
- Active participation by everyone
- Being guided by the 'voice of the child' and our practitioners
- Sharing the responsibility and risk
- Holding one another to account for delivery

3.4 Local Safeguarding Children Partnership Priorities

3.4.1 Tackling **Neglect** has been a continuing priority for the safeguarding partnership. The strategy for action has been reviewed in the past year and is ready for implementation in 2022/2023.

3.4.2 In 2019, Solihull Safeguarding Adults Board completed a Safeguarding Adult Review following the death of Rachel who was 20 years old. Rachel had previously been a victim of sexual abuse and had a history of mental health difficulties and self-harming behaviours. She had also been a victim of sexual exploitation and trafficking from the age of 17.

3.4.3 Since the Safeguarding Adult Review, Solihull Together, the Safeguarding Adults Board, the Safeguarding Children Partnership, the Safer Solihull Partnership and partners have developed the borough's first all age **Exploitation Reduction Strategy**.

3.4.4 The detail of the work in both of these priority areas is covered in more detail in section 4 of this report.

3.5 Solihull: A borough of diversity and contrast

3.5.1 The Solihull Metropolitan Borough Council area has 216,200 residents and is made up of the two constituencies of Meriden and Solihull, 17 council wards and 3 locality areas: north, east and west each supporting populations of 50-70,000.

3.5.2 Solihull is a broadly affluent borough in both the regional and national context, characterised by above-average levels of income and home ownership, but is also challenged by a prosperity gap, with the wards of Chelmsley Wood, Kingshurst & Fordbridge and Smiths Wood to the north of Birmingham International Airport significantly lagging the rest of the borough. Alongside below average income levels, these areas represent relatively higher population density, less green space per head and a substantially greater proportion of socially rented housing (62% of the borough total). The cumulative impact is felt across a broad range of outcomes, including educational attainment, employment, crime and health.

3.5.2 Solihull is in the midst of dynamic and rapid socio-demographic change. The Black and Asian Minority Ethnic (BAME) population has more than doubled since the 2001 Census and now represents nearly 11% of the total population. On this basis the borough is less diverse than England as a whole (and significantly less so than neighbouring Birmingham), but with BAME groups representing a relatively higher proportion of young people in Solihull (over 17% of those aged 15 and under) this representation is set to increase.

3.6 Connectivity with other Boards and Committees

3.6.1 A protocol exists between the Local Safeguarding Children Partnership, Solihull's Safeguarding Adults Board, the Safer Solihull Community Safety Partnership and the local Health and Wellbeing Board. The aim of this protocol is to define how these four partnership entities will work together in the pursuit of safeguarding and promoting the welfare and wellbeing of children, young people and adults.

3.7 Maintaining dialogue with regional and national partners

3.7.1 The LSCP Business Manager and the Independent Scrutineer are both members of the West Midlands regional Multi-Agency Safeguarding Arrangements (MASA) Network. Quarterly meetings are well attended by the 14 LSCPs across the wider West Midlands where national and regional issues are considered. The Solihull LSCP Business Manager is a lead on the development of a regional S11/Care Act Compliance Audit Tool.

3.7.2 The Solihull LSCP is a member of The Association of Safeguarding Partners (TASP) which enables the LSCP Business Manager to attend a national network of Business Managers to discuss relevant issues pertaining to the safeguarding of children.

3.8 Resourcing the Local Safeguarding Children Partnership

3.8.1 Partner agencies make financial contributions towards the annual LSCP budget. More details of the Local Safeguarding Children Partnership budget for 2021/2022 can be found at Appendix 1.

3.8.2 It should be noted that financial contributions are just one way in which the safeguarding partners provide resources to the Local Safeguarding Children Partnership. Strategic Leads who represent the named safeguarding partners in Solihull contribute their time and expertise to the partnership as members of the Executive Group and as Chairs of sub-groups. Nominated representatives from partner agencies also lead on Task and Finish work and represent their respective organisations on the sub-groups. The local Training Pool arrangements are another way in which considerable resources are shared to contribute to the work of the Partnership.

3.8.3 The additional resource required to supplement the capacity of the Business Unit, as highlighted in the Joint targeted Area Inspection undertaken in January 2022, is likely to result in even greater pressure on the Local Safeguarding Children Partnership's budget for 2022/2023.

The Local Safeguarding Children Partnership's Priorities for 2021 - 2022

4.1 Improvement Priority 1: Neglect

4.1.1 Neglect is a priority that the Local Safeguarding Children Partnership decided should be carried over from 2020/2021 into 2021/2022.

4.1.2 The focus of work in the past year has been to develop a Strategy to co-ordinate the multi-agency response. With this now in place, the challenge for 2022/2023 will be to implement and embed the Strategy across the partnership.

The data on Neglect

Performance Indicator Description	Mar 2022: Q4	Dec 2021: Q3	Sept 2021: Q2	June 2021: Q1	March 2021: Q4
ASSESSMENTS					
Percentage of assessments for neglect that determined further Children's Services action was required	89%	91%	95%	94%	
CHILD PROTECTION PLANS (CPPs)					
Percentage of all CPPs active at snapshot where the plans category of abuse was Neglect	33%	30%	37%	37%	29%
Of all CPPs active at snapshot for 12 months or longer, percentage where neglect is a category of concern	31%	35%	39%	55%	75%
Percentage of neglect CPPs commencing YTD where child becomes subject of a CP Plan for a second or subsequent time within 24 months of an earlier neglect plan being active	5%	7%	9%	16%	0%
Percentage of CP Plans commencing YTD where Neglect is a category of concern	32%	31%	36%	40%	32%

What the data tells us

4.1.3 Last year it was reported that 29% (43/149) of all child protection plans in Solihull had Neglect as the primary category of abuse. An increase on this figure was reported in every quarter in the year 2021/2022. The year ended with the proportion rising to 33%.

4.1.4 In a snapshot indicator at the end of March 2021, 75% of child protection plans lasting for 12 months or more specified Neglect as a cause of concern. One year later in March 2022, that value had more than halved (31%)

4.1.5 By March 2022 only four children (5%) became the subject of a child protection plan for a second or subsequent time within 24 months of an earlier Neglect plan being active.

4.1.6 Neglect remained the most common initial category of abuse recorded for children on child protection plans in England in 2021, accounting for almost half of children who were subject to a plan.

