OUR SAFEGUARDING CHILDREN PARTNERSHIP FOR CORNWALL AND THE ISLES OF SCILLY

Annual Report
2018/2019

www.safechildren-cios.co.uk
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1. Overview Report from the Independent Chair

In July 2018 HM Government published ‘Working Together 2018’, outlining how the new child safeguarding arrangements should operate. It also published the transitional guidance on how these new arrangements are due to come into effect.

Over the past two years the organisations involved in child safeguarding across Cornwall and the Isles of Scilly have been working towards the principles of the ‘Wood’ report and are therefore in a good position from which to implement the full guidance.

The guidance has provided additional clarity regarding reporting around ‘effectiveness’ and has provided the focus for this year’s Our Safeguarding Children Partnership for Cornwall and the Isles of Scilly (OSCP) annual report. Although the arrangements have come into effect after the period being reported upon, the report will follow the requirements of Working Together 2018 by:

- Reporting what the partners have already done as a result of the new arrangements, including child safeguarding practice reviews
- Outlining how effective the arrangements have been in practice
- Providing evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers
- Producing analysis on areas where there has been little or no evidence of progress on agreed priorities

This initial independent overview will outline the key information which will be expanded upon later in the report.

2018/19 has been another positive year for child safeguarding across Cornwall and the Isles of Scilly, with further improvements observed across all organisations and all agreed priorities.

No serious case reviews or child safeguarding practice reviews have been published during 2018/19. One local child safeguarding practice review (LCSPR) has been commissioned, but is yet to be completed.

The partnership itself is in a healthy position with strong engagement from senior leaders in all the key organisations and close working relationships between operational staff. This can be seen through the membership of, and participation within, the board and sub-groups of OSCP, and those actually working to help and support our families.
The approach to learning is positive with a strong commitment across all organisations and an energetic OSCP Learning Group. Our operational staff are provided with good-quality single and multi-agency training and, in particular, there is a comprehensive partnership curriculum that focuses on our priorities. The quality of the learning sessions and seminars is high and the feedback demonstrates that staff value them greatly.

The quality assurance processes are robust, using information derived from inspectorate reports, local scrutiny processes and performance data to create a multi-layered viewpoint. This has enabled the partnership to have an accurate and thorough insight into all of the key organisations and the priority subjects of the partnership. Through this the partnership has identified improvements in practice and performance across all organisation and all priorities. It has identified where further improvements can be made and these are subject of established and effective monitoring processes.

These processes ensure all organisations strive for and achieve improvements in both their single-agency and multi-agency child safeguarding efforts.

It is vital that we test the local quality assurance processes and the Joint Targeted Area Inspection into child sexual abuse in the family environment was able to provide such an external assessment during October 2018. The inspection - completed by Ofsted, the Care Quality Commission, Her Majesty’s Inspectorate of Constabulary, Fire and Rescue Services and Her Majesty’s Inspectorate of Probation - reported very favourably on our responses within Cornwall and verified many of the findings that had been made through our own processes. That said, the inspection did reveal a number of areas where we can improve and work is under way to make those improvements.

The partnership has a number of key strategic achievements over 2018/19.

- The re-development of a child sexual abuse (CSA) strategy has already made a significant difference. A comprehensive, contemporaneous approach has raised the profile of CSA, has re-vitalised working practices and has stimulated new ideas on how to work with victims and perpetrators. There has been a greater recognition of CSA, more effective support of victims and improved awareness amongst staff working with children.

- The focus on child sexual exploitation has evolved to look at all forms of child exploitation and this has raised the profile across our area. Operational staff are more aware of the different forms of exploitation, referring in more cases and demonstrating that they are more proficient at working with the victims they encounter. The multi-agency response is comprehensive, looks at a wide range of options and is accountable.

- The OSCP has developed stronger links with Safer Cornwall, the local community safety partnership, and this has had a positive effect on domestic abuse, with a new
integrated service, introduced in July 2018, more actively considering the needs of children and families and responding accordingly.

- The support for children with emotional health and mental health needs has improved overall, although individual concerns have been raised. OSCP has applied pressure to commissioners and lead organisations throughout the year and has promoted the safeguarding needs of the children being supported.
- There has been an improvement in the participation of Adult Mental Health Services within child safeguarding. A number of ‘champions’ have been trained with the service, processes help identify adult service users who are connected with children with help and support needs and staff are generally more aware. The number of referrals and the involvement of staff within child safeguarding work have increased during the year within further improvements planned.
- Children have increasingly been heard and responded to. Consistently through the quality assurance processes, excellent examples of meaningful work with children have been observed. Children have been able to contribute to safeguarding initiatives and have had many opportunities to speak at seminars, conferences and to address senior leaders. There is a positive approach to children and they are central to all that is done.

Although this overview is largely positive, there remain a number of areas where improvements are needed and the recommendations from an ongoing review are awaited.

Our approach to childhood neglect has not developed as effectively as was hoped, with the consequence that a number of children are not being supported as well as is intended. This has been identified through our scrutiny processes and action is already underway to rectify this situation.

Although the ‘voice of children’ is gathered effectively by most of the organisations in Cornwall and the Isles of Scilly, OSCP is not actively gathering that voice itself. It is a gap that has persisted for a number of years and has not yet been addressed. A dedicated member of staff is to be recruited and it is anticipated that during the next twelve months this situation will be remedied and OSCP will have a clear line of communication with children across the area.

Finally, the commitment and energy demonstrated by staff from across all organisations has been astonishing and humbling. At a time when there are huge amounts of pressure and many competing demands staff have provided high quality responses, continued to improve and adopted new areas of work, e.g. child exploitation. The children and young people who need help and support across Cornwall and the Isles of Scilly could not wish for better.

John Clements, Independent Chair 20 June 2019
2. Statutory, Legislative and Financial Context

2.1. Legislative Context

Our Safeguarding Children Partnership (OSCP) is the key statutory body overseeing multi-agency child safeguarding arrangements across Cornwall and the Isles of Scilly. During 2018/19 it was governed by the statutory guidance in *Working Together to Safeguard Children 2015/18* and the *Local Safeguarding Children Board (LSCB) Regulations 2006*. OSCP comprises of senior leaders from a range of different organisations.

2.2. Objectives

The Partnership had two basic objectives defined within the Children Act 2004:
- to co-ordinate the child safeguarding work of agencies, and
- to ensure that this work is effective.

2.3. Developments

Since 2017, OSCP has been working towards the principles outlined within HM Government’s response to the Wood Report, published in May 2016.

In July 2018 HM Government published the new statutory guidance, ‘Working Together 2018’, outlining the child safeguarding arrangements that should be provided in each local authority across England. OSCP reviewed its existing arrangements and felt, in the main, it was compliant with the measures outlined. The review gave OSCP the opportunity to assess how it operates, strengthen a number of areas of activity and publicise what it does. It is now confident that it fully compliant with the guidance.

By the time of this report being released, OSCP will have published its arrangements, notified the Department of Education and, as a result, its local safeguarding children board will have ceased to exist.

The purpose of the local arrangements is to support and enable local organisations and agencies to work together in a system where:

Children are safeguarded and their welfare promoted

- Partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children
- Organisations and agencies challenge appropriately and hold one another to account effectively
- There is early identification and analysis of new safeguarding issues and emerging threats
- Learning is promoted and embedded in a way local services for children and families can become more reflective and implement changes to practice
- Information is shared effectively to facilitate more accurate and timely decision making for children and families
2.4. Scrutiny Mechanisms

A key emphasis within the arrangements are the mechanisms that enable OSCP to scrutinise how effectively partner agencies are working together to safeguard children. The different processes are:

- An Independent OSCP Chair
- OSCP sub groups, including a Quality Assurance and Performance Sub-Group and Quality Assurance and Scrutiny Panels, to review performance against key quality assurance questions
- Section 11 procedure that reflects OSCP priorities
- Multi-agency performance data
- Single and multi-agency case auditing
- Independent multi-agency case file audits
- Review of inspectorate reports
- Serious case reviews and LCSPRs
- Child death overview arrangements

2.5. Financial Arrangements

Partner agencies continued to contribute to Our Safeguarding Children Partnership’s budget for 2018/19. Partner agencies provided funding as follows:

<table>
<thead>
<tr>
<th>Partners</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornwall Council</td>
<td>£158,000</td>
</tr>
<tr>
<td>Council of the Isles of Scilly</td>
<td>£ 4,800</td>
</tr>
<tr>
<td>National Probation Service</td>
<td>£ 1,274</td>
</tr>
<tr>
<td>NHS Kernow Clinical Commissioning Group</td>
<td>£ 69,652</td>
</tr>
<tr>
<td>Police and Crime Commissioner</td>
<td>£ 24,361</td>
</tr>
<tr>
<td>CAFCASS</td>
<td>£  550</td>
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<tr>
<td>Dorset, Devon and Cornwall CRC</td>
<td>£ 1,500</td>
</tr>
<tr>
<td><strong>Total Partner Contributions</strong></td>
<td><strong>£261,007</strong></td>
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</tbody>
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The total spending in 2018/19 totalled £224,123. This income ensured that the overall costs of running OSCP were met. Due to an under-spend on planned learning costs and a vacancy not being filled for longer than was anticipated an under-spend of £36,884 has resulted which has been transferred to the Safeguarding Children Partnership Reserve.
3. Council of the Isles of Scilly

2018-19 felt really positive and evidence from audit, external challenge and service user feedback suggests that we remain on an ongoing trajectory of ambitious and continuous improvement to develop some really strong services on the islands for children and families. One of the great benefits of working in a small professional community is that we both have to, and want to, work together. We have a really strong partnership in place on the islands but we do worry that that level of joint working, as well as our geographical isolation, might blind us to areas of weakness. Consensus can sometimes be a dangerous thing! Therefore the multi-agency partnership on the Isles of Scilly continues to prioritise robust external oversight of its arrangements for children in need of help and protection. To that end, a peer review by Essex Council was commissioned in February 2019 to check how we are developing services. Here are some of the key highlights of what they found:

- ‘There is strong, proactive and forward-looking leadership of the service. There are current plans to create a family hub model and to continue to work with other agencies to support children and families at the lowest tier possible.

- Review of case notes and direct work suggests that the service provides a good quality of social work practice. Children are seen frequently and their views are captured throughout, as well in formal feedback sheets.

- Direct work with children is evident and the service uses a range of tools and techniques including Video Interactive Guidance and a range of scaling and illustrative tools.

- Case records contain evidence of good management oversight with child-focused and reflective supervision records on file.

- A good model of three-monthly case review, involving the DCS and Children’s Social Care staff, provides an effective mechanism for reviewing the purpose and plans for all open cases.

- The service has an ability to critically reflect and review safety plans for children. Discussions exploring multiple options for intervention on one particular case demonstrated an informed and mature ability to reflect on risk, safety and long-term outcomes.

