Staffordshire Safeguarding Children Board

Annual Report

Staffordshire Safeguarding Children Board
2020/21

Contents

This 2020/21 report will focus, in the main on the effectiveness of the new arrangements in keeping children safe for Staffordshire Safeguarding Children Board. The Stoke-on-Trent Safeguarding Children Partnership will follow their own separate arrangements for reporting on the effectiveness of their arrangements.

Working together to keep children safe

Staffordshire Safeguarding Children Board

Foreword

Helen Riley, Deputy Chief Executive and Director for Families and Communities, Staffordshire County Council
The pandemic has tested local services to the limit. The disruption of family life has posed significant challenges and risks for the new partnership to address. However, the maturing relationship and growing trust across Staffordshire partners have resulted in swift, integrated, effective and comprehensive actions to ensure that our children and young people have remained visible and safe. The focus of the partnership has never wavered despite all the pressures for individual organisations because of Covid-19. The necessity to work together to respond proactively and promptly to the pandemic has helped forge stronger bonds between us that places us in a promising position as we work to fully establish the Staffordshire Partnership in 2021/22.

Jennie Mattinson, Temporary Assistant Chief Constable, Staffordshire Police
Covid-19 has created significant difficulties for all agencies and there have been particular challenges around child safeguarding. I am confident that across the partnership our staff and officers have risen to these challenges well with new and creative ways of working which have overcome the risks often associated with isolation. Despite the individual pressures within each organisation, all three statutory partners have remained engaged and committed to child safeguarding and the board priorities. The experiences during Covid-19 have highlighted the importance of close partnership working and I'm confident the board will continue to mature over the coming year.

Heather Johnstone, Executive Director of Nursing and Quality, Staffordshire and Stoke on Trent CCGs
The NHS has faced its biggest ever test throughout the ongoing Covid-19 pandemic. Throughout this time partnership working has been essential to the continued provision of high quality, safe services. The extension of remote working and remote access has provided a further challenge particularly in relation to safeguarding where previously face-to-face encounters with children, young people and their families would have provided the opportunity to identify risk. The continued evolution of the Safeguarding Partnership and associated sub-groups has enabled the collaborative management of safeguarding risks throughout and neither standards nor expectations have been allowed to drop as a result. As the work of CCGs and wider system partners transitions into the Integrated Care System I believe the partnership work will go from strength to strength and that together we will continue to do everything we can to safeguard the children and young people of Staffordshire.

Introduction

The Staffordshire Safeguarding Children Board (SSCB) 2020/21 annual report aims to present how we as safeguarding partners report the effectiveness of the arrangements to keep children safe. Whilst remaining compliant with Working Together 2018, changes to our governance arrangements as well as the impact of Covid-19 have afforded us an opportunity to embark on a more efficient and effective way of reporting. This is without doubt the beginning of a new, exciting, and continuous journey of improvement and self-reflection for the safeguarding partners in Staffordshire, and we hope this report offers you a sense of our journey, based on our collective efforts to work together to keep children safe.

Clearly, we cannot go on without reporting on the two biggest changes to the arrangements during this financial year.

Covid-19 continues to provide new, and exacerbate existing, challenges to everyone working with children and families. This report will provide an overview of how the safeguarding partners have responded to the pandemic and will share examples of where this has been evaluated as good practice. Equally, we will include areas that still present a degree of concern or have become an area of concern. The safeguarding partners recognise and appreciate the persistent struggle agencies have with staffing levels, unmanageable waiting lists alongside a reduced capacity supported by an increasingly exhausted workforce. The safeguarding partners wish to extend their sincere gratitude to all for their commitment to keeping children safe.