Graded Care Profile 2

4.1.7 The Graded Care Profile 2 (GCP2) is a tool designed to provide an objective measure of the care being provided for children. It is primarily based on the qualitative measure of the commitment shown by parents or carers in meeting their children's nine developmental needs. Solihull took the decision to endorse the Graded Care Profile 2 tool as the approach to be taken in direct work with families and the tool is referenced in the Local Safeguarding Children Partnership Neglect procedures and also on the Local Safeguarding Children Partnership website: https://solihulllscp.co.uk/practitioner-volunteers/neglect-strategy-20/graded-care-profile-2-97.php The Neglect Strategy identifies that the Graded Care Profile 2 tool is not yet sufficiently embedded into frontline practice and the delivery plan for the Strategy identifies mechanisms for raising awareness of the tool and for seeking the support of partner organisations in embedding it into practice.

Training on Neglect

4.1.8 The Local Safeguarding Children Partnership delivers a series of neglect modules within its multi-agency training programme, one of which addresses the use of Graded Care Profile 2 specifically. To date over 200 practitioners have been trained in the use of Graded Care Profile 2. The number of attendees on the neglect modules during 2021-22 are relatively low and the Neglect Strategy will require staff who need to be trained to be identified by

partner organisations and a commitment secured that staff will be released to attend the training.

Attendance at LSCP Training in Q1-4 2021-22

Module 6 - Neglect: Impact on child development (2 courses)	23
Module 6(b) - Neglect: Domestic Abuse (1 courses)	6
Module 6(c) Neglect: The Graded Care Profile 2 (2 courses)	13
Total	**42**

4.1.9 The Local Safeguarding Children Partnership promotes training on Graded Care Profile 2 through its newsletters and on its website.

Impact of the work on Neglect

4.1.10 It is not yet possible to report on the impact of the new Neglect Strategy due to delays in implementation during the year. During 2021/22 the focus of the LSCP was adapting to post-pandemic working with partners, the Joint Targeted Area Inspection and the Child Safeguarding Practice Review commissioned following the death of Arthur Labinjo-Hughes.

4.1.11 The multi-agency review of the Local Safeguarding Children Partnership Neglect Strategy has been completed and consulted upon and agreed with partner agencies.

4.1.12 Implementation of the Neglect Strategy will seek to embed:

- a shared definition of neglect across the partnership
- a consistent response to concerns about neglect
- improved outcomes for children and families

4.2 Improvement Priority 2: Exploitation

4.2.1 Exploitation is a priority that the Local Safeguarding Children Partnership decided should be carried over from 2020/2021 into 2021/2022.

4.2.2 As a result of the recommendations from a safeguarding Adults Review and recognition of the need to take a consistent and multi-agency approach to the issue of exploitation within Solihull, an All-Age Exploitation Reduction Strategy and Delivery Plan have been developed. The Exploitation Reduction Board, jointly chaired by the Director of Adult Care and Support and the Borough Commander for West Midlands Police, was created to oversee the implementation of the Strategy. The Exploitation Reduction Delivery Group, which is chaired by the Superintendent of the Neighbourhood Policing Unit,

has responsibility for delivery of the plan and he reports to the Exploitation Reduction Board.

The data on Exploitation

4.2.3 Quarterly data on Exploitation is reported to the Exploitation Reduction Board using the Vulnerability Tracker (a database of individuals in Solihull who are at risk of or experiencing exploitation) which was developed as part of the Exploitation Reduction Strategy.

4.2.4 In March 2022 there were 68 individuals who had been identified on the Vulnerability Tracker in Solihull, compared to:

- 70 in December 2021,
- 61 in September 2021,
- 69 in June 2021 and
- 73 in March 2021.

4.2.5 Of the 68 open cases, 31 were receiving interventions and 37 were newly opened cases. There have been a consistent number of individuals on the Tracker over the last year. Currently, the Tracker's trend line does not distinguish children from adults, however there are more adults than children identified through the Vulnerability Tracker. Given the significant level of increased awareness around exploitation in Solihull, it had been expected that the number of identified victims would have steadily increased, however this does not appear to have been the case.

4.2.6 Work is continuing to establish a single exploitation data set, however the position at the end of the reporting period was that establishing the current data available and filling the gaps in this information continued to be a complex task.

4.2.7 Both Children's Services and the Adult Care and Support Directorate within Solihull Metropolitan Borough Council have been developing their own internal data scorecards.

Solihull All Age Exploitation Screening Tool

4.2.8 The All-Age Screening Tool was launched over three sessions in July 2021. 144 people from organisations across the borough attended sessions and the All-Age Screening Tool has now been incorporated into the Exploitation Procedures and is in use.

The Commissioning Group

4.2.9 A series of 'Deep dives' were undertaken to identify good practice and any areas of learning and development. The Exploitation and Missing Team in

Children's Services supported this piece of work which included an exploration of case studies.

4.2.10 Themes and gaps were been identified from professionals and adults with lived experience include:

- That services need to be provided in a time critical manner
- Ensuring a period of stability before exit planning is crucial
- The transition pathway improvement work underway is important in terms of Children's services staff being aware of where to refer individuals who require adult social care support
- Access to safe spaces for young people are needed, particularly when young people go missing
- Housing options for under 25's in Solihull who are vulnerable are limited and often young people are moved to Birmingham away from their place of education and their support network

4.2.11 These themes have been shared with commissioners and will be used to consider how to effectively commission services within Solihull while further deep-dive work continues.

Multi-Agency Training

4.2.12 The LSCP delivered two multi-agency training modules on exploitation during the year. The numbers are relatively low although it is noted that these courses ran alongside the multi-agency webinars referred to in the section below.

Attendance at LSCP Training in Q1-4 2021-22

Module 5A – All Age Exploitation Awareness (5 courses)	**30**
Virtual learning – Parents as partners in tackling child exploitation (CE): Working with and supporting parents affected by Criminal Exploitation (3 courses)	**15**
Total	**45**

4.2.13 The SMBC Adult Exploitation Reduction Lead has been working with Children's Services and SMBC Workforce Development to develop an exploitation training programme aligned to the tiers in the Exploitation Capability Framework and the Corporate Safeguarding Board has endorsed a training programme for all frontline SMBC employees.

Multi-Agency Webinars

4.2.14 Several short webinars were held looking at a number of specific issues. Sharing experiences, perspectives of different professionals and engaging in

training together aims to build relationships between professionals and to ensure consistent information is being shared and delivered by experts within our partnership and through commissioned speakers.

4.2.15 In October 2021 West Midlands Police led a webinar on County Lines and in November 2021 Research in Practice led a webinar and group discussions on transitional safeguarding. These sessions were well-received and participants offered feedback and suggestions for future sessions. In February 2022 West Midlands Police led a session on the topic of missing people and in March 2021 Health colleagues led a session on the role of Health in responding to exploitation.

