BIRMINGHAM
Safeguarding
Children
PARTNERSHIP

Independent Chair's Accountability Report 2021-22

1. Purpose of the Report

1.1 This report formally discharges my responsibility to Safeguarding Partners in Birmingham.

1.2 It is my sixth Accountability Report and is something that I have undertaken to provide information and assurance to Safeguarding Partners, including my personal reflection on issues, learning, impacts and outcomes from the past year. It is prepared for the four lead statutory organisations charged with accountability for ensuring the safeguarding of children and young people in Birmingham - Birmingham and Solihull Clinical Commissioning Group (BSol CCG); West Midlands Police (WMP); Birmingham City Council (BCC) and Birmingham Children's Trust (BCT). It will be formally presented to them and their partners at the Safeguarding Leaders Assembly on Thursday 28th April 2022.

1.3 This report does not provide statistical data, that will come in Birmingham Safeguarding Children Partnership's Annual Report for 2020-22, which will be presented in the early summer.

2. Introduction

2.1 It is now three years since the introduction of the Multi-Agency Safeguarding Arrangements (MASA) in Birmingham.

2.2 We have retained the nomenclature of "Independent Chair" and the role description is attached as Appendix 1. I hope this report evidences the independent scrutiny and assurance elements of the functioning of the Chair. However, in a large, complex multi-agency system on a journey of improvement, the need for convening, supporting and challenging partners is equally vital. I was recruited 6 years ago to bring my CEO and strategic partnership track record to benefit Birmingham, the safeguarding of children and beyond. I could not fulfil my brief by scrutiny alone. By collaborating on leadership of a consistent improvement and learning agenda, I have evidence that we are instilling confidence in the wider multi-agency workforce, improving practice and outcomes, and turning around an unwanted reputation. It continues to be work in progress; we are restless to improve and learn.

2.3 This year's report I will structure around progress against our priorities. First, let me bring you up to date with our organisational arrangements.

3. Organisational Arrangements

3.1 We had reviewed and made changes to the Safeguarding Children Partnership arrangements in advance of the Wood reforms referred to as "Multi-Agency Safeguarding Arrangements". So the main impact of the Wood changes in Birmingham has been on learning from serious incidents and cases and sharing accountability for safeguarding across the accountable bodies of Health, Local Authority, Children's Trust and Police. We have updated our arrangements to be compliant with national expectations and timescales and have welcomed the focus on learning rather than process.

3.2 Our sub-group structure has stood us in good stead. As usual, I attach a simple chart of sub-groups and their connectedness at Appendix 2. Our arrangements allow for identification of policy or practice issues through the Serious Cases sub-group; in turn this informs the priorities and curriculum for the Learning and Development sub-group; and the Quality Impact and Outcomes sub-group does what it says on the tin. It tests how the system is performing, learning and practicing. Each sub-group is co-chaired by a pair of senior managers from across the partnership, providing resilience, modelling working together and offering support.

3.3 In addition, we have a Safeguarding Forum for Safeguarding Leaders each of the Health and Education systems. I attend all of these groups at least once during the year for the purposes of seeking assurance and offering support, challenge and appreciation.

3.4 The Executive Board which I chair meets bi-monthly.

3.5 Additionally, twice a year (April and October usually) we hold a Safeguarding Leaders Assembly. This half day meeting is for all leaders across the system (not all of whom attend the Executive) and provides a vital and lively opportunity for assurance and development.

3.6 There is a well-established and growing, open Practitioner Forum which gathers quarterly for a topic-based presentation and open discussion of any issue colleagues wish to raise. The summer (or in 2022 Autumn) session is replaced by a Practitioner Conference which has become a well-regarded and well attended event. Last year's conference was held virtually over two days (23rd and 24th June 2021) and it's focus was Tackling Child Exploitation in the Context of the Pandemic. The keynote address was given by Professor Carlene Firmin MBE, (previously of the University of Bedfordshire, now of Durham University). The benefits of the virtual event were that attendees could go to all workshop sessions in addition to the plenary. The attendance and feedback from the conference was excellent. This year's Practitioner Conference is being planned to happen in person with some filming of sessions to allow for virtual access too. Its focus is very relevant and will be "Neglect". Our conferences are generally over-subscribed.