Changes to our multi-agency safeguarding arrangements - the joint Staffordshire and Stoke-on-Trent Safeguarding Children Board separated in November 2020 after which the SSCB moved to a single Board with a revised structure including the publication of their new arrangements. An agreement was reached between the safeguarding partners that the Board would continue to support Stoke-on-Trent's transition to a new partnership, by retaining some existing elements including the business arrangements for the management and coordination of ongoing Child Safeguarding Practice Reviews (CSPR), along with the revision and hosting of local joint policies and procedures. Joint training products would also remain available with a distinction, where appropriate, between the differing products available to those working with children and families across the two geographical areas.

Existing quality assurance processes remained, with revisions to certain groups and terms of reference. The sub-group section sets out those changes in further detail, and where available, the impact.

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Our response to Covid-19

During the period of Covid-19 restrictions, services for children and young people were operating in limited capacity or virtually online with face-to-face meetings available only for those at most risk, in line with national guidance. Staff sickness, shielding and self-isolating affected service delivery across most of our services for children and families and many were operating to exceptional delivery models.

A joint Stoke-on-Trent and Staffordshire Safeguarding Children 'Covid-19' sub-group was established in June 2020 to identify and mitigate the immediate and on-going risks to service delivery and safeguarding for children and young people across the area. The challenges of the pandemic were felt to have strengthened communication, information sharing and supportive partnership working through sharing of ideas to work more creatively together to keep children and young people safe during the year.

Concerns around reduced face-to-face opportunities

- Professional concern regarding the virtual offer and the challenges in the identification of physical or emotional neglect, abuse, and domestic abuse
- Face-to-face visits cancelled or delayed due to lack of personal protective equipment
- Difficulties building relationships with families (also a theme from rapid reviews)
- Vulnerability of certain groups such as young carers, babies and children with special educational needs and disabilities were identified as a priority group for face-to-face visits

Concerns around provision of early help and safeguarding

- During the first lockdown, Local Authority early help services were suspended to new referrals, despite this there was an overall increase in new referrals to early help by 10% from the previous year (1,800 additional referrals)
- There was however a decline in overall safeguarding referrals to children's social care, a reduction of 13% (1,000 less referrals) with referrals more complex with children and families escalating into statutory services more quickly

It is not yet clear whether this reduction in referrals is due to the increase in early help activity or a reflection of missed opportunities due to Covid-19 related restrictions. Outlined are some of the specific challenges and concerns we identified and responded to.

Babies and infants - Covid-19 has created additional challenges for families with babies under two.

- Learning from a local review suggested this area could be strengthened to ensure that appropriate care and support is available to ensure children's outcomes are maximised
- Maternity services had to adapt to Covid-19 restrictions which meant that users were affected, for example partners were not able to attend antenatal appointments for parts of the year. However, Maternity Voices Partnership (MVP) champions ensured lines of communication were open to all maternity services users through digital and social media channels with positive feedback
- Health visitors despite reduced capacity continued with some face-to-face visits at home or in clinic when there were concerns for a child and where it was safe to do so with one parent, alongside virtual/telephone contacts
- It is likely that opportunities for early help and support were missed through lack of face-to-face visits

"Thank you so much to the [MVP] champions for the COVID Facebook page - it has reduced my anxiety tremendously."
"Thank you for keeping us all informed. I agree times are hard and people are missing out but the most important thing for me is that my little one is safe."
"It's a great group that has been set up and I appreciate that people are working hard for the physical safety of pregnant women."
Feedback from maternity services users

Impact on education and wellbeing

Whilst early years education remained mainly open uptake fell slightly due to parents concerns particularly during the first lockdown. When schools reopened in Autumn 2020, many children missed school due to self-isolation. The local authority in partnership with schools set up systems for monitoring attendance for children who were vulnerable with practitioners following up persistent non-attendance with families.

Children's emotional health and wellbeing

Children suffered because of Covid-19 with 43% of young people locally reporting being away from education during lockdown had negatively impacted on their wellbeing.