Self-Assessment

4.1.16 The Exploitation Reduction Self-Assessment Tool was developed to enable partner agencies to undertake a reflective evaluation of the extent to which they have in place the systems and processes required to support implementation of the Solihull All-Age Exploitation Reduction Strategy and where they need to improve.

4.1.17 Responses from partner agencies indicated that the key points from this first self-assessment submission were that:

- No partner agency had rated itself inadequate against any of the four strategic priorities (although there are a small number of inadequate ratings against some of the sub-standards);
- Most ratings against the four strategic priorities were either 'Good' (exceeding minimum requirements) or 'Requires Improvement' (meets minimum requirements and needs to improve).

4.1.18 Particularly strong aspects of practice included:

- Organisations having in place a senior staff member to lead and promote exploitation reduction
- Staff having access to supervision/management support
- Staff understanding the importance of information sharing and consent issues

Communications Plan

4.1.19 A Communications Task and Finish Group was established to co-ordinate Phases 3 and 4 of the Exploitation Communications Plan.

4.1.20 Following extensive research and some consultation with both children and adults with lived experience, Solihull's exploitation branding was developed: **"#say something if you see something Solihull"**

4.1.21 This key messaging was adapted with permission from the National Working Group who use the strapline to support their national campaign and has been localised by using "Solihull" to specifically target awareness within the Borough. It sets out the call to action required if someone is concerned that exploitation may be occurring and a dedicated phone line has been created to take calls where members of the public or local businesses have concerns.

4.1.22 Phase 3 of the communications plan was rolled out from January 2022 targeting local businesses with Phase 4 to follow from March 2022 aimed at the public, young people, adults and parents/carers.

4.1.23 A dedicated webpage has been developed on the joint Solihull safeguarding website located at: https://www.safeguardingsolihull.org.uk/exploitation-communications/

Next steps

4.1.24 The Exploitation Reduction Delivery Group has identified three significant priority areas where further work is required:

- Development of a dynamic problem profile using data available about victims, offenders and locations/spaces to support a shared understanding of exploitation in Solihull and help focus an operational and strategic response
- Co-ordinated approach to listening to the voice of people (children and adults) who have experience of interventions to inform development of the multi-agency response to exploitation reduction
- Risk management through the MAACE process

4.1.25 These priorities have been incorporated into the Exploitation Reduction Strategy delivery plan.

Impact from the work on Exploitation

4.1.26 By March 2022 the All-Age Exploitation Reduction Strategy had become more embedded in that Strategic Leads within partner agencies had evaluated their own organisation's compliance with its requirements and were actively working towards ensuring that their respective operating processes and procedures supported the Strategy, evidenced through the Exploitation Reduction Self-Assessment Tool. The number of individuals who were being identified as being at risk or experiencing exploitation did not increase as expected during the year as a result of this activity, but this will be closely monitored through the Exploitation Reduction Board going forward.

Responding to Arthur

5.1 The death of Arthur Labinjo-Hughes

5.1.1 On 17th June 2020 six-year-old Arthur Labinjo-Hughes died in Birmingham Children's Hospital after sustaining a serious head injury the previous day, whilst in the care of his father and his father's partner.

5.2 The local child safeguarding practice review

5.2.1 As required by Working Together 2018, a local child safeguarding practice review was commissioned by the Local Safeguarding Children Partnership. An independent Lead Reviewer had been appointed in December 2020 and the review was well underway, but was not yet completed, when Arthur's father and step-mother appeared at Coventry Crown Court for the start of their criminal trial on 5 October 2021.

5.3 The outcome of the criminal trial

5.3.1 In court proceedings concluded on 1st December 2021, Arthur's father's partner was convicted of Arthur's murder and Arthur's father was convicted of his son's manslaughter.

5.3.2 The Education Secretary's oral statement to Parliament on 6th December 2021 announced the following measures:

- The National Child Safeguarding Practice Review Panel will work with leaders in Solihull to deliver a single, national, independent review of Arthur's death to identify learning
- In accordance with section 20(1)(b) of the Children Act 2004, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue services and Her Majesty's Inspectorate of Probation will lead a Joint Targeted Area Inspection of services in Solihull.

5.3.3 At that time the local child safeguarding practice review had been paused due to:

- Limitations on contacting relatives who were witnesses in the criminal trial
- Recommendations that were awaited from Birmingham's related Domestic Homicide Review process, and
- The ongoing investigation by the Independent Office for Police Conduct

5.3.4 Once the Education Secretary's announcement had been made, work ceased on the local child safeguarding practice review and all work undertaken up to that point was handed over to the National Child Safeguarding Practice Review Panel.

5.4 The National Child Safeguarding Practice Review Panel

5.4.1 The National Child Safeguarding Practice Review Panel is part of the relatively new safeguarding architecture introduced under the Children and Social Work Act 2017. The Panel's primary role is to oversee the national system of learning from serious incidents where children have died or been seriously harmed in the context of abuse and neglect, and to recommend ways in which policy or practice should change in response.

5.4.2 The Panel has a unique perspective on the quality and effectiveness of safeguarding and child protection practice in England; its' evidence base of over 1,500 reviews of serious incidents since its inception in 2018, alongside a range of thematic reviews that it has commissioned, positions it well to discern and analyse patterns in practice involving both intra and extra-familial harm to children.

5.4.3 The work undertaken (information gathered, case notes, records, witness statements, review report drafts) on the now-ceased local child safeguarding practice review was submitted to the National Panel and was incorporated into its' own National Review process.

5.4.4 The National Panel's review report was subsequently published in May of 2022 and the findings (and the partnership's response) will be detailed in next year's annual report.

5.5 Joint Targeted Area Inspection – findings and responses

5.5.1 The Joint Targeted Area Inspection looked at how all local agencies in Solihull are working together to protect children and improve their well-being. The inspection took place from 10th to 14th January 2022.

5.5.2 The headline findings of the inspection were sent in a letter to the Local Safeguarding Children Partnership on 21st February 2022. They are as follows:

'Children in need of help and protection in Solihull wait too long for their initial need and risk to be assessed. This means that for a significant number of children, they remain in situations of unassessed and unknown risk. Weaknesses in the joint strategic governance of the multi-agency safeguarding hub have led to the lack of a cohesive approach to structuring and resourcing the multi-

agency safeguarding hub. The Local Safeguarding Children Partnership (Solihull's multi-agency safeguarding arrangements) does not have a clear understanding of the impact of practice from the multi-agency safeguarding hub or the experiences of children and their families that need help and protection in their local area'.