- There is a strong emphasis upon engagement with the community and agencies and organisations operating on the Island. Activity to raise awareness of Child Sexual Exploitation (CSE) has involved engagement with those working in hospitality, transport, housing, environmental health and the airport. The “Ask for Angela” scheme is now in place across the island. This work demonstrates that the service recognises and addresses the role that all sectors in the community have towards promoting children and young people’s safety.
• There is strong delivery of effective early intervention and early help to children and families. The service encompasses social care casework as well as early help support to children and families. Cases can, and do, step up or down between these tiers. The ability to offer support when issues and concerns do not meet the threshold for social care is undoubtedly valued and effective.

• There is good interagency communication and effective multi-agency working. Early help is delivered through the multi-agency network and this is an effective and user-friendly way of delivering support to children and their families.

• There are good relationships and structural connections with OSCP. The DCS is a member of the board and the head of service is a member of the QA and Learning groups. This is one of the ways in which the service on the island keeps informed and engaged with service developments and practise issues.

• The service delivers a carers group to support children who having caring responsibility toward a parent or sibling.

• The use of a common methodology for working with children and families. ‘Signs of Safety’ is embedded across agencies and is used at all tiers of engagement with children and families. There is widespread use of Signs of Safety as a framework for working with families and retaining a focus on what matters for children.

• The service has delivered a successful programme of training and awareness of domestic violence and coercive control. This has led to a rise in referrals and is a good example of the pro-active work that is undertaken to keep children safe on the islands.

• The service is delivering a programme of CSE activity including a schools based survey, and an awareness raising programme via local media.

• Agency partners described the service as being highly connected to the community and that there has been a significant improvement in the community’s perception and engagement with children’s social care.

Essex also noted the great working relationships with colleagues in Cornwall Council as a further means of ensuring ongoing challenge to our professional community.

The Isles of Scilly have also received a positive multi-agency Quality Assurance and Scrutiny Panel report – the third one to date. This was again very encouraging, with even further improvements noted, especially around emotional health. The Independent Chair continues to engage with the Children’s Trust Board on the islands as well as conducting regular case audits. The inclusion and consideration of the needs of children on the Isles of Scilly at Our Safeguarding Children’s Partnership has made a significant step change.
4. Reports from Key Partners

4.1. Health - NHS Kernow

**Successes:**

During 2018-19, the CCG continued its commitment to strengthening safeguarding with the appointment of the Designated Nurse for child safeguarding (DNCS) in April 2018 and Designated Nurse Looked After Children (DNLAC) in June 2018. The DNLAC post was increased from 0.4 to full time post. The CCG also successfully recruited to the role of Named GP, who commenced in post in November 2018.

**Assurance Process:**

The CCG Children’s Safeguarding Team developed a children’s safeguarding score card, which has been incorporated into the safeguarding commissioning standards. This has been negotiated into provider contracts and will become “live” from April 2019 with a phased approach to full implementation planned, as some providers will need to develop electronic systems to enable full reporting. Providers are keen to make this reporting system work as it provides them with additional safeguarding assurance. This tool will enable the CCG safeguarding team and commissioners to have greater understanding of safeguarding compliance across the health economy.

**Governance:**

2018-19 has seen CCG organisational change, as the Safeguarding Team has merged with the Quality Team. This has improved and streamlined the governance process through the Quality and Performance Committee, which reports to the Governing Body. The Serious Incident reporting system, where providers report to the CCG, includes a safeguarding oversight, with joint challenge from quality, safety and safeguarding as well as planning improvement plans and disseminating learning across the health economy. These arrangements are becoming increasingly sophisticated and embedded into a systematised process.

Other areas of improvement will need to be agreed, such as streamlined data collection and reporting to NHSE. Work is underway to ensure safeguarding arrangements are appropriately embedded in the new integrated care system arrangements for Cornwall and the Isles of Scilly.

**Contract development and monitoring:**

The Designated Nurses continue to be actively involved in contracting arrangements, such as the transfer of the health visiting and school health provision to Cornwall Council. The Safeguarding Team have been part of the development of the Service Level Agreement and contract meetings, to facilitate safeguarding continuity and securing the Named Nurse function. The DNCS was involved in writing the job description and interview process.
Inspections:

Between 8 October 2018 and 12 October 2018, Ofsted, the Care Quality Commission (CQC), HM Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and HMI Probation (HMI Probation) undertook a Joint Targeted Area Inspection (JTAI) of the multi-agency response to sexual abuse in the family in Cornwall. This inspection included a ‘deep dive’ focus on the response to sexual abuse in the family environment. On the whole, the Partnership were found to be committed to strong partnership working with reference being made to the multi-agency audits carried out in January 2018, which identified areas for development in practice. For health, this led to improvements in relation to the more effective use of non-forensic medical examinations for children who have made allegations of sexual abuse. However, further improvements for health providers were recommended, such as to improve GP’s participation in multi-agency meetings and conferences.

The JTAI corresponded with the opening of the South West Sector Sexual Assault Referral Centre (SARC); although this added increased challenge as new procedures were implemented, it has provided an opportunity for external scrutiny.

CCG Scrutiny:

The CCG were Quality Assured and Scrutinised by OSCP in May 2018; there were a number of recommendations including to develop the safeguarding scorecard, which has been finalised, with agreed summary data for quarterly sharing with the partnership group.

Multi-agency Referral Unit (MARU) Review:

During 2018-19, the DNCS and Designated Dr Children’s Safeguarding reviewed the nursing contribution to the MARU, with comparison to Cornwall’s statistical neighbours. The report, with recommendations, is currently being considered by the OSCP Board.

Looked After Children:

Looked After Children’s (LAC) services have been maintained with the appointment of a Named Looked After Children Nurse responsible for LAC leadership in the provider organisation and the appointment to vacancies for Specialist Nursing Posts. The introduction of Level 3 LAC Awareness training for health professionals into the Safeguarding Training programme has been well attended and positively evaluated.

Liaison with General Practitioners (GPs):

With the appointment of the Named GP there has been increased liaison with GPs and improving communication with general practice. Visits to practices have enabled discussions and improved information sharing about best practice as well as identifying practice safeguarding issues.
A considerable amount of work has been taking place, including discussion and liaison with the Local Medical Service, to establish how CARA’s\(^1\) could be usefully shared with practices.

**Multi-Agency Child Exploitation Panel (MACE):**

During 2018-19 Mace has become an established, yet continually evolving, multi-agency panel. The Designated Nurses have established a process which has gradually increased the number of participating health professionals sharing information and feeding back relevant action for practitioners. Participating health services include, Royal Cornwall Hospital, maternity, paediatrics and Accident and Emergency settings, Sexual Health Hub, Cornwall Foundation Trust, adult mental health Child Adolescent Mental Health, Minor Injury Services, Brook Services, Looked After Children, Public Health Nursing and others. The Designated Nurses collate information from the GP, University Hospitals Plymouth and North Devon Hospitals when required and make strategic clinical decisions when other health information advises the protection of children; for example, contact with the National Child Exploitation Agency has been elicited. Actions are shared with appropriate professionals. Common themes are emerging informing the partnership actions.

**Priorities:**

Safeguarding priorities for the CCG continue to reflect the partnership priorities including Neglect, for which the CCG led and completed the multiagency audit for the partnership. Child Sexual Exploitation, task and finish groups and Child Exploitation have included Designate leadership.

**Sharing safeguarding messages:**

This year the safeguarding team have delivered safeguarding updates to the county wide pharmacy meeting and key General Practices.

NHSE safeguarding research and information is shared across the health economy leads via the Safeguarding Children’s Partnership Forum, which includes all services involved in the MACE Panel (as noted above) as well as Dental, Outlook South West, Optometry - the Forum continues to grow.

**The Named Nurse:**

The Named Nurse Meeting has been re-established, to share challenges and find solutions, share audits and outcomes including JTAI and CQC actions. These may include Escalation and issues for which Designate leadership is required, such as an agreement to use a standard chronology format across the health system which reflects the chronolator.

\(^1\) Child At Risk Alerts which are generated by the police following attendance at an incident
Child Adolescent Mental Health Service (CAMHS):

CAMHS continues to be a challenge with considerable designated attention being required, this has led to the development of a multi-agency partners Protocol for CAMHS Crisis Prevention & Response for Children and Young People in association with the Children’s Commissioner. This multi-agency protocol was agreed and ratified by the One Vision Board.

This provides a flavour of some of the health work during 2018-19. As the CCG Safeguarding and Quality team become established, it is anticipated that Safeguarding will be increasingly integrated; internally in the CCG as well as continuing to strengthen adult and children’s partnerships.

4.2. Local Authority

2018/19 was a crucial year for Cornwall Council in continuing its progress as a top performing authority with achievements recognised regionally and nationally. The Joint Targeted Area Inspection (JTAI) gave us key learning points as an agency and for our partnership, but recognised the major strengths of the local authority as it works with partners in this area. Demand for Children Services, particularly in terms of special educational needs and social care, is increasing markedly both in Cornwall and nationally and puts significant pressure on budgets. However, the creation of the new Council Children Services, ‘Together for Families’ which includes Public Health Nursing, has been recognised as an innovative and exciting development. Research tells us that early help and integration are the most effective ways to approach children services and Cornwall is one of the leading authorities to develop this approach which has enabled us to work to provide early help to vulnerable children. There is still much to do and resources remain a key issue but we are confident our integration journey has started and goes beyond mere rhetoric.

More specifically, our achievements and developments for 2018/19 include the following:

• The Directorate has jointly led the transfer of Public Health Nursing into the Council, joining together the Council’s education, early years, community health, early help and social care services together in an integrated Children’s Service Directorate under a distinct identity.

• The Directorate is jointly leading the implementation of the ‘One Vision’ Partnership Plan for children, young people and their families, which establishes the basis for the development of an integrated commissioning strategy.

• The Directorate has jointly the led the development of a Cornwall-wide model for integrated place-based children’s services, supported by Local Development Plans developed by multi-disciplinary groups that are based upon extensive engagement with residents, service users, staff and partners.
Senior Managers and Leaders in Children Social Care have worked with the DCS as a DfE appointed Commissioner, to undertake an in-depth review of arrangements, culture and performance of another local authority in intervention by the Department for Education due to a systemic failure of its children’s social care services to meet the required standards.

The Directorate has continued to support a number of other local authorities, regionally and nationally to improve the effectiveness of their children’s social care services.

‘Edge of care’ (Gweres tus Yowynk) work has developed further by investing in 3 teams concentrating on Primary age children. This is already demonstrating its contribution to keeping children safe and well in their community.

Further strengthened management oversight and grip on the quality of practice has, through investigation and taking appropriate action, enabled early identification of shortfalls; this has, in turn, enabled core safeguarding practice to be protected despite increased demand, resulting in an overall raising of the quality and effectiveness of service provision.

Areas of outstanding and good performance have been maintained and further improved performance achieved in areas identified for development in the Ofsted inspection, notably child sexual exploitation and 16-17 year olds presenting as homeless.

Leadership has been provided to raise awareness, understanding and developing a more effective response to child sexual abuse in the family environment and working with vulnerable adolescents.

An independent national review of Special Educational Needs and Disability (SEND) identified Cornwall Council as being the 145th lowest funded out of 149 local authorities, but the 5th best performer by a wide range of criteria.