- 58% of young people in Staffordshire said they struggled to stay engaged with learning during lockdown
- 62% of parents struggled to keep children engaged with learning
- 53% of young people in Staffordshire felt communication between school and themselves had been good during lockdown; in contrast 69% of parents felt communication with schools had been good
- Only 14% of parents found home schooling to be a positive outcome

Impact on family vulnerability

Family vulnerability Increased including reduced household income, employment insecurity, insecure tenancy, lack of access to food, domestic abuse, and mental health concerns and demand for early help and domestic abuse services have risen across the County during 2020/21 compared to previous years.

Despite the UK Government's ongoing campaign "At home shouldn't mean at risk" focusing on tackling domestic abuse during the coronavirus pandemic, 36% of young people in Staffordshire said that they were isolating with a verbally abusive or physically abusive partner or family member but only one third of them knew how to access victim support for domestic abuse

Staffordshire Youth Commission Annual Report 2020

Ongoing feedback from parents has enabled the local authority to receive more information directly from parents which has offered insightful feedback and identified areas for improvement, particularly in relation to how we planned for and responded to Covid-19. As a result, the voice of parents is being shared with the Early Years Advisory Board to influence changes in practice that will result in a safer and more effective system for other parents.

Impact on training and development

The Board training programme was suspended from April 2020 and transferred its existing training and new products to a virtual platform by September 2020. This method of delivery transformed the way people are now able to access training and resulted in significant cost savings for the Board. Coupled with a newfound confidence by trainers in virtual delivery, products became more attractive to the delegates, with increases in attendance levels as well as a reduction in non-attendance and cancellation charges. Feedback from delegates showed an increase in confidence and knowledge in the workforce to achieve better outcomes for children.

"I feel much more confident in acting on cases in a pro-active way having received this training. "

"I know that it is possible to challenge other agencies when there are still concerns and that questioning is a positive action to take to keep children safe."

"I have a much better understanding of the importance of effective professional relationships between agencies."

Impact on the judicial services - courts experienced considerable delays and backlogs particularly in private law cases, adoption and the youth courts due to Covid-19. Partners including Staffordshire County Council (SCC) Youth Offending Service and Cafcass worked closely to manage the expectations of children and families during the initial phase and recovery plans led to easing of restrictions through the availability of buildings along with evening and weekend sittings, an increase in the number of sittings and block hearings for cases involving adoptions. The long-term effects of the pandemic still present on going demand for agencies, with concerns over capacity and allocation of increasing numbers of private law cases.

Learning from rapid reviews nationally

During the pandemic learning from rapid reviews nationally were identified as:

- an increase in parent and family stress factors
- exacerbated vulnerabilities for children and young people
- impact of school closure
- identification, contact with and support for vulnerable children and young people
- impact of adaptations for Covid-19 safe practice.

During the pandemic learning from our local rapid reviews during this period were similar and included:

- impact of virtual/telephone versus face-to-face with professional contacts on identification of vulnerability such as domestic abuse
- assessments and support
- building relationships
- suspension of some regular physical health and development checks such as growth monitoring including weight to support assessments.

Although acutely aware of the initial findings from those directly impacted by the pandemic through our reviews, further work by the safeguarding partners must continue to truly appreciate and understand the broader picture felt by those directly impacted by service changes.

Focus for 2021/22:

We will continue to monitor and provide assurance that the impact of Covid-19 on safeguarding and the welfare of children is understood in terms of both services and outcomes. We will continue to provide assurance that plans are developed and acted on to address/mitigate challenges and emerging risks with particular focus on those areas of concern identified within this report.

Our priorities

Neglect

Neglect has featured in both local and national serious case reviews and child safeguarding practice reviews. There remain concerns over our collective response to neglect, particularly for families that are re-referred once support is withdrawn, be it early help or statutory intervention. Neglect also remains the largest category of abuse for children subject to a child protection plan and at the end of March 2021 featured in around 65% of child protection plans in Staffordshire.