5.5.3 In addition, the inspection identified two areas for priority action:

❶ *Leaders of the local safeguarding children partnership need to take urgent action to understand and identify the initial needs and risks of children presenting to Solihull's 'front door' services. This includes:*

- *ensuring that there is sufficient multi-agency capacity within the multi-agency safeguarding hub to meet children's needs promptly*
- *ensuring that comprehensive performance information and a robust audit programme, relating to practice and impact for children in the multi-agency safeguarding hub, are delivered and regularly considered by the Local Safeguarding Children Partnership*
- *ensuring that the right agencies are represented in the range of the Local Safeguarding Children Partnership's activities and that there are sufficient resources to support the Local Safeguarding Children Partnership to carry out its statutory functions.*

❷ *West Midlands Police need to take urgent action to improve the quality of information held on the 'Connect' system to make sure that links to connected individuals are present and accurate, and to reduce multiple records held against the same person, so that risk to children can be clearly seen, recognised and shared when appropriate.*

5.5.4 Immediately following the initial feedback from inspectors at the conclusion of the inspection in January, work began to address the areas for improvement.

5.5.5 By end March 2022 the LSCP had started to develop its own Improvement Plan in response to the findings of the Joint Targeted Area Inspection. Key areas for improvement related to:

- Agency representation, capacity, data and quality assurance activity within the Multi-Agency Safeguarding Hub;
- LSCP governance to improve the line of sight of the safeguarding partners on frontline practice;
- Capacity within the Local Safeguarding Children Partnership Business Unit;
- Multi-agency audits;

- Development of a multi-agency dataset containing high level data in respect of the wider safeguarding system;
- Embedding of learning following serious incidents.

Learning and Improvement Framework

6.1 Learning from multi-agency data

Children's Services data for 2021/2022:

Key performance indicator	National average	Figures for 18/19 (end of quarter 4)	Figures for 19/20 (end of quarter 4)	Figures for 20/21 (end of quarter 4)	Figures for 21/22 (end of quarter 4)	Incr. decrease from previous	Commentary
Referral Rates (per 10,000 children)	560.5	711	652	484	559	⬆	There has been a significant increase in the number of referrals in comparison to 20/21, this year's figure is very close to the national average. This increase reflects an upturn in referrals as we have emerged from the COVID -19 pandemic and is also thought to be attributed to the impact of the ALH case.
Repeat Referral Rates	21%	21%	33%	21%	20%	⬇	In 2019/20 the re-referral rate of 33% was significantly higher than the national average and for previous years. It is believed that this figure reflected double counting of referrals because of the change-over during the year from the Carefirst system to Liquid Logic. The Q4 21/22 rate is in line with the rate for the same period in 20/21 and with the national average, suggesting that the repeat referral rate for 2019/20 was an anomaly.
Proportion of referrals proceeding to Section 47 enquiry or single assessment	No data	61%	56%	100%	98%	⬇	This figure significantly increased in 20/21 during the pandemic where referral rates were significantly down, but the percentage which required S47 enquiry or assessment was very high. This trend has continued into 2021/22. Given that referral rates for the year were back in line with the national average, this would suggest that the screening process at the Front Door resulted in virtually all referrals coming into the MASH at Level 4 which require a social work assessment or child protection enquiry.
Percentage of children on a Child Protection Plan by category							The percentage of children on a CP Plan for emotional abuse had increased significantly

Neglect	47%	49%	51%	29%	32%	↑	in 20/21 (thought to be linked to the high numbers of domestic abuse referrals during the pandemic). This has decreased in 21/22 bringing it more in line with the national average. Children on CP Plans for Physical Abuse has increased significantly from 13% in 20/21to 29% in 21/22 and this is well above the national average of 8%. This trend will need to be compared with the national average when reviewed to establish whether this is a Solihull specific trend (impact of the ALH case) or a national trend.
Emotional	38%	28%	29%	56%	37%	↓	
Physical	8%	11%	12%	13%	29%	↑	
Multiple categories of concern	3%	10%	6%	1%	0%	↓	
Sexual Abuse	4%	1%	2%	1%	2%	↑	
The proportion of children with Child Protection Plans for 18 months	No data	6%	6%	6%	9%	↑	This indicator provides a marker as to the timeliness of decision making to prevent drift and delay. Whilst there has been an increase from 6% (20/21) to 9% (21/22), it is important to note that due to small numbers, one sibling group could reflect a 2% increase. The Solihull figure of 9% remains lower than the West Midlands average of 11%.
The proportion of children becoming subject of a Child Protection Plan for a second or subsequent time within 2 years (rolling year)	No data	8%	3%	4%	8%	↑	The figure from 21/22 has doubled since the previous year. It is important to note than due to low numbers an increase of 4% could amount to 4 children. Despite the increase, the percentage is still within the established target which is a positive picture and is below the West Midlands target of 11%.
Number of Looked After Children (LAC)	No data for nat'l avg.	424	461	532	526	↓	The number of looked after children has decreased slightly, but has remained high for Solihull following the significant increase in 2020/21.

6.1.1 The Joint Targeted Area Inspection found that the safeguarding partners were not sufficiently sighted on the experiences of children referred into the Multi-Agency Safeguarding Hub (MASH). This finding came at the end of the reporting period.

6.2 Learning from multi-agency themed audits

THE VOICE OF THE CHILD

6.2.1 As part of regular scheduled audit activity, a multi-agency audit was commissioned to explore the extent to which the voice of the child was heard by agencies during their work with children and families. Audits were completed between 13th September and 12th November 2021.

6.2.2 Before the data from the multi-agency audit could be analysed and reported, a Joint Targeted Area Inspection took place in December 2021, when Inspectors conducted a joint case evaluation of 7 cases.

> *"The voice of the child or an understanding of their lived experience was not sufficiently strong in a number of the cases, although there was evidence of strong practice in this area by some schools. One of the cases prompted a discussion about the circumstances in which a young person should be seen face to face, as opposed to a telephone call, and the circumstances in which they should be seen alone. It was noted that opportunities had not always been taken to utilise support from schools to engage with children who have additional communication needs"* – findings from the Joint Targeted Area Inspection.

6.2.3 The Case Audit Group met virtually in January 2022 to look at the raw data and initial analysis. The group worked together to agree the key findings from the audits and to develop recommendations for consideration by the Assurance and Review Group.

Findings of the local multi-agency audit

6.2.4 Not all agencies recorded that they have given consideration to ethnicity or cultural sensitivities in their work with children and families.

6.2.11 The weakest area for agencies who deliver planned interventions with children and their families (Tier 3) related to 'giving choices' to children and young people.