The number of disabled children and their families benefiting from an innovative approach to identifying need, providing information, advice and guidance at an early stage, based on family strengths, greater self-determination and self-help through direct payments and personal budgets has further increased.

Further strengthening and embedding of ‘Signs of Safety’ across the partnership as the core multi-agency approach to working with children, young people and their families to understand and manage needs, risks and family strengths where children are in need of help and protection.

Further progress has been made in developing and embedding the Family Partnership Model as the strengths-based, collaborative approach for working with families.

Further investment in the core learning and development curriculum for frontline social care practitioners, as the foundation for high quality practice; the offer has been
extended to early help practitioners and key partners, including practitioners working in commissioned services.

- Holding a Children’s Social Work Conference and Aiming Higher for Disabled Children Conference for parents and carers, practitioners and managers, as well as a themed conference and two learning from experience workshops on child sexual abuse in the family environment.

- Managing the increased demand for care placements and containing an increase in the children in care population through effective prevention and supporting the contribution of wider family and friends as an alternative to care, in line with the wishes and feelings of children and young people – including re-unification.

- Maintaining high performance in supporting children to achieve permanence through adoption and special guardianship. Maintaining top performance in adoption standards overall.

- Maintaining the number and range of case audits as the basis for learning from practice, including work with children who go missing, children at risk of sexual exploitation/abuse and children in care who are subject to three or more placement moves.

- Providing systems leadership in developing and contributing to Our Safeguarding Children Partnership’s Quality Assurance and Scrutiny Panel process. Contributing regularly to the multi-agency Quality Assurance and Scrutiny Panel.

- Undertaking further developments of the integrated children's system, involving practitioners in further efforts to reduce bureaucracy and streamline recording. Integrated recording by Public Health nurses into our Integrated Children’s System (MOSAIC), thereby improving safeguarding.

These are just some examples of the intensive work that staff in Children’s Services in Cornwall Council have undertaken during 2018/19. It must be emphasised that this work is always undertaken with the needs and wishes of the child, in the context of the family’s situation, at the centre.

4.3. Devon and Cornwall Police

As a statutory partner, Devon and Cornwall police are key in helping Our Safeguarding Children Partnership deliver their priorities. As well as covering the Cornwall & Isles of Scilly partnership, the police also look to service Torbay, Plymouth and the rest of Devon. In order to do this, Executive responsibility sits with the Assistant Chief Constable for Crime and Vulnerability and delegated authority is given to each of the four Basic Command Unit (BCU)
Chief Superintendents who then directly service the partnerships for which they are responsible.

For Cornwall, the police ensure that local policing resources impact the work of the partnership as well as specialist resources from the Public Protection Unit (PPU). This ensures that enforcement and safeguarding protection is also supported by prevention and education, and the BCU has a business plan which aims to focus on these aspects as part of its daily delivery.

A police superintendent is also the chair of the Missing and Exploitation group and police inspectors from both the east and west of the county, coordinate activity from this group across all policing sectors. This is further supported by a joint protocol between Children and Family Services and Devon and Cornwall Police, which seeks to drive disruption and prevention of exploitation within the county by ensuring that the full range of criminal and civil orders and injunctions are being considered and utilised. As a result, this year, a large number of civil orders have been issued, such as Child Abduction Warning Notices, Sexual Risk Orders and referrals to the National Referral Mechanism to inform instances of Modern day slavery.

In order to make it much easier for partners to submit intelligence relating to exploitation, Devon and Cornwall Police have recently launched the Partnership Intelligence Reporting form web based, and it can be accessed at this address: partner agency information sharing form. Submissions have been steadily increasing since its introduction.

To further support the development of intelligence and disruption of offending, the Police within Cornwall and IOS have created a dedicated team of officers – the Proactive Disruption Team (PDT). This team has responsibility for targeting County lines organised crime but also has a specialist remit around missing and exploitation of all ages, but especially children.

**An example of work being conducted is Operation Ligament.** The investigation is focussed on County Lines Drug supply with associated Modern Day Slavery & Human Trafficking offences, involving the exploitation of children. The main perpetrators of the criminality are resident in North London. The criminal networks were well established within mid Cornwall and were ‘cuckooing’ addresses from which to facilitate the supply of controlled drugs. Rather than adopting a more traditional approach of prosecuting all offenders for identified offences, the team looked at the issue in a more rounded way and concluded that the young people, whilst clearly selling controlled drugs, were actually the victims of criminal exploitation. These young people were referred into the national referral mechanism and were engaged with social care from their respective areas. Despite initial challenges, there has been good engagement with partners and a comprehensive multi-agency safeguarding plan is in place. 10 offenders are due to appear in court charged with supplying class A drugs.
and modern day slavery offences. All the children concerned have been successfully safeguarded.

The force have a single safeguarding process and the Vulnerability Screening Tool (ViST) is the tool that front line officers use to assess threat, harm and risk against children. In 2018, through this process, just under 5500 Child at Risk Alerts were created within Cornwall. This shows that the process is being used robustly to keep children safe. Each alert is assessed by the Central Safeguarding team (CST) and where appropriate, information is shared with safeguarding partners. This could be conducted with an individual agency or via the Multi-Agency Referral Unit (MARU), especially for higher risk concerns. Another process which the CST help manage is the sharing of information to schools about children who have been present in a household where domestic abuse has occurred – this is Operation Encompass.

Bodmin police station was proud to host a Royal Visit earlier this year where the scheme and its founders, Elisabeth and David Carney-Haworth, were formally recognised.

During the last year, there has been significant emphasis on training of police officers within Cornwall to ensure that their knowledge and skills-base is kept up to date. All Neighbourhood officers have been given inputs on understanding and identifying vulnerability, risk assessments, looking beyond the obvious and professional curiosity, legal guidance and powers, child neglect, understanding the mind-set of the victim, Adverse Childhood Experiences’ and multi-agency processes. An awareness programme on the ‘Voice of the Child’ has also been provided.

All trainee detectives are now required to spend a minimum of 3 months within the Local Safeguarding Investigation Teams (who are specialists in child and professional abuse). New recruits also spend time within the Central Safeguarding Teams (CSTs) and spend a day at the MARU, to better understand and improve confidence in multi-agency processes and information sharing.

Devon and Cornwall Police continue to invest in youth engagement. The Youth Intervention Officers (YIOs) provide early intervention measures in partnership with the Youth Offending Service (YOS). They also provide awareness sessions and mentoring in schools and seek the opinions of young people about their experiences with the police force. Moving forward, the YIOs will work more closely within the missing person agenda and their numbers have been increased and responsibilities changed to become Youth and Missing Officers (YMO). The YMO will help to target repeat missing episodes and safeguard high risk or specialist cases – such as unaccompanied asylum seekers – as well as continue with the engagement and mentoring already offered.

Operation Muskroot, is an example of the work completed this year. The operation identified two female teenagers, 16 and 17yrs old, who had been contacted by unknown males and were travelling to meet them for sex. The teenagers would travel across the
country and leave without telling anyone where they would be going and so were often reported as missing. Two younger siblings were starting to mimic their behaviours. These circumstances show the complexity of cases such as this, where young people do not engage with agencies and perpetrators are unknown. Also, this highlights the difficulties for frontline staff, where victims are also perpetrators and the appropriate courses of action available to them are linked to their knowledge and understanding of CSE. Through the development of linked intelligence, strong partnership intervention and enforcement where needed, the safeguarding of all concerned has been managed successfully.

Looking forward, Devon and Cornwall police are intending to tackle some concerns raised by both HMICFRS and the Joint Targeted Area Inspection (JTAI) regarding investigative delays. To address these issues the police have set up an Investigative Standards Board to oversee improvements. Key areas of work include: focus on the first opportunities of evidence gathering; further engagement with Criminal Prosecution Service (CPS) to improve delays in decision making; addressing delays in examination of digital media by forensic providers; clearer direction in relation to investigative updates; the trialling of risk based workload reviews across the PPU.

The Specialist Child Abuse Training Programme will also be reviewed this year, to ensure it is current and includes recent learning from Serious Case Reviews and College of Policing national improvements.

A Child Centred Policing Strategy is currently under consultation for Devon & Cornwall Police and will seek to focus future plans and give clear strategic direction. Also to help deal with demand, the CST processes are being reviewed to help streamline and improve efficiency and effectiveness.

Devon and Cornwall police’s involvement within the OSCP over the last 12 months has been scrutinised by both independent bodies as well as the OSCP’s own quality assurance. Whilst the force recognises and strives to improve its processes for some of the higher demand issues, reports do consistently indicate the strength of teamwork and leadership, specialist knowledge and commitment to keeping young people safe –especially in the cases where threat of harm is considered high. We look forward to seeing this work grow over the next 12 months, detecting and preventing harm and keeping the vulnerable safe.
5. Quality Assurance and Performance Framework

5.1. Structure

One of the key objectives of Local Safeguarding Children Boards was:

‘To ensure the effectiveness of what is done, by each person or body represented on the Board, for the purposes of safeguarding and promoting the welfare of children in the area’.

In monitoring this objective the LSCB and OSCP has, over the last three years, used the following means:

- Independent case file audits
- Multi-agency case file audits
- Section 11 self-assessment audits
- Quality Assurance and Scrutiny Panels
- Section 175/157 self-assessments of schools
- Review of inspectorate reports, e.g. Ofsted, Her Majesty’s Inspectorate of Constabulary, Fire and Rescue Services, Care Quality Commission
- Review of reports provided regarding the Local Authority Designated Officer (LADO) role

The LADO report is elsewhere in this annual report. The following sections will outline OSCP’s findings from the other measures.

5.2. Independent Case File Audit

OSCP did not conduct an independent case file audit during 2018/19. It was felt that, as it had completed two detailed audits in previous years and there was a wealth of information from other scrutiny processes, it was unnecessary to complete one for this year.

5.3. Multi-agency case file audits

OSCP completes multi-agency case audits as part of its own quality assurance processes. Quarterly audits have been conducted into child sexual exploitation and emotional wellbeing and mental health. The audits have revealed effective multi-agency practice across the topics covered as well as identifying a number of issues where further work has been necessary, e.g. reviewing education provision for out of area care placements. It is hoped that the use of multi-agency case audits will be extended during 2019/20.

5.4. Section 11 Self-Assessment Audit

The Section 11 audit process for 2018/19 focused again on those organisations not covered by the more exacting Quality Assurance and Scrutiny Panel process. As a result of the feedback received last year and the observations of members of the review panel, the self-assessment was changed.
The self-assessment requested the organisations and departments reflected upon its performance in the following areas:

- Adherence to OSCP’s Principles of Safeguarding
- Adverse childhood experiences (ACEs)
- Neglect
- Child sexual exploitation (CSE)
- Domestic abuse
- Child sexual abuse within the family environment
- Emotional wellbeing and mental health
- Voice of the child
- Oversight of safeguarding
- Training

The process was completed by the following organisations and departments:

- Cornwall Council - Customer and Support Services Directorate
- Cornwall Council - Economic Growth and Development Directorate
- Cornwall Council – Neighbourhoods
- Dorset, Devon and Cornwall Community Rehabilitation Company (CRC)
- Group of Companies – Cornwall Housing Limited, Cornwall Development Company, CORMAC and Cornwall Airport Limited
- National Probation Service (NPS)
- Careers South West Limited

A review of the submitted documents was undertaken by a multi-agency group of safeguarding professionals.