During 2020/21 we undertook a multi-agency analysis of single-agency audits and case studies to understand how agencies currently operate and the challenges within the system in relation to neglect. Low level neglect and its impact remain difficult to recognise and respond to and whilst there was good evidence of how the lived experience of the child and/or the use of restorative practice approaches have improved outcomes in some settings this was inconsistent across the area and between settings. Many of the themes we identified are similar to those previously identified and grouped into three key areas; workforce (skills, knowledge, and confidence); understanding services and pathways (both from a professional and child/family perspective); and commissioning.

Our Priorities

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During 2020/21 safeguarding partners continued to progress improvements for children who were neglected. These include:

Prevention and early help

Continuing to seek assurance from partner agencies and from each other, on the work with other strategic partnerships and influence the importance of early help and support through a whole family approach. An example of this is whereby the early years delivery plan now has a "Staying Safe" section in which all partner agencies have agreed to contribute to activities that will impact positively for under ones. During the year we also identified a training need for education settings in relation to early help and have rolled out training to support our education colleagues to build confidence and recognise that many are already providing early help and support. Neglect has also been a key area of focus for our primary care colleagues during the year with communications focusing on neglect within newsletters and featuring in the GP annual safeguarding audit. There has also been a focussed effort with dental safeguarding leads to improve safeguarding training and increase recognition of neglect including dental neglect. We will track progress on early help outcomes through our performance framework, and work with the Health and Wellbeing Board to negate some of the parental risk factors for neglect.

Development of multi-agency guidance for neglect

Using the learning from rapid reviews, and Child Safeguarding Practice Reviews, the guidance brings together evidence-based approaches to preventing and responding to neglect such as the NSPCC's Spotlight on Preventing Child Neglect and is aimed at improving our ability to spot the emerging signs of neglect, to listen to the voice of the child, appreciate their lived daily experience, and respond much earlier to prevent an escalation of abuse or need for a much higher and longer intervention.

Commissioning of evidence-based Graded Care Profile (GCP2) assessment tool

In July 2020, both local authorities commissioned the use of GCP2 to improve our response to neglect at the earliest opportunity. With support from the NSPCC, a multi-agency steering group was set up to oversee implementation across the area. During March 2021 we trained 30 professionals from a range of agencies to become GCP2 champions. Our champions will deliver awareness sessions and training events to help other professionals become licensed to use the GCP2 tool. A peer support programme has been set up to support our champions and we now have dedicated communication channels across the Partnership. We have also updated our training packages to reference the use of GCP2 and are working to monitor the impact of GCP2 locally.

"For too long, staff have struggled to evidence that there is neglect present making their challenges with parent or professional even harder. Using GCP2 assessments they can evidence areas of neglect to both parent/carer and other professionals."

"It is important that staff working with children and families on a daily basis have the opportunity to understand how useful this tool is and to use this tool in a way that supports families when issues and concerns are identified ensuring better outcomes for the children."

NSPCC

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Focus for 2021/22:

Following several rapid reviews for under ones in the area where neglect appeared in all of the children's daily lived experience the Board will be focusing their efforts next year on babies and infants and will continue to roll-out the GCP2 assessment tool across the County.

The Board will also continue to strengthen their relationship with other Strategic Boards to align and agree how they can work together to reduce the impact of parental neglect on infants across the County and develop a Voice of the Child e-learning package to support our aim of ensuring that the voice and lived experience of children and families is utilised in driving service improvements.

Our Priorities

Child exploitation

Research conducted by the Staffordshire Youth Commission found that over three in five (62%) of young people were worried about knife and gang crime. Exclusion from mainstream school is a key trigger point for significant escalation of risk and serious harm and up until last year rates in Staffordshire were higher than statistical neighbours.

The Stoke-on-Trent and Staffordshire Child Exploitation Joint Task Group, set up in 2019/20, continue to lead on this priority for the Board with the key priorities being to develop a child exploitation strategy and performance framework to monitor its impact. Plans were in place to launch the strategy in March 2020, but this was delayed due to the pandemic and the **child exploitation strategy** was therefore formally launched this year with around 500 delegates attending two virtual conferences. The focus of the conferences was on spotting and understanding early signs of child exploitation and involved people with lived experiences of exploitation as well as the voices of children and families.