6.2.13 Recording does not always reflect the richness of the conversations held with children/young people, including when professionals have asked the next question/s when exercising curiosity about a child's situation, views or wishes.

6.2.14 There was evidence of good practice in capturing observations of pre-verbal children by Health Visitors and this being used to understand the lived experience of those children.

6.2.15 Triangulation was not always evident from case records. It is important to ensure that what a child or young person is saying 'fits' with the perception of other family members or is consistent with what they are saying to other professionals or with what other professionals are seeing

6.2.16 Audits were undertaken at three GP practices where there had previously been issues identified in case reviews about capturing the voice of the child and where there had been improvement activity supported by BSOLCCG. The audits highlighted good practice in many of the cases providing evidence of impact of the improvement activity.

6.2.17 There was strong practice by some agencies who evidenced a 'Think Family' approach: children being considered, specific details being recorded and attempts to establish the voice of the child by observation, reflection or liaising with other professionals involved. Children's mental health services (SOLAR) in particular evidenced examples of listening and responding to the child, adapting to their needs/wishes and advocating for their voice.

Overall conclusions

6.2.18 The audit did not provide full assurance that the voice of the child and/or an understanding of the child's lived experience consistently informs practice across the partnership.

6.2.19 Children's Services identified actions to be undertaken in respect of the individual cases audited. Whilst there is evidence of children's views being recorded, it is still unclear as to the extent to which these views are consistently informing practice.

6.2.20 At the time of writing this report, formal assurance that action plans have been implemented and that partner agencies have in place processes to evaluate the impact of their improvement activity on practice has been requested and will be reported in next year's annual report.

Recommendations resulting from the multi-agency audit

6.2.20 Guidance to be developed to provide a toolkit for partner agencies to ensure that the lived experience of children is considered by all professionals, including those who work predominantly with adult service users. This guidance is located at: https://westmidlands.procedures.org.uk/local-content/1UzN/miscellaneous-additional-local-information/?b=Solihull

6.2.21 The local Safeguarding Children Partnership's Assurance and Review sub-group is to co-ordinate feedback from partner agencies on the progress made in respect of individual agency action plans developed as part of this audit. An

assurance position to be presented to the Local Safeguarding Children Partnership Executive group within an agreed time scale.

EXPLOITATION

6.2.22 A multi-agency audit on the theme of Exploitation was commissioned as part of the LSCP's audit schedule providing a focus Exploitation as one of its' strategic priorities.

6.2.23 20 cases of individuals who had been subject to criminal or sexual exploitation in Solihull were chosen. The total sample was made up of 8 adults and 12 children (under 18), including 2 transitions cases.

Overall conclusions from the multi-agency audit

6.2.24 This multi-agency audit indicated that whilst there is an awareness of the All-Age Multi-Agency Exploitation Reduction Safeguarding Procedures and some evidence of processes being in place, it is apparent that some aspects of the procedures require specific and targeted focus to embed them fully.

6.2.25 Some partner agencies have demonstrated strong practice in some aspects of practice but, in general, the picture is variable across the partnership.

6.2.26 The audit did not provide full assurance that the All-Age Multi-Agency Exploitation Reduction Procedures are fully embedded into practice across organisations in Solihull.

Recommendations resulting from the multi-agency audit

6.2.27 The majority of recommendations and actions from the audit (already reported in Section 4.2 above) have been incorporated into the Exploitation Reduction Delivery Plan which is overseen by the Exploitation Reduction Board and reported through to the Executive Group on a quarterly basis.

6.3 Learning from single-agency audits and reviews

EDUCATION

6.3.1 There are 89 education providers in Solihull including local authority-maintained schools, academies, independent schools and post 16 provision. Education safeguarding provision in Solihull is at least good. The evidence base for this assertion comes from a range of activity including:

- Section 157/175 audits;
- multi-agency Local Safeguarding Children Partnership audits and reporting;

- safeguarding reviews;
- visits by senior education advisers to schools;
- commentary around safeguarding effectiveness in school;
- Ofsted inspections.

6.3.2 The education audits provided assurances in relation to the following areas of practice:

- Designated safeguarding leads, headteachers and chairs of governors confirm that they have compliance to Part 1 (Safeguarding information for all staff) of Keeping Children Safe in Education 2021
- Designated safeguarding leads and safeguarding governors confirm that they have compliance to Part 2 (The management of safeguarding) of Keeping Children Safe in Education 2021
- Headteachers and chairs of governors confirm that they are compliant with the Safer Recruitment and Managing Allegations requirements that constitute Parts 3 and 4 of the guidance

REVIEWS OF DEATHS BY SUICIDE AND SELF-HARM

6.33 At a meeting of the West Midlands Regional Child Death Review Network in December 2020, it was agreed to trial a regional themed review focusing on deaths by suicide. All Child Death Overview Panels in the region were invited to submit cases for consideration with a view to identifying common themes across the region and potential learning to prevent further deaths. The themed panel met virtually on 29 April 2021. All Child Death Overview Panels in the region were invited to send two representatives, with representatives from mental health services, public health, paediatrics, education, children's safeguarding and a lay member.

6.3.4 The panel reviewed deaths of children aged less than 18 years from suicide or self-harm that had occurred across the West Midlands during 2019-2020 where coroner's inquests had been completed. A total of nine deaths were reviewed. Two deaths occurred during the COVID pandemic. Other deaths that occurred during the pandemic could not be reviewed as inquests were awaited. Members of the panel met again on 27 May 2021 to analyse the findings and key learning points arising from the panel discussion; and to draw up this summary.

6.3.5 The themed panel acknowledges that a small sample of deaths was reviewed; and that some issues identified may be unique, although common learning points in relation to the context of the children's lives were identified. It was recognised that despite the best efforts of professionals, families and friends, some deaths may be unpreventable. Nonetheless, that should not stop every

effort being made to identify common issues and to improve professional processes and practice.

6.3.6 The themed regional review concluded that the process had identified common themes across several deaths, which may not have been recognised had deaths only been reviewed at local Child Death Overview Panels, showing the benefit of this process.

6.3.17 A number of questions were posed for Local Safeguarding Children Partnerships and Solihull's response to these questions will be reported in the 2022/23 annual report.

PRIVATE FOSTERING

6.3.8 In Solihull, Private Fostering arrangements are invariably referred to or identified by children's social work teams. On receipt of notification of an impending or current arrangement the Local Authority carries out its statutory duties in line with the Replacement Children Act 1989 Guidance on Private Fostering 2005 and National Minimum Standards for Private Fostering 2005 where notifications are referred to the Fostering Team to assess the carers. Simultaneously, the child's social work team will assess and monitor the child's welfare within the arrangement under Regulation 8 visits. Managers will make a decision on the outcome of the assessment.