3.7 As Independent Chair of the Birmingham Safeguarding Children Partnership (BSCP), I am a member of the City Board. It has a wide membership from leaders of all sectors across the City with the wellbeing of Birmingham's citizens, economy, culture and infrastructure at heart. I see myself as championing the interests and safeguarding of children and young people in this arena.

3.8 As BSCP Independent Chair, I was a founder member of the Birmingham Children's Partnership (BCP), which takes as its agenda the priorities which will ensure that the city is a place where all its youngsters can thrive, and happily achieve their potential. In March 2022 the ambitious strap line "BIRMINGHAM CHILDREN THRIVE" was agreed with the aspiration that they be "SAFE, ACHIEVING, INCLUDED, CONFIDENT and HEALTHY".

3.9 Based on evidence, the current partnership priorities are agreed to be:

1. Inclusion of children with Special Educational Needs and Disability (SEND)
2. Young People with complex needs and in crisis
3. First 1001 days
4. Early Help (on a locality basis)

5. Serious Youth Violence
6. Reducing Infant Mortality
7. Domestic Abuse
8. Learning, Skills and Pathways to Employment

3.10 This ambition and priorities will be worked up into a Children and Young People's Plan developed in co-production with young people, staff and leaders across the Partnership. It is expected to be agreed and published late in 2022.

3.11 As well as meeting regularly with the Cabinet Member for Children and Young People (since the Summer of 2021, Cllr Sharon Thompson) and the Chair of the Birmingham Children's Trust Board (Andrew Christie), I meet with the Cabinet Member for Adults, Social Care and Health (Cllr Paulette Hamilton) who is also Chair of the Health and Wellbeing Board. Now that Cllr Hamilton has been elected as a local MP, I expect a change of Lead Member. They are all invited and attend the Safeguarding Leaders Assembly. Cllr Thompson has recently published a blog recognising the importance of and progress in the partnership services to children and young people.

3.12 Since the arrival of Sue Harrison into the role of DCS (Children & Young People) we have initiated a Strategic Safeguarding Leaders Group for the 4 Accountable Leads of the Birmingham system (DCS; CEO of Children Trust; Lead Chief Superintendent for Birmingham; Chief Nurse for CCG) which I chair. Its purpose is to provide a safe space for the system leaders to work together, problem-solving, forward planning and offering support and challenge.

3.13 Finally, Birmingham Safeguarding Children Partnership is a leading member of the West Midlands MASA Chairs and Business Managers Network. Meeting 4 times a year, this group is responsible for the Safeguarding Policy and Procedures across the 14 Local Authority areas. It seeks to share learning and promulgate good practice arising from audit or other performance activity and, of course, learning from serious incidents.

3.14 In June 2021, the group received a valuable presentation from Mark Gurrey of the "National Panel" which now oversees Rapid Reviews (RR), Local Child Safeguarding Practice Reviews (LCSPRs) and commissions National Reviews. He shared the guidance for partnerships on making best use of Annual Reviews with a focus on: Evidence, Assurance, Learning and Impact.

3.15 Mark Gurrey also shared the analysis of cases across the country and the emerging themes for practice:

1. Understanding the daily life and experience of children and their families
2. Working with reluctant families
3. Critical thinking/challenge - open minds and curiosity
4. Responding to changing risk and need - assessment as a dynamic process not an event
5. Timely and effective Information sharing by partners -the full picture is made up of pieces
6. Organisational Leadership and Culture - a healthy, open, learning one gives best outcomes

3.16 Given the size of Birmingham and thus our contribution to the collection of reviews assessed by the National panel, it is reasonable to sense check this list of issues against our own understanding of learning from reviews. When doing so, we conclude that this is a meaningful set of issues for us, and we want to use it to drive progress and improvement. We are developing an innovative Regional proposal to develop actions to improve practice.