Since the conference:

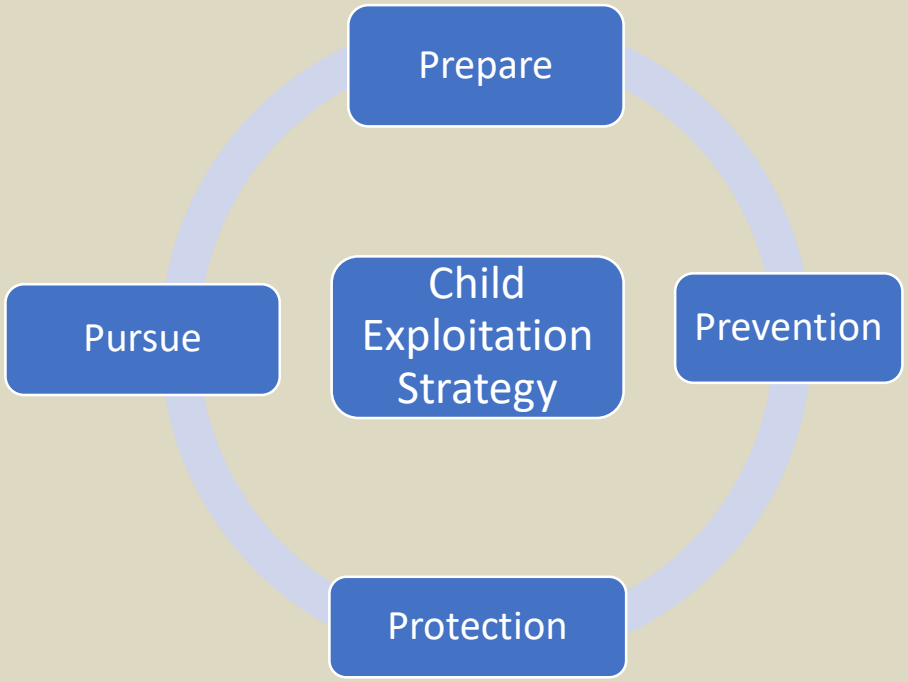
"I have been more professionally curious when having conversations with parents and students to see if they are being subject to exploitation"

"I have been able to offer families and children the support when the signs of possible exploitation were visible"

Tackling Child Exploitation (TCE) support programme

As part of the TCE we have been supported in developing a performance framework. Partners were strongly committed to ensuring that the lived experience of the child was at the heart of the framework and the TCE workstream resulted in the identification of multi-agency datasets across the partnership. The task group are now in a stronger position to develop the framework with a data leads group in place to bring these multi-agency datasets together.

As part of the implementation of the strategy individual organisations have developed their own operational plans to tackle child exploitation. During 2020/21 safeguarding partners continued to develop or progress improvements for children who were exploited or at risk of exploitation.



Some of the achievements include:

Extensive **training** was delivered to all partners. Feedback has been positive, and this has helped shape future practice including developing Level 2 child exploitation training.

County Lines awareness campaigns delivered throughout the year which focus on encouraging parents and carers to spot the signs of child exploitation and drug activity as well as identifying young people who are at risk so they can be offered early help. Campaigns were also accompanied by 'intensification' operations by officers across the area.

Activities aimed at reducing **knife crime:** training within hospitals; 'Ditch the Blade' campaigns; knife bins; knife wands in schools; and encouraging professionals to talk about knives to children when they are known or thought to be carrying them and sharing intelligence with the Police to support disruption. Staffordshire Police with partners also delivered over 4,000 letters to local schools for parents and carers to encourage engagement with children during an intensification campaign.

Continuing to develop our responses to **children who go missing** through a Strategic Missing Group which was evidenced by an overall reduction in the numbers of children who go missing during 2020/21.