6.3.9 After assessment, case responsibility for the privately fostered child/young person transfers to the Fostering Team to undertake the monitoring visits to the child and will also continue to deliver duties to the carer for the length of the Private Fostering arrangement. The suitability and duration of the Private Fostering arrangement is kept under review within the regular visiting with a more formal review of the arrangement undertaken annually.

6.3.10 The number of Private Fostering referrals received by the Fostering Team in Solihull remain low. However, there has been increased discussions taking place between the fostering team and staff in the MASH team in respect of potential referrals where Private fostering arrangements may be taking place. Whilst the majority of cases discussed have not constituted Private Fostering arrangements, it is clear that there is consideration of private fostering within the initial assessments being completed.

6.3.11 Activity in the year to March 2022 was as follows:

- One Private Fostering arrangement came to an end as an alternative private order was granted in respect of the child
- The fostering team is overseeing one Private Fostering arrangement, with a view to securing permanence for the child

- 2 Further Private Fostering assessments were undertaken: 1 assessment was not fully completed as the child become 16 years old and so the arrangement was no longer considered to be Private Fostering. 1 was fully assessed within timescales but not considered appropriate as a private fostering arrangement under the Regulations.

6.3.12 It has been another challenging year for the fostering team due to the ongoing pressure in respect of identifying foster placements and recruiting new foster carers. Despite this there has been positive developments in a number of areas:

- Solihull Metropolitan Borough Council expects to be awarded fostering friendly employer status in July 2022. This means that foster carers including Private fostering are recognised within the council's Human Resources policies and there are provisions in place to support these carers in looking after children under a private fostering arrangement. They will receive appropriate adjustments to allow them to attend assessment sessions, training and appointments relating to any child in their care.
- Private Fostering awareness has been raised in Solihull's corporate parenting board, leading to its' inclusion as a standing agenda item in future meetings.
- Private Fostering in included in the LSCP multi-agency training Module 1 & 2. From a multi-agency perspective this is raising awareness of the need to identify and report.
- The internal Private Fostering procedures have been reviewed alongside the MASH team manager considering the changes to the social care database. As a result it is now clearer how the fostering team should be alerted in respect of potential Private Fostering arrangements.
- A presentation on Private Fostering was delivered at the Solihull Faith Forum annual AGM meeting.
- Private Fostering carers can access the Fostering Team's online Social Care Training Hub whenever there is a training need identified. This offer can extend to virtual or face-to-face training, if required.

6.4 Learning from external challenge

Focused visit by Ofsted

6.4.1 On 23rd and 24th June 2021, three of Her Majesty's Inspectors were primarily on site to look at the local authority's arrangements for the protection of vulnerable children from extra-familial risk.

6.4.2 This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. The lead inspector and the director of children's services agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19.

Headline findings from the focused visit

6.4.3 It was found that vulnerable children in Solihull are cared about and well protected from extra-familial risks. The approach to exploitation reduces risk to the most vulnerable young people but the response to children going missing needs to be improved. Leaders have been creative and proactive in ensuring children receive the right support at the right time. Children benefit from well-trained and effective practitioners, supporting children and their families based on strong professional relationships and strength-based practice. A well-embedded culture across the partnership recognises vulnerable children as victims. Staff working with exploited children positively encourage children's engagement with support services. A new exploitation strategy enables young people up to the age of 25 to benefit from continued support into adulthood, but it is too early to see the impact of this.

6.4.4 Inspectors identified the following improvements required in social work practice:

- Timely referral to the missing triage to ensure consideration is given to safeguarding, mapping activity and return home interviews for every child who goes missing.
- The quality of return home interviews.
- The accessibility of documents to staff on children's records, including exploitation screening tools and return home interviews on children's files.

The LSCP is continuing to seek assurance on the work undertaken to address these improvements through its quality assurance activities.

Review of sexual abuse in schools and colleges

6.4.5 Ofsted was asked by the government to carry out a review of sexual abuse in schools and colleges. The review included two-day visits to 32 schools and colleges, but this was not a fully representative sample of all schools and colleges nationally. In these, inspectors spoke to over 900 children and young people about the prevalence of peer-on-peer sexual harassment and sexual violence, including online, in their lives and the lives of their peers. Inspectors also spoke to leaders, teachers, governors, LSCPs, parents and stakeholders. Finally, the inspection team reviewed the extent to which inspection has given

sufficient oversight of this issue and considered how statutory guidance could be strengthened.

6.4.6 The review did not report on individual schools and colleges or cases, all of which remain anonymous. The review presented a picture of strong and weaker practice across participating schools and colleges, from which Ofsted drew its' conclusions. The report of the review was published on 10th June 2021.

Ofsted's conclusions

6.4.7 The thematic review by Ofsted revealed how prevalent sexual harassment and online sexual abuse are for children and young people. It is concerning that for some children, incidents are so commonplace that they see no point in reporting them. The review did not analyse whether the issues are more or less prevalent for different groups of young people, and there may well be differences, but it found that the issues are so widespread that they need addressing for all children and young people. It recommended that schools, colleges and multi-agency partners act as though sexual harassment and online sexual abuse are happening, even when there are no specific reports.

6.4.8 Ofsted's report made a number of recommendations including one for safeguarding partners: 'to review work to improve engagement with schools of all types in their local area, tailoring their approach to what their analysis (produced in partnership with schools/colleges and wider safeguarding partners) indicates are the risks to children and young people in their local area'.

Solihull's response

6.4.9 A senior education improvement adviser from the Education Outcomes and Intervention Service within SMBC has started several information gathering activities and reviewed the support provided to schools during the 2021-2022 academic year so far, to contribute to Solihull LSCP's understanding of and response to, child-on-child sexual abuse.

6.4.10 Information has been collected from schools/colleges and pupils through two key activities:

- Section 157/175 audit (November 2021)
- School/college (secondary age pupils only) survey (March 2022)

6.4.11 Further data to inform the study is expected from the administration of a health-related behaviour questionnaire, to be completed in April 2022.

6.4.12 Once complete, the study will report its' findings to the Local Safeguarding Children Partnership, with a plan of action. This report is expected to be presented to the LSCP's Assurance and Review sub-group early in 2022/23 and the outcomes will be reported as part of next year's annual report.

Joint Targeted Area Inspection – findings and responses

6.4.13 The widest and most in-depth scrutiny of local safeguarding arrangements took place as part of the Joint Targeted Area Inspection from 10th to 14th January 2022. The inspectorates' findings and Solihull's responses have been reported earlier in this report at section 5.5.