Overall, the new self-assessment form increased the amount of reflection undertaken and it was clear that those completing it had been encouraged to consider issues in greater depth. There have been some complaints over the difficulty in completing the form but the actual quality of submissions has improved.

Child safeguarding remains a priority for all organisations and departments and there is a significant commitment to providing appropriate responses. In particular the non-safeguarding directorates within Cornwall Council have demonstrated a commitment and desire to safeguard beyond what is expected. The continued use of ‘safeguarding advocates’ creates a positive environment in which safeguarding is routinely considered and discussed. This is regarded as good practice.

A key message from the self-assessments is that some organisations and departments are not as connected to OSCP as was intended and more needs to be done to improve communication, stimulate change and provide support. This will be acted upon during 2019/20.
Organisations and departments have become much more aware of the concept of ACEs and this is provoking discussions over how the information can be gathered and used. For many these discussions are very much in their infancy but there are signs of changes in culture of staff considering that ACEs could be behind the behaviours of many people.

Neglect is regarded as a priority and there is a clear understanding of the harm that it causes. Many organisations and departments are not sure how they can contribute when they are not actively involved with families and it is clear that further discussions with OSCP may encourage different ways of thinking. This is very much pushing on the limits of child safeguarding but there is a commitment to continually advance.

Child sexual exploitation is recognised as a priority by all and there are good levels of awareness, knowledge on who to speak with and how to report concerns. Staff are increasingly aware of child exploitation in other areas such as labour and drug supply.

Domestic abuse is a priority for all organisations and the self-assessments demonstrate an awareness of how it affects children. The organisations and departments outline a number of initiatives to support families and children, which is encouraging. Those who do not have direct contact with families have continued to focus on supporting their own members of staff, which in turn is helping children.

Child sexual abuse is another difficult topic for many organisations and departments as they do not have contact with families. For those that do have contact there is good knowledge of the new strategy and the improvements being sought.

The response to emotional wellbeing and mental health continues to improve with a number of the ideas put forward last year now a reality, e.g. mentoring, placements, better environments. The self-assessment has been useful in identifying what else can be done, especially in relation to supporting the trauma-informed approach adopted across Cornwall.

The voice of the child has come out much more positively this year with plenty of good examples of children being involved strategically and operationally, e.g. domestic abuse service consultation, home visits by the National Probation Service. There was clear improvement in respect of children being considered and their opinions valued.

The level of oversight across organisations and departments is good, with all organisations and departments having processes that review performance.

The Section 11 process was extremely worthwhile and a process that combines self-reflection with an opportunity for OSCP to review its relationships with organisations not at the forefront of its routine activity. The process this year has led to a number of actions to improve communication and generate new ideas.

5.5. Quality Assurance and Scrutiny (QA&S) Panel

The methodology for the panel, as outlined in previous years, has largely remained the same. It has changed slightly in that to complement operational work across the area more
of the questions have been based on ‘Signs of Safety’. This has been particularly so within the multi-agency themed panels, where the use of ‘Signs of Safety’ has proven to be very effective.

In addition, organisations appearing before the panels have been able to present their evidence in an attempt to improve the quality of the discussions. The ability of panel members to ask challenging questions has not been affected.

Over the course of the business year the following organisations were subject to the full QA&S Panel process.

- Cornwall Partnership NHE Foundation Trust (CFT)
- NHS Kernow Clinical Commissioning Group (CCG)
- Devon and Cornwall Police
- Royal Cornwall Hospitals NHS Trust (RCHT)
- Cornwall Council – Children and Family Services (CFS)
- Cornwall Council – Education and Early Years
- Isles of Scilly (multi-agency panel)

In addition the following themed panels were undertaken:

- Neglect

For the second year running the panels assessed that all the individual organisations subject of scrutiny during the year had improved their overall child safeguarding performance.

All organisations were found to be effective and some were assessed as high performing. There were no significant concerns raised during the panels and although a number of recommendations were identified these, in the main, related to making further improvements as opposed to addressing key gaps.

The Isles of Scilly is always a special case in that its size makes it viable to complete a true multi-agency review. The panel members came to the following conclusions:

- The partnership staff working on the Isles of Scilly continue to provide a high quality service to support children in need of safeguarding. Many of the aspects reported as good or outstanding in previous years have been maintained and a number of others have improved. The panel members were impressed by the level of service provided.
- Multi-agency working is actively practised on the islands with close, effective relationships enabling good communication, efficient information sharing and good outcomes for children and their families. The close working arrangements enable improvements to be achieved quickly and with minimal effort. There is a focus on early intervention, with all agencies recognising the value of being involved as early as possible; activity is reflecting this intention too.
- Children remain a precious part of the community and the efforts to safeguard them are focused on them. Children have a strong voice on the islands and it is apparent that what they say is listened to.
In relation to the topics examined at the panels the observations are as follows:

**Child Exploitation (CSE)**

The response to child exploitation has changed significantly over the past twelve months, with the initial focus on child sexual exploitation being expanded to cover all forms. The most significant and obvious of these is child criminal exploitation and it has been encouraging to note the willingness of organisations and staff to recognise and respond to it. This has been supported by a general understanding of exploitation and established communication channels and referral processes have ensured that concerns have been managed effectively. The partnership working in this area of activity is particularly strong and there is active strategic and operational working. Case auditing, an identified gap last year, has been addressed through multi-agency and single agency case audits. Performance management has developed with a partnership outcomes framework, supported by Safer Cornwall, providing a good overview of prevalence, activity and outcomes. There is work still to do but this is a positive indication of effective working in this area. The focus on this area of work has not diminished and a highly motivated sub-group is driving further developments.

**Domestic Abuse**

Domestic abuse continues to be a priority across all organisations in Cornwall and the Isles of Scilly and significant resources are devoted to respond to the harm it causes to families and children. The focus on children and the harm they suffer from domestic abuse has continued to improve and a stronger relationship between OSCP and Safer Cornwall, the community safety partnership, has supported this development. A key difference has been a new contract commissioned by Safer Cornwall. This ensures domestic abuse cases are reviewed in the context of the impact on the whole family and has benefited those adversely affected by more thorough assessments, improved communication and better coordinated family-wide interventions. There is still a gap with understanding the outcomes being achieved for children. This is possible in some services but not so clear in others.

**Emotional Health and Wellbeing**

After a promising 2017/18 further improvements were achieved during 2018/19. Schools across Cornwall are focused on the ‘trauma informed’ approach and this is having benefits for the whole school population. The roll out of the multi-agency ‘Bloom’ approach to all areas of Cornwall is seen as a good step forward and one with much potential. This approach uses local resources to support children with emerging emotional wellbeing needs who require help, but not from a specialist mental health practitioner.

Further investment has been made in the recruitment of a number of clinical associate psychologists in the child and adolescent mental health services. More are to follow and this should provide speedier access to specialist mental health support. The number of children on the Isles of Scilly requiring specialist mental health support has remained at the lower levels achieved since local non-specialist staff were appointed. The general emotional wellbeing of children has improved.

**Child Sexual Abuse**

The response to CSA has improved during 2018/19, the improvements being underpinned by the introduction of a new strategy and work undertaken as a result. Training has been
provided across all organisations and levels of awareness have improved. The response to children identified is good, although increases in demand have put pressure on resources. Further work is planned regarding initial prevention and identification. The Joint Targeted Area Inspection (JTAI) conducted by Ofsted, Care Quality Commission (CQC), Her Majesty’s Inspectorate of Police, Fire and Rescue Services (HMICFRS) and Her Majesty’s Inspectorate of Probation (HMIP) during October 2018, focused on child sexual exploitation and reported favourably on the partnership’s collective response.

Feedback has been provided and OSCP has learnt that improvements have already been made. The Partnership will closely monitor this aspect over future quality assurance processes.

Neglect
This is an area where, although improvements in the response have continued, there are concerns over their pace. The strategy is still appropriate but not all organisations have adopted the recommended tools. There is a variation in the outcomes being achieved, particularly with some complex and deep seated problems. The focus remains strong as does the desire to improve. A revitalised approach is required.

5.6. Section 175/157 Self-Assessments of Schools

OSCP was supported by Cornwall Council’s Education and Early Years Service, who administrated and reviewed the self-assessment process for the whole of Cornwall and the Isles of Scilly. The format of the self-assessment was revised marginally in line with the changes outlined in last year’s report and the requests by OSCP for more information on specific areas e.g. ‘hate’ crime and ‘gangs’. The quality assurance process was commissioned by the Schools Effectiveness Team with feedback to schools given towards the end of the summer term and over the summer holidays 2018.

The outcome of the process gives Cornwall Council and OSCP an overview of the key strengths and areas of development in relation to schools across Cornwall and the Isles of Scilly.

The results from the 2018 review are as follows:

- There was a 100% return from all 31 secondary and 235 primary schools.
- Eight independent schools responded.
- The other education establishments that responded were:
  - Five Islands School (Isles of Scilly)
  - Two post-16 colleges
  - Six WAVE Alternative Provision Academies (APAs)
  - The Virtual School
  - Three ‘specialist’ schools
  - Three Bridges – Spectrum
  - Oak Tree
  - WAVE Hospital school
  - T-Plus
Every establishment was provided with feedback highlighting strengths, areas of improvement and recommendations.

The submissions were generally detailed in most sections, with some schools providing more robust action plans demonstrating they had used the self-assessment effectively to review safeguarding practice.

Concerns were highlighted in five primary schools due to a lack of information and content contained within the self-assessment. The concerns were referred to the school effectiveness team to pursue individually.

The majority of schools completed responses that indicated their safeguarding responses were appropriate and effective. One issue arising from the submissions from multi-academy trusts (MATs) is that of providing the same ‘corporate response’ across its schools to many questions. Hopefully this indicates a consistent level of good practice across MATs, but an amount of ‘copying and pasting’ of responses suggests some schools were not benefiting from going through the full assessment process, one of its real benefits.

All six of the APAs and the WAVE hospital school were reviewed by two senior officers within the Education and Early Years Service as a formal review of all alternative provision in Cornwall.

There was an increase in the number of schools using electronic recording systems such as ‘My Concern’ and CPOMS.

A higher number of schools reported they were supporting children who were transgender, particularly within primary schools. Many of the secondary schools reported support groups for LGBTQ students run by the Intercom Trust. The majority of schools reported needing more mental health support for children and training for staff. Local resources and guidance was provided and recommended.

A greater number of schools reported the effective use of the Resolution of Professional difference policy with most issues not going above Stage Two. There was extremely positive feedback on the role of multi-agency referral unit (MARU).

The findings of the review were presented to OSCP’s Board.