3.17 I do not want to give the impression that partnership activity is limited to these meetings. There is a whole set of arrangements which support day to day working together. The Partnership Operations Group, chaired by Jenny Turnross, the CASS/MASH Management Board, the EmpowerU Hub, the SEND Partnership, the Early Help Partnership and of course the daily strategy meetings and Child Protection Conferences and Reviews, to name but a few. Additionally, colleagues attend the Community Safety Partnership and other satellite groups to advance shared concerns especially in the areas of Youth Violence, Domestic Abuse and Sexual and Criminal Exploitation.

3.18 It is to be hoped that the Children's Plan for Birmingham will articulate the shared purpose, ambition, values and priorities that practitioners, volunteers and leaders can unite behind to deliver on the promise that "Children in Birmingham Thrive".

4. Progress against our 4 Key Priorities 2021-23

4.1 Let's consider now the progress we have made against our specific BSCP priorities:

5. Strong Leadership and Strong Partnership demonstrating Effective Accountability

5.1 Our Safeguarding Partnership ambition remains that ***"Birmingham is a Family Friendly city where children will flourish, feel safe, listened to, learn and grow up, able to contribute to society"***. In the updated plan we should align the wording to that of the Birmingham Children's Partnership – "***Birmingham Children Thrive***".

5.2 And our Purpose is to work collaboratively providing "system leadership and challenge and to hold organisations to account". All of this is underpinned by creating a "learning culture, sharing good practice and driving improvement in partnership working to deliver better outcomes." That stands as relevant and true as ever.

5.3 The organisational arrangements described above hold to this purpose and ambition, and have been sustained and strengthened despite the second year of Covid-19 and the restrictions and challenges that this has provided. I should acknowledge the commitment of colleagues whose attendance at Executive and sub-group meetings has been excellent. As usual, I have met with System Leaders regularly and ensured induction sessions with new joiners, supported by our Business Manager. I have attended sub-groups and Forums and taken assurance from the respectful, open and frank exchanges at Serious Cases and Quality Impact and Outcomes.

5.4 I must also pay tribute to the Safeguarding Business Support Team under Simon Cross's leadership, who have continued to support our system, enabling the business of the partnership to be sustained, timescales met, and learning to underpin all our endeavours.

5.5 However, the churn in Leaders across the system, in the Local Authority, NHS, and the Police, has slowed progress, in my view. In particular, the further change of Chief Executive and Director of Children's Service at the Council; the retirement of the Chief Executive at the Clinical Commissioning Group and now sickness absence of the Chief Nurse, and organisational change in the NHS with more turnover, is unfortunate and is destabilising. It creates serious gaps and pressures for those manager and clinical staff remaining. As well as creating operational challenges (most recently in the staffing for the MASH), they have combined to slow down some really sound initiatives, such as the development of the universal and specialist agendas owned by the Birmingham Children's Partnership.

5.6 I expect the Non-Executive and Executive members of the new NHS organisational arrangements to take note of the impact of the loss of organisational memory and focus that could result from the move the 'Integrated Care System' (ICS) with its Partnership and Board. Priority must be afforded to safeguarding and the wellbeing of children and young people in the youngest city with its considerable challenges, economic and social. Recent meetings with the interim CEO (designate), David Melbourne and Improvement Advisor Michelle McLoughlin, have provided significant reassurance that they are seized of the importance of Babies, Children, Young People and Families and the need for capacity and capability to provide both leadership and staff on the ground to enable the Partnership to practice effectively. The need for a reset of the Health Safeguarding Leaders forum is accepted, I think.

5.7 The honourable exception to this churn is found in the Birmingham Children Trust. Here, the stability at Chief Executive and Senior Officer level posts has enabled that organisation to make demonstrable impact especially in progressing key issues: sustaining essential face to face services; addressing sexual and criminal exploitation; meaningful engagement of young people as users of services; response to seriously troubled youngsters, the Early Help offer on a locality basis and the concept of the team around the school, to name but a few. The Trust is offering to lead on developing and adopting a shared relational approach to working with children and young people across all organisations and professions in the city and I hope that this will be embraced.