Development of 12-month pilot which has a **targeted intervention programme** for children at risk of Child Criminal Exploitation which is now being evaluated.

During 2020, around 420 children were discussed across **Multi-Agency Child Exploitation (MACE) panels** across the County, which is a significant but expected increase on the previous year (230 children). The increase is due to all exploitation being considered rather than just child sexual exploitation along with the impact of training professionals to spot the signs. Learning and good practice from the panels are also shared regularly with practitioners to strengthen good practice across the Partnership.

The introduction of police staff on the **Early Intervention and Prevention Unit (EIPU)** helps with a wider focus on prevention of exploitation as they link with schools, hotels, and other premises.

Experts in the field of Child Criminal Exploitation were brought to the police to offer guidance as part of their **force peer review** from the Vulnerability Knowledge and Practice Programme (VKPP). Feedback has already been implemented with a force action plan. One of these actions is implementing a multi-agency tool to better measure and understand child exploitation in the County and map the extent of the issues.

Methods by the police to introduce the **Violence Reduction Unit (VRU)** has assisted with a greater focus on the higher risk children for Child Criminal Exploitation and helps build rapport and assist in diversion.

Several **multi-agency operations** have been run with local partners from Staffordshire and Stoke-on-Trent targeting the four Ps (outlined in the CE strategy). Operation Campus - secured eight charges for modern day slavery (MDS) offences and conspiracy to supply. Operation Glera diverted several males and resulted in drugs charges for the core nominal.

Focus for 2021/22:

Our focus will be on the continued implementation of the child exploitation strategy and to build on the work of the TCE programme to ensure that we have an intelligence-driven and child-focussed performance framework that allows us to monitor outcomes through the joint task group. We will also develop our training efforts on recognising and responding to the early signs and emerging signs of child exploitation. We will specifically focus on children who present as both victim and perpetrators to challenge our thinking of how we see the vulnerability of the child before we see the perceived criminality.

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Ensuring effective multi-agency safeguarding practice

As part of our core business the focus of this overarching priority is to demonstrate that there is a multi-agency approach to our safeguarding practice which is effective. We will ensure that learning is identified, its improvements embedded at both individual and multi-agency level, be alert to emerging risks and understand systemic issues which policy and practice changes will address. These are implemented and monitored through our structure and sub-groups.

Sub-groups

- **Scrutiny and Assurance Group (S&A)**
- **Child Safeguarding Practice Review Group (CSPR)**
- **Joint Child Death Overview Panel (CDOP)**
- **Review of Restraint Task Group**
- **Learning in Practice Forum**

Scrutiny and assurance

'The safeguarding system is complex with many different organisations and individuals playing their part. Reflecting on how well that system is working is critical as we constantly seek to improve our collective public service response to children and their families'

Working Together to Safeguard Children 2018

A strategic partnership group was set up to support the Board to fulfil its statutory functions as laid out in Working Together 2018 with one of the key roles being to provide assurance that the system is working well across the Partnership and that learning, and improvements are being embedded to improve practice through sharing of intelligence. Following the new arrangements, a revised Partnership group was set-up with updated Terms of Reference and membership including a new Chair to reflect these arrangements.

During 2020/21, the group developed and agreed a Performance and Quality Assurance Framework as well as their workplan for the year. The framework allows learning to be identified through a range of methods including the use of single and multi-agency performance and audit data as well as feedback from children, young people, and practitioners. This intelligence, in-conjunction from feedback from other sub-groups, is used to identify where and what improvement activity may be required across the system with a particular focus on the Board's priorities.

Focus for 2021/22: our focus will be on monitoring **impact and outcomes**. A multi-agency performance dashboard was developed to focus on our outcomes, initially for neglect as well as some of our 'core' safeguarding business of keeping children and young people safe across the pathway from early help to looked after children and care leavers. This has allowed us to monitor how we are doing against our priorities and by triangulating this with other insight across the Partnership continually challenge ourselves and identify gaps to improve our outcomes for children and families. The dashboard will be further developed to include child exploitation and measures around the critical moments in children's lives when a decisive response is necessary to make a difference to their long-term outcomes.