5.7. Review of Inspectorate Reports

As ever, it is very useful for OSCP to have the insight of the statutory inspectorates during the course of a business year. During 2018/19 it was fortunate to have the following inspectorates publish their relevant reports:

- CQC Quality inspection of Royal Cornwall Hospitals (RCHT) NHS Trust 26 – 27 June 2018 2017, published 20 September 2018
- HMICFRS, Devon and Cornwall Police Data Integrity Re-inspection, 1 August – 30 September 2017, published 10 April 2018.
- Joint Targeted Area Inspection (JTAI) of child sexual abuse within the family environment conducted by Ofsted, CQC, HMICFRS and HMIP 8 – 12 October 2018, published 23 November 2018.
In addition, CQC re-inspected Cornwall Partnership NHS Foundation Trust’s child and adolescent mental health services (CAMHS) during March 2019. The report was not available at the time of writing this report.

The CQC inspection of RCHT was a re-inspection following concerns raised during an earlier full inspection. Although no significant concerns were raised in respect of child safeguarding, the findings of the re-inspection were closely monitored. The re-inspection focused on areas identified as being of concern, with only one relating to a child safeguarding issue.

The overall finding was as follows:

*During this inspection we found the trust had made significant improvements against the requirements in the warning notice and had fully met the requirements in surgery, maternity and outpatients.*

In respect of child safeguarding the following finding was made in respect of the issue previously raised:

*Children’s safeguarding concerns had been resolved. An area had been designated as the children’s waiting area. Processes to book separate appointments for children were being followed.*

Within HMICFRS’s re-inspection of data integrity within the Devon and Cornwall Police it commented as follows:

*Devon and Cornwall Police has improved significantly its crime-recording accuracy since our 2016 inspection. We found that it has improved its:*

  * recording of crimes of violence and sexual offences (including rape);*
  * recording of modern slavery crimes;*
  * timeliness of the recording of reported crime;*
  * use of classification N100; and*
  * crime-recording audit arrangements*

*The advances made by the force mean that victims of these crimes can be more confident that their reports of crime will be recorded. In addition to these victims receiving an improved service, with a prompt referral to the force’s in-house victim care unit, the force also has improved its understanding of the demand for its services and of the extent to which crime is affecting its communities.*

*We did find, however, that the force still needs to improve its recording of:*

  * crimes reported directly to its safeguarding teams; and*
  * equality information so that it can better understand and provide an appropriate response to communities affected by crime*
The report expands on the comment relating to its safeguarding teams as follows:

- **We found that Devon and Cornwall Police has made little progress to ensure that crimes reported directly to its public protection teams are recorded. The recording of these crimes is important for the force to be confident that vulnerable victims receive the support they need.**

- **We examined 50 vulnerable victim records. We found that of 14 crimes that should have been recorded, only six had been. The eight crimes which were not recorded included common assault, inciting sexual activity with a child, sexual assault, harassment and ill treatment by a carer. In 5 of the 8 cases we found the force provided sufficient safeguarding to the victim, and in 7 of the 8 cases no investigation was undertaken. This potentially leaves these vulnerable victims and the wider community at further risk, and the perpetrators of these crimes at large.**

- **We also found that some sergeants and constables working in the multi-agency safeguarding hubs and in the forces’ central safeguarding teams had not completed the mandatory crime-recording training and, as a result, do not fully understand their responsibilities for crime-recording.**

These observations raised concerns over the force’s performance in this area and this has been followed up across the business year by OSCP. It has been provided with information to demonstrate officers and staff have received training and that crimes are now being recorded in line with the national standards. The force is confident that children are being effectively safeguarded.

The JTAI provided OSCP with an unrivalled opportunity to gain a comprehensive and objective insight into multi-agency safeguarding performance. A substantial team of inspectors from the four inspectorates examined all the key areas of activity and produced the following findings:

*There is a strong culture and commitment to partnership-working across the agencies in Cornwall that are involved in improving practice and services for children at risk of child sexual abuse in the family environment. There is a clear ambition to be innovative, to proactively learn and to provide better multi-agency support and help for children who are at risk of child sexual abuse in the family environment and for children who display sexually harmful behaviour. There are some significant challenges to agencies involved in helping and protecting children in Cornwall due to its geographical isolation, the dispersed nature and smaller size of its communities, and an influx of high numbers of visitors in the summer months. However, this has not impacted on the ability of senior leaders and staff across the partnership to provide and deliver a wide range of services for children who are at risk of or subject to child sexual abuse in the family environment and who need support, help and protection. There is a committed stable and well-trained workforce, most notably in children’s social care and health services, where staff morale across the partnership is high.*

*The OSCP used its existing knowledge and expertise to improve services for children who are subject to criminal exploitation, including learning from police initiatives, to proactively develop a comprehensive child sexual abuse strategy. Since January 2018, a multi-agency task*
and finish group has progressed developments to operational practice effectively. The child sexual abuse strategy is thorough and provides a useful and informative framework for the partnership to implement this area of practice to meet the full range of children’s needs. This is beginning to improve and enhance professional understanding and awareness of child sexual abuse in the family environment. For example, learning workshops in July 2018 and a conference on child sexual abuse held on 24 September 2018 were both well attended by a wide range of multi-agency professionals, who reported improved learning about and understanding of child sexual abuse in the family environment.

There is an established culture in Cornwall of effective direct work and practice with children, and inspectors saw strong and sensitive work from many professionals who are committed to improving support and help for children and their families. There is a wide range of appropriate commissioned services and a strong involvement of schools and of specialist psychological and therapeutic services, such as Jigsaw, which provides individual psychological support to children and their carers. All of this contributes to improved life chances and outcomes for children.

...the existing partnership arrangements and leadership are strong. Senior leaders have already launched a clear strategic plan and are already progressing developments in multi-agency practice in order to improve outcomes for children who are at risk of or are subject to child sexual abuse in the family.

A number of issues were identified and the following comment provides a clear insight:

During this JTAI, inspectors found some areas where intervention by professionals could be strengthened and improved. For example, when children are first identified as being at risk, there are sometimes delays in sharing information and risks between partners at strategy meetings in order to inform decision-making. Relevant health partners are not always invited to contribute, and while minutes and actions arising from strategy meetings are always recorded on the children’s social care system, they are not always shared between partners and are therefore not recorded on their systems. Inspectors noted a lack of challenge from professionals towards some police decision-making, particularly when considering whether a single or joint agency investigation would be most appropriate in understanding the risks that children may face and in planning effective safeguarding actions. Senior leaders in the partnership took immediate action as a result of the findings of this inspection in order to strengthen and disseminate shared learning for improving processes and practice. While no children were found to be at risk of significant harm during this inspection, some risks to children had not been evaluated quickly enough, or there were avoidable delays in ongoing police investigations.

5.8. Conclusion

Over 2018/19 OSCP has maintained its approach of pulling together information from a range of sources to create an accurate and reliable understanding of child safeguarding performance. The JTAI referred to above was extremely useful in providing validation of other findings.
The overall finding for OSCP from its quality assurance processes is that child safeguarding is effective across Cornwall and the Isles of Scilly. All organisations have continued their trajectory of improving year on year. There are plans, resources and commitment to continue the improvements and there is an ambition across the whole area that drives the positive culture that exists.

There is honesty over what needs to be done and precious little defensiveness from members of OSCP over single agency or multi-agency performance. There is no complacency or ‘resting on laurels’.

6. Safeguarding and Child Protection Activity

Our approach
The Unifying Model for Cornwall Children & Family Services is Social Justice and Pro-Social Learning. When children and young people become involved with children’s social care, it is vital that their rights are safeguarded and their wishes and feelings are respected. This is particularly important when children are in care or subject to child protection plans.

The Signs of Safety model as a framework for practice in the protection of children is at the heart of our aim to improve outcomes for children and families in Cornwall. Embedding the Signs of Safety model in the Child Protection Conference process has improved our understanding of the voice of the child and of parents/carers, and their views are more evident, informing decision-making and safety planning.

The role of a Child Protection Conference is to bring together the family and professionals in an inter-agency setting, to analyse relevant information and plan how best to safeguard and promote the welfare of the children. It is the responsibility of the Multi-Agency conference to make recommendations on how agencies work together to safeguard the children. In Cornwall Child Protection Conferences are chaired by a Children’s Rights Advocate. The primary role of a Children’s Rights Advocate is to ensure that the rights of the child are central to the assessment of their needs and the plans to support them. They promote their rights under the United Nations Convention on the Rights of the Child (1989) at all stages. Crucially, Children’s Rights Advocates ensure that all options for family life are considered and actively explored, and that if the child is not able to live safely within their family and community, there is confidence that the alternative plan for them reduces the risk of harm and secures emotional permanence supported through a legal order.

The picture in Cornwall
The number of children and young people subject to a Child Protection Plan between 1/4/18 and 31/3/19 was 448 (228 families); this included variations where the lowest number of plans was in July 2018 (378) rising to the most in March 2019 (451). The number of children subject to plans is currently 393. During the same period there were 1852 strategy discussions of which 1218 (65.8%) resulted in a Section 47 Enquiry and a further 634 (34.2%) with another outcome. Of the 1126 Section 47 Enquiries which were undertaken 434 (38.5%) resulted in and Initial Child Protection Conference with a further 692 (61.5%) with another outcome. The overall rate of child protection plans per 10,000 as of 31/3/19 was
40.39 an increase from 39.00 in 2017/18 which at that time compared to 39.60 for our statistical neighbours and 45.30 for England and Wales. The number of children subject to a Child Protection Plan for a second or subsequent time in the period was 90 (20.9%).

There were 132 (33.6%) children made subject of a child protection plan for emotional abuse; it is thought that this is in part due to high levels of domestic abuse and the fact that Cornwall identifies itself as a trauma informed authority. Of the remaining children, 160 (40.7%) were for neglect, 63 (16%) for physical abuse and 38 (9.7%) for sexual abuse.

Relatively equal numbers of children made subject to child protection plans were between the ages of 1 and 5 (31.8%) and 6 and 10 (31%) with a further 35 (8.9%) under 1 and 111 (28.2%) over 11.

The performance data in relation to the statutory timescale for initial and review child protection conferences shows that we completed 85.04% within timescales for ICPC and 95.4% of RCPCs.

**How are children’s views represented?**

Advocacy for children subject to child protection plans is provided through a commissioned service with Barnardo’s; advocates represented children on 284 occasions during 2018/19. The majority of children represented 179 (46.1%) were aged between 6 and 11 years of age with a further 142 (36.6) being aged between 12 and 16 years of age.

**Planned improvements**

A thematic audit in relation to repeat plans is currently being undertaken alongside an audit to understand our relatively high numbers of children on child protection plans for emotional abuse. Other thematic audits have evidenced the need to improve the quality of our danger statements and explore the greater use of family group conferencing prior to an initial child protection conference. Children’s Rights Advocates are also focussing on better supporting the Multi-Agency conference to consider the scaling of risk within the context of the Multi-Agency danger statement and what agencies need to see to ensure that the risks are being reduced and safety is increased for children.
7. Child Death Overview

The child death review processes for Cornwall and the Isles of Scilly are part of a larger set of arrangements that cover the Devon and Cornwall peninsula. OSCP works with Devon LSCB, Torbay LSCB and Plymouth LSCB to jointly commission a service that reviews child deaths across a population of in excess of 1.8 million people.