5.8 So, having remarked on the negative impact of the churn described above, there are reasons to be positive and encouraged, if not cheerful.

5.9 Within a few months of her arrival in the Council, the Director of Children's Services has assessed her inheritance and determined an agenda for improvement. She has "reignited" the Birmingham Children's Partnership, building on good work from last year with an ambitious timetable for action.

5.10 There is progress in developing a "Serious Youth Violence Strategy", led by the Community Safety Partnership chaired by Cllr John Cotton, and supported by ourselves. Cllr Cotton and I have written to the Home Secretary to argue the case for Offensive Weapon Homicide Reviews to be considered for under 18s and to learn from the effectiveness of the Rapid Review decision-making and learning process.

5.11 The impact of trauma on children and specifically through Domestic Abuse is being recognised and West Midlands Police is now introducing "Operation Encompass" to enable early

information-sharing with schools which will alert them to incidents that could have implications for the wellbeing and behaviour of specific children.

5.12 The "Who's in Charge" campaign continues to be relevant and impactful as it addresses issues emanating from some children being negatively impacted by parental alcohol and substance use, especially during the period of lockdown and increased isolation, occasioned by the pandemic. This was a great example of a partnership initiative started by the Birmingham Community Healthcare Foundation Trust and then supported by the Birmingham Safeguarding Children Partnership with practical and financial help.

5.13 The Council's new Chief Executive, Deborah Cadman, has determined that children and young people should be a priority for the youngest city, and plans are underway for signalling this through designation of 2023 as the "Year of the Child". Building on the legacy of the Commonwealth Games this would signal the start of a new era, friendly to and ambitious for children, driven through the City Board as the Children's Partnership.

5.14 The Director of Children's Services in the Council is stepping up as a system leader. She is bringing energy to the agenda of the Children's Partnership, supporting schools, voluntary and community sectors to support recognition and Early Help; to manifestly improve the offer to children with Special Educational Needs and Disabilities; and to support the work of the Children's Trust.

5.15 The new Detective Chief Superintendent heading up the Public Protection Unit (PPU), Caroline Marsh, and her colleagues in local Policing acknowledge the need to improve the quality of investigations and to work well with partners in frontline safeguarding. She reports to acting Assistant Chief Constable Claire Bell who led the PPU for a number of years and they have a commitment to our system improvement agenda.

5.16 With new leaders in key roles there is a need to invest in developing relationships, based on shared purpose, ambition, values and priorities. Time is required to establish trust and an appreciation of inter-dependence.

5.17 Working over screens and mobiles in the virtual world arguably slows down relationship and trust building, so essential to collaborative working. So hopefully the next few months will see a greater return to some face to face interactions, which will support the development of these new leaders in the system and their shared commitment to strong leadership and strong partnership. I have high hopes for our Safeguarding Leaders Assembly at the MAC on 28th April 2022.

5.18 So there is evidence that the largely new cadre of senior leaders are jointly committed to improving services and outcomes. There is assurance that the system is working together. As I will go on to show, there is ample learning from practice. The impact of all this is yet to be fully realised.

6. Continuously improve Child Safeguarding Practice across the system and in all agencies

6.1 One of the primary functions of the statutory Multi-Agency Safeguarding Arrangements (MASA) is to support effective safeguarding practice, providing procedures and guidance, training, and timely learning from serious incidents, inspections, audit activity and research.

6.2 As outlined in the 'Organisational Arrangements' section, we put a high premium on supporting practitioners through our Forum, Annual Conference, comprehensive Learning & Development offer and succinct Briefings.

6.3 The work of the Serious Cases sub-group, well supported by the Partnership Team is pivotal in identifying and communicating essential learning, from serious cases.