Child Safeguarding Practice Reviews (CSPR)

The CSPR sub-group is a multi-agency group, comprising of the statutory partners as well as education, probation, youth offending service, voluntary sector services and representatives from other agencies on a case-by-case basis, that has delegated responsibility from the Board to oversee reviews and to report to the national Child Safeguarding Practice Review Panel on learning and progress made in line with Working Together 2018.

During 2020/21 there were five rapid reviews, three for Staffordshire children and two for Stoke-on-Trent children.

Prior to this between September 2019 and March 2020 there were seven rapid reviews involving babies under one year of age (from Staffordshire and Stoke-on-Trent) which resulted in the decision to complete a thematic CSPR of infants under one, which was finalised in March 2021.

There were three Serious Case Reviews (SCRs) or Child Safeguarding Practice Reviews (CSPRs) which were also completed during the year of which one has been published whilst the other two are yet to be published due to parallel legal proceedings.

Key themes identified from the reviews (some of them recurrent) include.

- Neglect
- Physical harm to babies under one year
- Intra-familial child sexual abuse

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Findings have been identified using a systems-focussed approach with positive outcomes achieved through agencies working together to improve systems and processes and ultimately improving safeguarding practices to improve children's lives.
Examples include the ongoing collaborative working towards.

- Multi-agency chronologies
- Improvements in strategy meetings and core group membership where the sharing of information is critical
- The capturing of family history in the child protection medical process
- Recognition of the vulnerability of babies under one year where there is domestic abuse
- Listening to the voice of the child
- Early identification of the need for support where neglect is emerging and the implementation of the GCP2 assessment tool
- Introduction of the multi-agency neglect performance framework as an assurance tool to identify gaps across the safeguarding system and make improvements in early identification and response to neglect
- Approaches to increase practitioner confidence enabling professional challenge and escalation
- Going live with Operation Encompass which is a significant step towards better partnership working to protect children living in households were domestic abuse occurs. Operation Encompass ensures that information is shared between the police and the child's school so that effective support and safeguarding can be provided

Sharing learning / feedback from practitioners - the Board have developed a series of feedback and engagement events as well as improvement to our communication channels to share the learning as soon as possible after a review. The Board recognise the importance of the voice of front-line staff, sharing their experiences and thoughts to understand how the learning can be embedded tangibly and with confidence in day-to-day interactions with their families and children. The essence of learning from reviews is to change hearts and minds, process, and practice by the inclusive involvement of our valuable workforce.

Focus for 2021/22: We will continue to provide assurance that learning and improvement activity from reviews and thematic reviews are identified and find new and innovative ways to embed messages. We will also aim to measure the effectiveness of the system by way of single and multi-agency audits and other performance measures, as well as an analysis of the support given in the very early days of signs emerging. Learning and actions related to Stoke-on-Trent Safeguarding Children Partnership will be shared and jointly approached to ensure smooth transition of cases and workstreams.

Review of child deaths

The Child Death Overview Panel (CDOP) reviews deaths of all children and young people under 18 years resident in a specified area to learn what happened and why, whether there were any modifiable factors whereby local activity could prevent or reduce similar child deaths in the future. The local CDOP is made up from a range of partner agencies and an update is distributed to partners giving an overview of recent notifications and reviews with recommendations, learning points and any emerging themes. The CDOP also sends data to the National Child Mortality Database (NCMD) so that learning can be identified and shared at a national level.

During 2020/21:

- 69 notifications of child deaths with neonatal deaths (deaths within 28 days of life) accounting for the largest proportion (57%).
- Of these, 18 (26%) were categorised as unexpected requiring a joint agency response (JAR).