As local child safeguarding children boards are being replaced, the responsibility to maintain child death review processes is being passed jointly to the respective local authorities and clinical commissioning groups that cover local authority areas. The organisations will be known as ‘child death review partners’ and as the arrangements they introduce can cover multiple areas, it is anticipated the existing South-West geographic area will remain.

OSCP will continue to support action that responds to lessons learned through child death review processes.

For the 2018/19 business year there were 89 deaths of children and young people across the South-West peninsula, a decrease of ten on the previous business year. Of the 89 deaths, 30 related to children and young people from Cornwall and the Isles of Scilly. This is a decrease of two deaths from 2017/18.

During 2018/19 71 deaths of children and young people were reviewed at child death overview panels. 25 of those deaths related to children and young people from Cornwall and the Isles of Scilly. It has not been possible to determine how many of those 25 deaths are modifiable.

The communication of findings from child death overview panels has improved over the past year with aggregated findings, plus information received from other parts of country, distributed after the end of each quarter. Within Cornwall and the Isles of Scilly this information is received by OSCP’s Learning Group. The Learning Group decides what action is required and then ensures that activity takes place. In line with this work-flow, the following examples demonstrate the type of action that has been undertaken:

7.1. Sudden Infant Deaths (SID)

The number of sudden infant deaths assessed as being modifiable continues to be a significant proportion of the overall deaths reviewed. There are numerous factors within these deaths and the addressing of each can help reduce the overall likelihood of sudden death. Within Cornwall and the Isles of Scilly OSCP has continued to ensure midwives and health professionals working with young children are providing advice and guidance to reduce these factors being present in a child’s life. Examples include: not smoking in the

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2 The panel has identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.
same premises as the child; not co-sleeping after smoking; consuming alcohol or controlled drugs; ensuring infants sleep on their backs.

7.2. Care of next infant

When infants die unexpectedly and without an apparent cause there are concerns that any subsequent child for the same parents could be exposed to a heightened risk of sudden unexpected death. In view of this ‘care of next infant’ (CONI), processes ensure investigative work is undertaken with those parents and additional preventative measures are put in place, e.g. the provision of apnoea alarms. These processes have been reviewed for families Cornwall and the Isles of Scilly and measures are in place to provide a good level of support.

7.3. Suicide

There has been an increase in suicides over the past twelve months and two of these are now being considered under a local child safeguarding practice review. Leaders and operational staff across Cornwall and the Isles of Scilly are working to identify what additional activity could be undertaken to more effectively help and support children and young people who could end up taking their own lives.

7.4. Risk of prescribed drugs

The risk of harm or death to children associated with parental drug use has generally focused on the use of illegal drugs. There are distinct risks associated with the use of prescribed drugs, e.g. opiate patches, but professionals have not always been aware or indeed prompted to consider them. Information has been shared with general practitioners and staff working in acute trusts to consider the risks whilst deciding upon the medication to be used by adult patients.

7.5. Conclusion

There is confidence that the forthcoming organisational changes to CDOP processes will not affect operational activity and that the progress achieved thus far will be maintained, or indeed improved upon.
8. Learning from Experience, Rapid and Child Safeguarding Practice Reviews

Working Together to Safeguard Children was reviewed and published in July 2018. Chapter 4 Improving child protection and safeguarding practice outlines the new arrangements for reviewing and learning from the serious injury or death of a child as a result of child abuse or neglect. Serious Case Reviews are replaced by Child Safeguarding Practice Reviews (CSPRs) which can be held at either local or national level. The purpose of CSPRs is to improve child protection and safeguarding practice.

Whilst the responsibility for learning from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the National Panel), at local level it is the local safeguarding partners who are responsible for:

- identifying serious child safeguarding cases which raise issues of importance in relation to the area and
- commissioning and overseeing the review of those cases, where they consider it appropriate for a review to be undertaken

Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review (LCSPR).

Cornwall and the Isles of Scilly OSCP adopted the new process in July 2018.

The Serious Case Review Recommendation Panel has been replaced by the Rapid Review Recommendation Panel (RRRP). The RRRP is comprised of OSCP Board members, who may delegate their responsibility to managers within their organisation, as appropriate and who make a recommendation as to whether a LCSPR should be carried out; the final decision continues to lie with the OSCP Independent Chair.

Six RRRPs were held in 2018/2019 in Cornwall. The Isles of Scilly has had no RRRPs in this time frame.

Two RRRPs concerned young babies who had received life threatening injuries which resulted in serious life limiting conditions. While the criteria were met for a local CSPR for both children, the themes identified matched those from a ‘Learning from Experience Review’ held in 2017/18, the actions from which were still live across the partnership. Immediate and single agency actions were initiated from the Rapid Review process and it was agreed that no further review should be undertaken.

There have been three RRRPs in respect of teenage children, who it is understood have taken their own lives (the inquests have yet to be held on all three deaths, where cause of death will be confirmed.) The first RRRP held in October 2019 concerned two geographical areas as the child had recently returned to Cornwall from living in another county. The
criteria were met for a CSPR and the panel, endorsed by the Independent Chair, recommended to the National Panel that a national CSPR be held given national concerns around teenage suicide. The National Panel did not accept this recommendation and subsequently a Local CSPR has been commissioned. This CSPR, undertaken by an independent reviewer, is currently underway and is being overseen by local safeguarding partners. It is anticipated that this review will be published in the autumn of 2019.

A further RRRP was held in January 2019 following the suspected suicide of a teenage child in the west of the county. Single agency actions were identified from this and, although the criteria for a CSPR were met, the recommendation was not to commission another as there is a live CSPR currently being undertaken as outlined above.

In April 2019, a RRRP was held in respect of a teenage child who is believed to have taken their life in the west of the county. Again single agency actions were identified from this and, although the criteria for a CSPR were met, the recommendation was not to commission another as outlined above. The RRRP recommended that learning from all three suicides should be identified.

A RRRP was held in May 2019 in respect of an unborn baby, due to the concerns around the health and wellbeing of the mother in late stages of pregnancy. The criteria for a CSPR were not met. Single agency actions were identified, and further review is to be held between children and adult services.

The Quality and Performance Sub-Group has responsibility for overseeing actions arising from the RRRPs.

Any learning from the above processes is overseen by the Learning Sub-Group. The OSCP annual conference was themed round the learning from the RRRPs held in 2018/19.

The OSCP procedures for Rapid Reviews and Child Safeguarding Practice Reviews are in the final stages of being drafted and will be available on OSCP website.
9. Partnership Sub-Groups

9.1 Learning Group

The Learning Group has had a busy year. It has met regularly with excellent attendance from partner agencies. In addition to the existing membership we welcomed the new OSCP Board Manager, the named GP for Cornwall, representatives from Public Health and Cornwall Association of Primary Heads (CAPH), and virtual members from Cornwall Association of Secondary Heads (CASH) and Housing. Learning is now a standing agenda item for all subgroups, with the learning identified or training need being fed back to the Learning Group to incorporate into the business of the group.

A summary of the business undertaken over the year is as follows:

**SCP Training Contract**

In January 2018 the Board agreed to proposals to change the way the training contract is managed from the end of the previous contract on 31st March 2018. The OSCP training offer is now managed through Children and Family Services (CFS), overseen by the specialist professional development lead who is a member of the Learning Group, supported by a dedicated commissioning administrator. Training is commissioned as required in response to Board’s priorities and business requirements.

The Level 3 Multi-Agency Working Together training programme was awarded to Family Action and the new contract started on 23rd April 2018. The first Multi-Agency Working Together to Safeguard Children course was held on 19th June 2018 and they have been held on a regular basis since. There has been a very high demand for places, and we have worked hard to prioritise the right people with the right mix of agencies to ensure participants have a genuinely multi-agency experience. Adjustments continue to be made with regard to who attends the Level 3 Working Together Training, with partners in the Learning Group clearly reinforcing the criteria agreed within their own agencies, ensuring that single agencies make Level 1 and 2 training available within their own organisations.

OSCP training available in 2018/19 included:

- Allegations Against Staff – LADO workshop
- Domestic Abuse and Sexual Violence
- Level 3 Understanding Childhood Neglect
- Level 3 Advanced Course – Understanding Childhood Neglect
- Level 3 Multi-Agency Working Together to Safeguard Children
- Masked Faces of the Sexual Predator
- Signs of Safety
- Stopping Me Seeing the People I Love – Child Sexual Exploitation
Signs of Safety
Signs of Safety 5 day training was commissioned by CFS, and offered to OSCP in April 2018. While predominantly CFS staff attended, there was an appropriate multi-agency mix of delegates which has helped to consolidate Signs of Safety as the overarching practice model and an integral part of the commissioning of OSCP training.

Conferences
A Conference to launch the Child Sexual Abuse (CSA) Strategy was held on 24th September. Speakers included Dr Debbie Allnock, Senior Research Fellow, University of Bedfordshire and co-author of No-One Noticed, No-one Heard (NSPCC, 2013); David Poole from the Truth Project; Josette Lawrance on recognising perpetrator behaviour and two survivors of childhood abuse. The evaluation of the conference was very positive, with it being clear that awareness had been raised, and delegates were taking their learning into practice.

In March 2019, the annual OSCP conference, Reading Between the Lines - Recognising the Risks in Safeguarding Children, was held at the Royal Cornwall Showground. The conference reflected on areas of risk that are common to a number of recent Rapid Reviews both locally and nationally. Alison Hadley OBE, Director, Teenage Pregnancy Knowledge Exchange, discussed the importance of pre-birth assessment in supporting teenage parents. Professor Ray Jones considered issues surrounding Neglect and the conference included the experience of Teenage Parenthood locally and the impact of Domestic Abuse.

Learning Lessons Workshops
A Learning Lessons Workshop was held on 3rd July 2018 to bring partners together to share knowledge and experience on working with Child Sexual Abuse in the family environment. This interactive session was well attended and gave colleagues across the partnership an opportunity to share their knowledge and experience, and contribute to the development of the CSA strategy.

The Learning Lessons Workshop in February 2019 gave an excellent opportunity to consider the learning across the partnership in respect of CSA and to develop the action plan arising from the Joint Targeted Area Inspection held on CSA in October 2018.

Website
It has been recognised for some time that the OSCP website needs to be updated. The Board has agreed to meet the costs of this from current reserves and the procurement process was started to commission a web developer to work with the Learning Group on this exciting project.

Participation is a priority for the new website, and the Board Manager who is leading this on behalf of the Learning Group will work with the newly appointed Children’s Rights Officer to ensure that children and young people are involved in development of the site.
Newsletter

The OSCP newsletter has been reviewed and refreshed in 2018/19 with quarterly publications from January 2018. The newsletter aims to provide an easily accessible link for the partnership to current initiatives, to introduce new appointees, as well as highlighting available training opportunities.

CDOP, Rapid Reviews and Local Child Safeguarding Practice Reviews

The Child Death Overview Panel remains an important area of learning for the partnership, and regular reports are received by the Learning Group to ensure that learning is disseminated and acted upon.