6.5 Section 11 Audits

6.5.1 Section 11 of the Children's Act 2004 requires Local Safeguarding Children Partnerships to assess whether local organisations are fulfilling their statutory obligation to safeguard and promote the welfare of children. This covers all those who work with children including teachers, nurses, midwives, GPs, health visitors, youth workers, early years practitioners, police, social workers and voluntary community workers.

6.5.2 Solihull's last full S11 Audit was undertaken in 2018/19, with a follow up assurance exercise undertaken with Partners in 2019/20. Further activity was curtailed due to the Coronavirus pandemic.

6.5.3 In February 2022 the Local Safeguarding Children Partnership Executive agreed that an interim position statement would provide sufficient assurance until a new Audit is commissioned when the West Midlands S11 Audit process goes live in the summer of 2022.

6.5.4 The interim position statement demonstrated that there is a wide range of assurance activity being undertaken across all agencies who work with children, young people and their families in Solihull. The weakest area across agencies is around listening to Children and Young People. This is consistent with findings from multi-agency audits and from the recent Joint Targeted Area Inspection, and work streams have been developed to support improvement in this area.

6.5.5 Agencies such as CAFCASS and British Transport Police provide assurance reports to the Local Safeguarding Children Partnership annually.

6.6 Learning from practice reviews and safeguarding incidents

6.6.1 Safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to Solihull. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

6.6.2 There was one Rapid Review undertaken during the reporting period following a serious incident where a young man was stabbed by another young person known to him. A number of actions were identified for individual partner agencies and these are monitored through the Solihull Child Safeguarding Practice Review Panel.

6.6.3 A multi-agency panel was subsequently convened to consider the local learning from several historical exploitation case reviews, including the learning from this case. The learning themes from this review were reported to the Exploitation Reduction Delivery Group and three further priority areas were identified and added to the Exploitation Reduction Delivery Plan (see paragraph 4.1.25).

6.6.4 Following the death of Arthur Labinjo-Hughes in 2020 Solihull developed the new Physical Abuse procedures on behalf of the West Midlands consortium incorporating immediate learning from the case. These procedures are located at: https://westmidlands.procedures.org.uk/pkyzqy/regional-safeguarding-guidance/physical-abuse and were launched in Solihull in January 2022 at a multi-agency event. During 2022/23 assurance will be sought from Strategic Leads as to the action taken to embed these procedures into their organisation's operating processes.

6.7 Learning from the child death overview panel

6.7.1 The multi-professional Child Death Review Team (CDRT) is part of the Safeguarding Team at NHS Birmingham and Solihull Integrated Care Board (ICB). Birmingham and Solihull Child Death Overview Panel is managed by the Child Death Review Team. The meetings were a mixture of virtual and face to face; the Neonatal Panel meetings were all virtual and the General/Sudden Unexpected Death In Childhood meetings were face to face/hybrid meetings where possible.

6.7.2 Birmingham Child Death Overview Panel took over the responsibility for reviewing Solihull child deaths from 1st April 2021, so cases reviewed include children resident in either Birmingham or Solihull.

6.7.3 The Child Death Review Team is directly responsible for the co-ordination of the Joint Agency Response (JAR) to unexpected child deaths (SUDIC – Sudden Unexpected Death In Childhood) for both Birmingham and Solihull resident

children. The Child Death Review Team oversees Child Death Review services provided by NHS Trusts.

6.7.4 The statutory guidance requires that all child deaths should be reviewed at a local child death review meeting (CDRM). With the exception of deaths requiring a Joint Agency Response (JAR), which are directly managed by the Child Death Review Team, it is the responsibility of the health care trust caring for the child at the time of death to hold the child death review meeting.

6.7.5 179 deaths were reviewed by Birmingham Child Death Overview Panel, compared to 62 in 2020-21 and 180 in 2019-20. COVID was the reason for the reduction in reviews in 2020-21, with several Child Death Overview Panel meetings cancelled and delays in getting the information required from acute hospitals. The number of cases that have been reviewed in 2021-22 is similar to pre-COVID figures. There were 161 deaths in 2021-22, and 120 in 2020-21. There has been some catch up of the backlog of cases that were not reviewed in 2020-21 due to COVID.

6.7.6 The majority of deaths are in infants under the age of 1 year.

6.7.7 63 of the 179 reviews identified relevant learning, even though in most cases this would have made no difference to the outcome for that child. Much of the learning was identified by provider trusts at internal child death review meeting or through Healthcare Safety Investigation Branch.

6.7.8 Learning themes for peri-neonatal deaths included:

- the need for better processes for management of mothers who are book late for antenatal care (5 cases),
- improving intrapartum care, such as giving steroids and magnesium in a timely way for mothers in preterm labour (4 cases), and
- better interpretation of Cardiotocography monitoring to identify fetal distress (4 cases).

6.7.9 There was also learning regarding the early management of neonates;

- giving correct adrenaline dose (2 cases), and
- ensuring timely stabilisation of the baby on the Neonatal Unit (golden hour) is met (3 cases).

6.7.10 There was also learning regarding management after death;

- Ensuring the Joint Agency Review process is followed correctly (5 cases)
- Ensuring adequate post-mortem tests (2 cases)
- Ensuring admission of twins in Sudden Unexpected Death In Childhood cases (2 cases)

- More sensitive communication of post-mortem results to family (3 cases)

6.7.11 Other themes included:

- Communication between healthcare professionals (3 cases) and issues with IT systems, for example, difficulty sharing results/information across different services, trusts or agencies (6 cases).
- The importance of good communication with families and patients (4 cases) such as involving young people in their care planning and the use of interpreters.
- The importance of timely referral to palliative care services (3 cases).

6.7.12 The Integrated Care Board is working with hospitals and West Midlands Ambulance Service to ensure that young people with critical injuries are taken to the Emergency Department (ED) best equipped to deal with their clinical presentation rather than selecting the ED based on age alone.

6.7.13 One death identified lessons to be learnt regarding the management of developmental delay. As a result, a training package regarding developmental delay, arrest and regression was produced by the Child Death Review Team and rolled out to primary care staff.

6.7.14 It is an important role of Child Death Overview Panel to review and highlight positive factors in provision and examples of best practice. 54 of the 175 deaths reviewed had examples of positive service provision or best practice. Examples included members of staff coming to work on their days off to help, good joint working with hospital teams and palliative care, support from primary care providers such as GPs and Health Visitors, and support from school for families both before and after children had died.