Deaths from suicide were down from the previous year, which were the highest figures seen since the panel formed in 2008. (Note: fluctuating figures due to the very small numbers involved). However there remains concerns nationally that as Covid-19 restrictions and isolation continues the number of suicides may rise in subsequent years. As a result, we plan to conduct a thematic review during 2021/22 and participate in a region-wide review.

During the year 65 child deaths were reviewed in Staffordshire and Stoke-on-Trent. Of these 15 were considered to have modifiable factors with the most frequent themes being:

- smoking
- non-attendance for health care appointments
- alcohol / drug use by parents/carers
- poor mental health of parent / carer and poor mental health of children.

Communication focusing on concerns that many families may not receive the level of health and care support they needed during the pandemic and would also be less willing to attend hospital for their children's health care needs until they escalated meaning that in some case children would be seen much later, arriving very sick, or worse, already deceased due to the fear of acquiring Covid-19 in hospital.

Focus for 2021/22: several areas of improvement activity will continue against recurring modifiable factors we have identified through campaigns, support and multi-agency training such as Safer Sleep; unintentional injuries. We will also roll out ICON to partner agencies and continue to seek to improve services by engaging child and families in the process.

The review of the arrangements for restraint of young people in Werrington Young Offenders Institute

The Review of Restraint Task Group meets quarterly within Werrington Young Offenders Institution (YOI) and is chaired on behalf of SSCB by the local authority's Head of Youth Offending. The group are keen to hear the voices of young people and during a meeting this year children have joined us to talk about their experiences of being restrained.

On average there are between 30 and 40 restraints monthly which are reviewed on weekdays by social workers within the YOI. However, in addition to this scrutiny, each quarter a small sample of around six to 10 incidents are reviewed further using video footage and the associated paperwork for these restraints. Once the footage is reviewed there is a reflective discussion highlighting good practice and learning.

During 2020/21 the group has been focusing on the following:

- **Reducing the use of pain inducing techniques** - these are used as a last resort, for example when there is a serious threat to life. In the one instance that took place during 2020/21 had pain not been applied there would have been a serious injury or death to another child.
- **Increasing the use of body worn camera footage** - there has been a steady increase in usage with 100% of incidents being captured with sound during January 2021.
- **Reducing the use of restraint for passive non-compliance** - the group has focused on reviewing restraints that happen following a child not complying with an order from an officer. The learning from this is being used to inform the behaviour policy within the establishment.
- **Hearing the voices of our children** - due to Covid-19 children have only attended one formal meeting to talk about their experience. However, it is intended that they become core members going forward to inform discussions.

Some of the areas of concerns we identified during the year were:

- **Minimising and Managing Physical Restraint (MMPR) training** - the delivery of regular refresher training for officers has been affected by Covid-19 and there was some evidence within the footage reviewed that the lack of the refresher training was impacting on how restraints were applied. Training has now recommenced.

- **Levels of violence** - this is the biggest risk within Werrington. Despite all attempts the establishment remains one of a few sites with the highest levels of violence. The worst period was in May 2020, where there were 16 assaults on staff members alone. Feedback regarding the reasons and themes for violence have openly been shared by both staff and children; gang rivalry in the community; regime delivery; family group make-up; relationships; rewards and sanctions; separation; and time out of room. It is hoped that the return to a normal regime will reduce some of the violent episodes, which will be supported by the new behaviour management policy.

Review of restraint and the use of pain

An independent review on the use of pain in restraint by Charlie Taylor displayed several recommendations, including the establishment of a national scrutiny group to review individual restraints across the secure estate. The Governor at Werrington will be involved in initial discussions to set up this group and national learning will continue to be captured by the Review of Restraint Task Group.

Focus for 2021/22: we will continue to provide assurance to the Scrutiny and Assurance Group that the national learning is reflected locally; continue to focus on and celebrate the positive outcomes and strengths of the Review of Restraint Task Group, both locally and nationally. We will also focus on our strategies for reducing the levels of violence.

Staffordshire Safeguarding Children Board

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