The new processes required by Working Together 2018 for the partnership when there has been a death or serious injury to a child are outlined elsewhere in this report. The Learning Group continues to identify the learning from these processes, and uses this local perspective to inform the commissioning of training, provision of Learning Lessons Workshops, and other methods of disseminating information and influencing practice across the partnership.

9.2 CSA subgroup

The OSCP Child Sexual Abuse (CSA) task and finish sub-group was established in 2018, and throughout spring and early summer the draft strategy for CSA within the family environment was developed. An excellent interactive Learning Lessons Workshop was held in July 2018, where colleagues across professional disciplines and organisational settings worked together to inform the draft strategy.

An OSCP conference on CSA in the family environment was held in September 2018 to launch the multi-agency strategy to help and protect children and young people from sexual abuse. Nearly 100 delegates attended the conference. In addition to launching the strategy, the conference sought to improve knowledge of the many facets of CSA, and encourage managers and practitioners to apply their knowledge in practice. The conference was reported as the first item on the drive-home news programme of BBC Cornwall, including an interview with the independent chair of OSCP. An electronic survey was sent out following the conference to capture feedback regarding the impact of the learning gained and how this will be applied to practice. 80% of those who attended responded to the survey. Their feedback informed the ongoing work of the CSA sub-group in respect of the strategy action plan, and the development of the learning offer across OSCP.

In October 2018, Ofsted, the Care Quality Commission (CQC), HM Inspectorate of Constabulary and Fire and Rescue services (HMICFRS) and HMI Probation (HMI Probation) undertook a joint targeted inspection of the multi-agency response to sexual abuse in the
family in Cornwall. The inspection included an evaluation of the multi-agency ‘front door’, which receives referrals when children may be in need or at risk of significant harm, the Multi-Agency Referral Unit (MARU), and a ‘deep-dive’ focus on the response to sexual abuse in the family environment. In the feedback letter, the JTAI team recognised “a strong culture and commitment to partnership-working across the agencies in Cornwall that are involved in improving practice and services for children at risk of child sexual abuse in the family environment”. The report also acknowledged “the challenges to agencies involved in helping and protecting children in Cornwall due to its geographical isolation, the dispersed nature and smaller size of its communities with an influx of high numbers of visitors in the summer months”.

Key strengths included the acknowledgement that “Work in Cornwall to tackle child sexual abuse in the family environment is underpinned by strong and inclusive strategic leadership, modelled by the director of children’s services and his leadership team. There are established links between strategic boards, particularly the OSCP and the overarching children’s ‘One Vision Partnership’.”

The CSA task and finish group became a permanent sub-group of OSCP in 2019. Priorities for the work of the group are:

- Oversight of the CSA action plan
- Development of clear recognition, referral and response pathways for children and families
- A public campaign to raise awareness of CSA in Cornwall and the Isles of Scilly.

9.3 Missing and Exploitation Group (MEG)

Tackling the exploitation of children, young people and adults at risk is a shared priority of the Community Safety Partnership, Safer Cornwall, Our Safeguarding Children Partnership and the Safeguarding Adults Board.

The Missing and Exploitation Group (MEG) are responsible for setting the strategy and delivery plan as a multi-agency response to exploitation across Cornwall, which is now in the final year of the current 3 year plan. The strategy is based upon best practice, local, regional and national evidence and has this grown to respond to the developing picture of the nature and extent of exploitation in Cornwall. It covers those who are at risk of sexual exploitation and the scope of the group was recently formally widened to include criminal exploitation and those who go missing from home, care or education and young adults up to the age of twenty-five.

The strategy follows the four national principles – Prevent, Protect, Pursue and Prepare, and at the centre is ensuring that the voices of children, young people and adults at risk are heard and responded to.
Child sexual exploitation is defined as follows:

“Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator.

The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.”

Where there was previously a dedicated focus on child sexual exploitation, practice and governance has shifted to include consideration of children who are at risk of other forms of exploitation such as criminal exploitation relating to drugs and gangs (county lines).

Criminal exploitation is defined as follows:

“Child Criminal Exploitation is common in County Lines and occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology”.

Safeguarding children remains a priority which is reflected within the agendas of all individual agencies represented within the MEG, where they are supported to fulfil their roles and responsibilities to safeguard children under Working Together 2018.

The Strategy is delivered through planned partnership activity across 12 key areas of work within the Delivery Plan and is supported by an outcomes framework created to measure the effectiveness of the response across the system. Over the past 12 months it shows:

**Achievements**

- A downwards trend in missing children
- A consistent identification of vulnerability factors for children
- An improved referral practice to the Missing and Child Exploitation Panel (MACE)

**Challenges**

- A decline in the proportion of children receiving return home interviews (RHI) in the 72 hour window after returning home
- Use of CSE flag in police systems is still low but improving. The Majority of crimes do not progress due to evidential difficulties.
• An increase in multiple referral episodes to MACE, which requires further understanding and activity

• A temporary gap in data from some Domestic Abuse and Sexual Violence (DASV) service providers, due to transition to new contracts and a new case management system

The MEG has captured these challenges within the refreshed delivery plan and over the next year will be working to improve this performance.

Cornwall has adopted an innovative approach to disruption and prevention of exploitation when concerns are identified; there is greater confidence that where there is evidence of concern about potential perpetrators and locations, effective action can and will be taken to disrupt and prevent exploitation. Persons and locations of concern are targeted so that those who seek to harm or exploit vulnerable adolescents are identified, disrupted and prevented from hurting other people and supported to change behaviours.

The multi-agency arrangements overseen by the MEG include the Missing and Child Exploitation panel (MACE) and the Disruption Legal Planning Meeting between Children Services and Devon and Cornwall Police. The MACE panel is where at operational level multi-agency assessment of the risks to missing and children at risk of exploitation are completed. All partnership, voluntary and community sectors attend the fortnightly panel to confidentially pool information and intelligence on those highlighted as at risk of exploitation. The panel, which replaced the MACSE in 2018, has developed over the past year, relationships between partner agencies have matured and there is now better sharing of information, support and challenge when required.

This way of working has enabled an approach of early intervention, giving the opportunity to have informed and timely decisions on safeguarding interventions and disruption activity which is appropriate to individual cases. The efficiency of the panel has improved with the introduction of a strategy discussion workflow and multi-agency Practice Standards for Strategy Discussions.

Examples of actions resulting from or influenced by the MACE panel include:

• Incidents of child employment in locations of concern have led to a joint agency approach between the Child Employment Officer in the Education Welfare Service and the Police to disrupt the illegal employment of a young person.

• Joint working in relation to those that are missing and at risk of Child Sexual Exploitation and Criminal Exploitation leading to a number of safeguarding and investigations which are ongoing.
• Information gained at MACE can inform multi-agency practice such as ‘walkabouts’ in towns to educate the retail and hospitality sectors on the signs to look out for and how to report concerns.

To ensure the effectiveness of the MACE panel process and its impact and outcomes, MEG has commissioned a review which is due to report in July 2019.

The Disruption Legal Planning Meeting held by Children and Family Services and Devon and Cornwall Police (DCP) has been in place since September 2017 and there have been a number of joint police/authority Civil orders such as Sexual Risk Orders and Child Abduction Warning Notices which have proved to be very effective. If breached, further police action can be taken (police have had one breach of an SRO which is currently being investigated).

An holistic and innovative approach is taken to children and young people who may be both victims and perpetrators of exploitation and abuse. For example, effective statutory services for offenders are complemented by an innovative specialist service for young people with Harmful Sexual Behaviour via Gweres Kernow.

Sharing of training, such as ‘County Lines/Gang’ inputs by St Giles Trust in relation to child exploitation, has improved standards and decision making in operational practice over the past year. This means that front line staff have a clearer, research-informed understanding of the risk factors and vulnerabilities associated with exploitation, and a more holistic understanding of the dynamics of grooming and exchange which underpin exploitation relationships. Staff are reporting a greater confidence and knowledge about how to take effective action. All agencies recognise that the training provided supports staff by raising awareness and supporting good practice in the delivery of CSE related issues and are willing to invest in it.

The annual OSCP conferences have also provided a great opportunity to bring in good practice and evidence-based research to inform local working and continuous improvements in the response to exploitation.

A Member briefing on child exploitation and county lines was completed by Children and Family Services (CFS) jointly with Safer Cornwall in March 2019. This has also been covered in the local media, to raise public awareness of exploitation and the Council’s response to it.

The focus on the next 12 months will be to continue to improve our understanding and identification of exploitation in all its forms. This would translate into wider training for first responders, not just specialist staff from individual organisations. It will also concentrate on interventions that give the best outcomes for young people and how we can measure if those interventions have made a positive difference.

The continued support and engagement from leaders is needed to ensure agencies fully commit to ‘working together’ so that teams are empowered to take forward innovative
approaches/interventions linking into evidence-based practice and learning from experience.

Looking forward to 2019/20 additional improvements are being sought; we have also added to the ‘4 Ps’ to provide two additional areas of focus regarding the Voice of Young people and Governance, along with producing the new strategy for 2020 onwards.

10. Multi-agency Training

Our Safeguarding Children’s Partnership (OSCP) aims to promote, deliver and assure training of a high standard, which is appropriate to the needs of staff in providing quality services to children and families across all agencies and sectors. The OSCP Training Strategy outlines the key principles of multi-agency training and sets out the framework for multi-agency safeguarding training.

The Learning Group is the primary mechanism for delivering the OSCP Training Strategy and is comprised of members who have an understanding of and influence on strategic training priorities within their own organisation.

New Arrangements

In 2017/18 the OSCP Board made the decision to end the previous contract for training. Following an unsuccessful procurement process new arrangements were made in 2018/19 whereby the Learning Group would oversee the commissioning of training, administered by the Specialist Professional Development Team within Child and Family Services. This approach offers the Partnership greater flexibility and the capacity to be more responsive to changing priorities.

In June 2018 Family Action became the new provider of our core safeguarding training. The new course, Working Together to Safeguard Children, is targeted at those in lead safeguarding roles in their organisation and has replaced the training that has previously been described as ‘core level 3’. Since then key guidance documents including Working Together, Keeping Children Safe in Education and the intercollegiate document on Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff have all been updated. In all of this guidance it is now only the intercollegiate document that refers to training in terms of levels.

This Working Together 2018 guidance stresses the importance of supervision and support for staff including safeguarding training as well the need for practitioners to have regular reviews of their practice to ensure that their knowledge, skills and expertise improve over time. All of the training offered by Our Safeguarding Children Partnership (OSCP) meets the requirements for Intercollegiate Level 3 and is intended to enable colleagues working in a
range of organisations to comply with the professional and statutory guidance relating to their roles.

In our first year, a range of training has been offered at no cost to individuals working with children in Cornwall. This has included:

- Working Together to Safeguard Children
- Understanding Childhood Neglect - Recognition and Response
- Advanced Understanding Childhood
- Allegations Against Staff LADO workshop
- Masked Faces of Sexual Perpetrators
- Signs of Safety Multi Agency briefings
- Stopping Me Seeing the People I Love
- Reading Between the Lines - OSCP Annual Conference
- Child Sexual Abuse in Cornwall and the Isles of Scilly - Developing a Multi-Agency Approach (an OSCP Conference)

A total of 1558 people from a breadth of organisations have attended these events over the past nine months.