6.7.15 2021-22 was a busy year for the Child Death Overview Panel, as there was a backlog of cases due to the pandemic. The quality of information has improved significantly, which has led to better recognition of modifiable factors and more learning arising from deaths. However, this rich information also, in turn, has associated challenges as Child Death Overview Panel meetings and the associated preparation takes much more time. The Panel's aim is to continue working closely with the Birmingham Infant Mortality Task Force and to develop further themed Child Death Overview Panel meetings over the next year.

6.8 Learning from the Local Authority Designated Officer

6.8.1 Statutory guidance requires Local Authorities to deal dealing with allegations against adults that work with children. The statutory guidance requires Local Authorities to have a Local Authority Designated Officer (LADO) to be involved in the management and oversight of individual cases. The LADO provides advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

6.8.2 In March 2022, a dedicated full-time, interim LADO was appointed. A business case has been submitted and accepted for this post to become permanent. This represents good progress, as within the West Midlands LADO network of thirteen Local Authorities, Solihull had been the only Local Authority without a dedicated LADO. The introduction of a permanent LADO will provide consistency within the role that has not been in place previously. It will also enable the LADO role to be further developed.

6.8.3 In Solihull the LADO sits within the Child Protection and Reviewing Unit and will usually be managed by the Principal Officer.

Sources of referrals

Referring agency	Number of referrals in 2021/2022
Senor school/college	38
Primary/infant school	41
Special school	8
Early years/nursery	20
Other LA	25
Police	12
Fostering agencies	7
Other	15
Ofsted	8
Solihull MBC	29
Individual	10
Probation	1
Children's home	19
Health	3

6.8.4 Over the 2021/2022 period, the LADO had a total of 235 contacts with other professionals. The term contact in this context means any contact that the LADO has had regarding a person in a position of trust. Many of this cohort were discussions about thresholds and the LADO giving advice where threshold for a Position of Trust (POT) meeting wasn't met.

6.8.5 Almost a quarter (61) of the 235 progressed to a Position of Trust meeting as seen in the table below; 174 did not. Very few allegations will be resolved in the initial Position of Trust meeting and often require follow up meeting/s to reach a conclusion and outcome.

6.8.6 The number of Position of Trust meetings held during this period is higher than the previous two periods although not significantly so.

Year	2019/20	2020/21	2021/22
Number of initial Position of Trust meetings held not including review meetings	47	49	61

Table 1: *Total number of initial Position of Trust meetings held during 2021/22*

Outcome following allegation	Number of cases
Unsubstantiated	21
Substantiated	20
Malicious	1
False	1
Unfounded	12
No abuse to investigate	1
Not yet concluded	7

Table 2: *Outcomes of allegations made in 2021/2022*

6.8.7 Of the 7 allegations not yet concluded, one relates to a matter commenced in September 2021. There was an ongoing Police investigation and now a trial.

6.8.8 The other six relate to Position of Trust meetings that commenced in February and March 2022. They are either awaiting the outcome of Police investigations or other enquires. For two of the allegations the outcomes were recorded as unsubstantiated and unfounded.

6.8.9 The LADO provided assurance that there is good awareness of the Management of Allegations process in Solihull and noted the only gap in referring agencies relates to faith schools.

6.9 Sharing learning across the partnership

6.9.1 Joint Targeted Area Inspection said this was not robust enough.

6.9.2 A Learning and Development sub-group is to be developed under the new LSCP governance arrangements and a process developed for taking learning from LSCP activities and distilling the key messages and target audiences.

6.9.3 The Learning and Development sub-group will be responsible for reviewing the LSCP Learning and Improvement Framework and for introducing a new Dissemination Action Plan to embed learning across the partnership, including mechanisms for evaluating the impact of learning on frontline practice.

An evaluation of the effectiveness of local safeguarding arrangements by the key safeguarding partners

As the Safeguarding Partners for Solihull, we readily acknowledge that in the year covered by this Annual Report, local safeguarding arrangements have not been sufficiently effective.

The Partnership's own quality assurance processes have indicated this and they have been confirmed by the findings of the Joint Targeted Area Inspection and the National Child Safeguarding Practice Review Panel's report 'Child Protection in England'. The Partnership accepts these findings unreservedly.

Despite these disappointing judgements, there is still cause for hope. There is a lot of good work being done to take forward improvements, particularly around the strategic priorities of Neglect and Exploitation. The 'front door' response to contacts and referrals has been transformed and continues to improve. The Local Authority Designated Officer is to become a permanent post, dedicated to investigating allegations against adults in positions of trust.

As we embark on our improvement journey, the Partnership is not under any illusions about the scale of the task before it. We must do better. We must work together more effectively. The safety and welfare of children and young people is our shared paramount concern.

We are determined to improve the quality of services for children, young people and families, in a challenging time for the economy and society. Two years since the first national lockdown, Covid is still present in our communities. All the difficulties that the epidemic brought are being exacerbated by an emerging cost-of-living crisis which puts additional pressure on the poorest and most vulnerable in our society.

The critical focus brought to bear by our external partners has highlighted the areas for improvement and the Partnership is already making major changes to bring about developments in the services to help to protect and support children and families.

In March 2022 the LSCP agreed its priorities for 2022/23:

- Implementation of the Neglect Strategy

- Response to children and young people in need of Early Help support
- Implementing learning from the Joint Targeted Area Inspection (JTAI undertaken in January 2022) and the National Child Safeguarding Practice Review (published May 2022)

Appendix 1 – LSCP Budget 2021/22

Expenditure	Actual 20/21	Actual 21/22
	£	£
Pay and Overheads	166,672	175,341 (pre-JTAI) then in April onwards
Training	0	0
Car allowances	185	0
Telephones	236	175
IT Equipment and Related	3,860	10,585
General Office Expense	2,926	202
Internal Overhead Recharge		2,000
Professional fees - CSPR/Other	4,200	6,350
Other fees - Child Death Overview Panel	0	0
Other fees - Independent Chair	5,217	10,509
Grants and Subscriptions	704	1,504
Internal Room Hire	0	178
Information Communication Technology	2,303	2,303
Income		
Childrens Services	-132,180	-132,180
Clinical Commissioning Group	-60,300	-60,300
West Midlands Police	-13,008	-13,010
University Hospitals of Birmingham	-6,200	-6,200
Solihull Community Housing	-10,000	-10,000
National Probation Service	-477	0
Community Rehabilitation Grant	-1,500	0
CAFCASS	0	0
External/Other income	-1,116	-2,484
Carry forward	-23,715	-60,096
Net Budget	**-60,096**	**-70,757**

Gross Expenditure	**186,303**	**209,147**
Gross Income	**-248,496**	**-279,904**
Net Shortfall /-Surplus	**-62,193**	**-70,757**