One of the key aims of the new Working Together course was to increase the number of social workers attending. In 2018-19 there were 142 people who identified themselves as working for Cornwall Council (not schools) who attended the Working Together course; almost one third of these were social workers, which equates to around a third of social work practitioners in Child and Family services. This is a significant improvement in a relatively short period of time.

**Evaluation and feedback**

Feedback for all courses has been consistently good. In general less positive comments have tended to focus either on the venue or on the difficulties of ensuring that multi-agency training is equally relevant to all those attending. This has been an issue particularly for some early years practitioners.

**Neglect**: I found the content to be really helpful when working with families where there are concerns about neglect. The content provided me with tools to reflect on situations and focus on areas of concern. Now have a new way to approach assessments, providing focus and tools to reflect and share with other professionals. This is the most informative course I have ever been on.

**Masked Faces**: A really brilliant course which just hit home in terms of how perpetrators operate and the different ways they groom those around them, both children and partners and professionals.

**Signs Of Safety Multi-Agency Briefing**: This training is incredibly relevant to my practice, as we are filling out contact observations daily which use the signs of safety method. I personally feel much more confident doing this now after the training. I feel as a new colleague you should be able to undertake this training a lot quicker, as I was in my sixth month before being able to attend.
Development areas - looking ahead to 2019-20

- Completing the training strategy
- Additional training for new Designated Safeguarding Leads. Feedback from course participants and trainers suggests this would be a useful addition for those who are new to a lead or designated safeguarding role.
- Online Safety - The Learning Group is considering commissioning South West Grid for Learning to deliver some multi-agency training which could potentially include online bullying, gaming, child sexual exploitation, virtual self-harm, online sexual predation & grooming.
- Child Sexual Abuse - Specific training to be commissioned to support the intra-familial Child Sex Abuse strategy. The content and focus of this training is being led by the OCSP CSA sub-group
- Neglect training – identifying a new Neglect training provider as the existing contract for Neglect training expires.
- Refresher training – potential introduction of a half day Refresher course to complement the existing Working Together course.
- Online Booking System - moving the course booking management to an on-line management system.

11. Local Authority Designated Officer

11.1. Role of the LADO

The function of the Local Authority Designated Officer (LADO) remains a key aspect of the overall safeguarding activity of the Local Authority and partner agencies. The purpose of the LADO is to oversee and ensure that agencies work together effectively to safeguard children from harm and abuse by professionals and those in public office (employee, volunteer or student, paid or unpaid) who work with children.

Working Together (WT) 2018 statutory guidance sets out the requirement that each county level and unitary Local Authority should have a LADO, or team of officers to be involved in the management and oversight of individual cases. It emphasises the need to ensure that any action necessary to address corresponding welfare concerns in relation to the child or children involved should be taken without delay and in a co-ordinated manner. The LADO Service takes into account what children have said that they need (p10 WT) particularly in terms of ‘protection: to be protected against all forms of abuse and discrimination.’

Our Cornwall & Isles of Scilly Safeguarding Children Partnership (OSCP) has adopted the South West Child Protection procedures which places a duty on all agencies to co-operate with the LADO Service in order to manage individual allegations against those who work with children, to ensure natural justice for those against whom an allegation has been made and to promote the overall aim ‘to create safer organisations’.
The LADO Service is committed to supporting the One Vision Partnership Plan by contributing to:

• **Priority Outcome 3** Helping and protecting children from the risk of harm by coordinating investigations where harm including domestic abuse, child sexual abuse and child sexual exploitation are identified

• **Priority Outcome 5** Making a positive contribution to the community in respect of community safety by raising awareness of the LADO safeguarding role within the voluntary and community sector

The LADO Service supports the aspiration of the OSCP Local Working Together Arrangements and the Cornwall and Isles of Scilly Leadership Board that ‘all partners should work together to achieve the goal that Cornwall should be the best place to be a child.’

11.2. **How it works**

**National/Regional Viewpoint**

The Principal LADO is the regional South West LADO chair and sits on the National LADO Network (NLN) board. There has been significant progress made over the last year by the NLN in terms of creating a common understanding of the LADO ‘threshold of harm’ and sharing good practice under the NLN Principles. The current definition of that threshold, as set out in WT, is a person in a position of trust who works with children who has:

• Behaved in a way that has harmed a child, or may have harmed a child

• Possibly committed a criminal offence against or related to a child; or

• Behaved towards a child in a way that indicates that they may pose a risk of harm to a child

The NLN has entered into a consultation with the DfE in respect of the next version of Keeping Children Safe in Education in order to formalise the existing consensus amongst LADOs that the ‘pose a risk of harm’ threshold can also include any behaviour not just against a child e.g. act of violence, which indicates they may pose a risk of harm to children.

11.3. **Overview of Professional Allegations Data (April 2018-March 2019)**

The LADO Service received 507 contacts over the year; 182 related to formal referrals requiring a multi-agency response and 325 advice and guidance episodes to individual agencies to address safeguarding concerns.

In terms of engagement with the LADO, the data shows 36% arose from the East, 33% Mid and 30% West; this is fairly consistent across the county, irrespective of the number of schools and child population.
The length of a case subject to a formal referral has decreased from 9.8 weeks to 6.9 weeks while the average length of an Advice and Guidance episode is 4.5 weeks.

The main referrers by sector indicate that education (academy/maintained schools combined) account for 32%; police 21% and social care 17%. Other referrals are received from a variety of organisations including transport for children, voluntary sector, sports clubs and faith groups.

The primary cause for concern remains physical abuse of children at 45%, then sexual abuse (including online activities) at 22% and ‘pose a risk of harm’ (concerns arise within personal or activities which create a transferable risk) at 19%.

Case outcomes indicate that 30% of formal referrals are substantiated, where it is recommended that it is more likely than not that the harm or abuse occurred. This has resulted in 10 criminal investigations and 13 disciplinary proceedings, occasioning 1 conviction and 13 dismissals, all of which have been subject to an obligatory DBS referral by the employer.

11.4. CIOS LADO Organisational Viewpoint

The LADO Service has continued to engage and support agencies to consider how allegations are managed and what learning impact they have, to create a safer organisation for children.

It has contributed to the CSA Strategy, launched in September 2018, and Joint Targeted Area Inspection on the same theme last year. Whilst the Strategy focuses on familial CSA, it is still very relevant for agencies to consider the LADO threshold within cases, as 33% of the LADO sexual harm cases last year involved an adult within the household who held a position of trust with children and was a person accused of sexual harm and/or online offending; 17% of those cases related to non-recent sexual abuse.

The LADO Service has been invited and has undertaken workshops in conjunction with Cornwall Association of Primary Head teachers; OSCP; Cornwall Sports Partnership and short break providers (CC and CFT) and Isles of Scilly to explore the question – ‘What does a safer organisation look like?’ The LADO workshop focus has followed the CSA theme, providing case studies on local cases and national serious case reviews where common themes within organisations have emerged around:

- How low level concerns around staff behaviour have been recorded and addressed
- The significant impact of the leadership’s culture in highlighting safeguarding
- The importance of regular training and clear and frequent narrative in policies and practice to ensure that safeguarding is not lost in competing priorities
• How children and staff under investigation both benefit from open and full information-sharing in a timely and fair way under the LADO process, in order to achieve an early outcome.

**OSCP multi-agency LADO course feedback:**

**LADO:**
Very confident to now cascade this information to other senior staff and share excellent practice.

**LADO:**
The course content was very good and informative, but it would have been good to have information relating to the early years sector.
12. OSCP Strategic Business Plan 2018/19

Our Safeguarding Children Partnership Business Plan guided the activities of the Board during 2018/19.

The aims and objectives of the Safeguarding Children Partnership and the key principles guiding multi-agency collaboration are the following:

**Aims and Objectives**

OSCP continued to follow the objectives of LSCBs, as set out in the Children Act 2004 (Section 14):

- to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- to ensure the effectiveness of what is done by each such person or body for those purposes.

**Key Principles underpinning the work of OSCP**

- Visible to all stakeholders across Cornwall and the Isles of Scilly
- Planning based on good quality information and effective analysis
- Effective governance arrangements and operating structure
- Links and clear accountability with other strategic groups across Cornwall and the Isles of Scilly
- A culture of challenge
- Learning is embedded in all agencies and within multi-agency practice
- Authoritative oversight of the quality of performance across agencies, singly and multi-agency
- Understands how it is affecting the quality of performance
## 13. OSCP Board Membership and Attendance during 2018/19

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**Statutory Safeguarding Partners:**

**Cornwall Council:**

- **Children and Family Services**
  - Jack Cordery: ✓ Sub ✓ ✓ ✓ ✓ Sub ✓ ✓
- **Children, Schools and Families**
  - Trevor Doughty: ✓ ✓ Sub Sub ✓ ✓ Sub Sub
- **Children’s Community Health Services**
  - Alison Cook: ✓ ✓ ✓ ✓ ✓
- **Education and Early Years**
  - Jane Black: ✓ Sub ✓ Apol Apol Sub ✓ ✓
- **Council of the Isles of Scilly**
  - Aisling Khan: ✓ ✓ ✓ ✓ ✓ ✓ ✓ Apol
- **Devon and Cornwall Police – Basic Command Unit (BCU)**
  - Jim Pearce: Apol ✓ ✓ ✓ ✓ ✓ ✓ ✓
- **Devon and Cornwall Police – Public Protection Unit (PPU)**
  - Sheon Sturland/ Jo Hall: ✓ ✓ ✓ Apol Apol ✓ ✓ Sub ✓
- **NHS Kernow**
  - Natalie Jones: Sub ✓ ✓ ✓ ✓ ✓ ✓ ✓

**Safeguarding Partners:**

- **Cornwall Association of Primary Headteachers**
  - Ian Bruce: ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
- **Cornwall Association of Secondary Headteachers**
  - Tina Yardley: Apol ✓ ✓ ✓ ✓ ✓ ✓ ✓
- **Cornwall Partnership Foundation Trust**
  - Sharon Linter: Sub Sub Sub Apol ✓ ✓ Sub Sub
- **Further Education Colleges**
  - Cheryl Mewton: ✓ ✓ DNA ✓ ✓ ✓ Apol ✓
- **Office of the Police and Crime Commissioner**
  - Lyn Gooding: Apol Apol DNA DNA ✓ DNA DNA DNA

**Participant Observers:**

- **Cornwall Council – Lead Member for Children’s Services**
  - Sally Hawken: ✓ Apol ✓ Apol ✓ ✓ ✓ ✓
- **Council of the Isles of Scilly**
  - Joel Williams: Apol DNA ✓ ✓ DNA Apol Apol Apol
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<td>Scilly – Lead Member for Children’s Services</td>
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<td>Royal Cornwall Hospitals Trust</td>
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<td>Safeguarding Children Partnership Manager</td>
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<td>Jack Cordery</td>
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