6.4 The new national arrangements for Rapid Reviews with their opportunity to identify and address issues quickly, are working well. The judgment that is now made as to the benefits of undertaking a Local Safeguarding Practice Review, is enabling a more focussed use of resources. A third of our Rapid Reviews were then the subject of Local Child Safeguarding Practice Reviews, which is in line with National Practice. The endorsement by the National Panel of our decision making is reassuring.

6.5 And the commitment of partners to produce their analysis of work undertaken against the challenging national timescales set, has been nothing short of impressive. All our Rapid Reviews in 2021/22 of which there were 6, met the 15-day target except one.

6.6 At the year-end we have two legacy Serious Case Reviews, both from 2017, still unfinished and unpublished, due to continuing court action. In both cases significant learning has been identified and acted upon.

6.7 A further two cases were published during this past year.

6.8 In September 2021, we published a Local Child Safeguarding Practice Review which we titled "Reachable Moments". I attach the Learning Briefing note as Appendix 3. This sad case focused on the fatal stabbing of a teenager who was the victim of Child Criminal Exploitation (CCE). There was learning for all practitioners about the opportunity for "Reachable Moments" at times of crisis, and especially for education settings, in terms of early help and the prevention of exclusion.

6.9 In October 2021, we published a legacy Serious Case Review involving the death from catastrophic brain injury of a 21-month-old child in 2017. The perpetrator was found guilty of murder in March 2021. I attach the Learning Briefing note entitled "Unexplained Bruising" as Appendix 4. Here the learning focused on the need for risk awareness in the case of new partners joining a vulnerable household, and the importance of curiosity in the face of unexplained bruising. This was a situation where the child had been placed on a Special Guardianship Order and there were practice changes made to the support for such situations, following this case.

6.10 A further seven cases are currently the subject of a Local Practice Safeguarding Review. In these cases, early identification of learning and practice improvement is prioritised and acted upon, we do not await formal publication of the Review.

6.11 Birmingham is a large city with a significant child population of 286,500. It is not an outlier in terms of the numbers of serious incidents or reviews. Because of its size there is an opportunity to identify, share and act on trends if they exist.

6.12 "Right Help, Right Time" is the guidance we developed to support practitioners in their safeguarding responsibilities. It is regularly reviewed to ensure it is up to date and this happened again this last year, resulting in a re-launch in December 2021. There is a particular drive to identify needs early and to enable early help to be provided in localities, where families reside. We seek to equip Lead Professionals in all settings to be curious, to be pro-active and enable family foundations to be strengthened with appropriate targeted support.

6.13 The Learning and Development sub-group supported by a Programme Manager, have the vital role of ensuring that a comprehensive and up to date curriculum of multi-agency training is on offer to all practitioners. As well as basic training, the offer includes the learning from serious cases and topics of particular interest or of priority to the partnership. For the second year, the learning and development offer has been online, the take-up has been strong and feedback good.

6.14 Capturing the voice and experience of children and young people is a fundamental element of the process of assessment and planning in individual cases. The need to improve practice here is a regular feature of reviews where the benefit of hindsight shines a light on unseen experience and unheard views. The Partnership is keen to explore ways of enhancing practice and has accepted the offer of leadership in this from the Children's Trust who have made real headway in the engagement of young people over the last years.

6.15 Already the Children's Partnership has benefitted from the 'Young Researchers'whose work with 4,000 youngsters through surveys and workshops produced evidence of their priories for action.

6.16 They strongly align with the ambition and priorities for the partnership. They wished for Birmingham to be:

- Safer – 83%
- Less poverty -73%
- Clean -57%
- Happier-41%
- Community spirit-41%
- Green parks & spaces – 41%
- Eco-friendly -40%

6.17 Before the pandemic, in almost unforgotten times, we moved the meetings of the Executive around the City and in different settings. We were hosted by partners in schools, children's hubs, hospitals, third sector organisations and the like, enabling us to meet real young people and adults working with them. We will need to review whether we return to this approach in

the fullness of time, and if not, what other ways we have of genuinely hearing from youngsters to inform our efforts.

6.18 An initiative for this year was to engage with the Faith Communities of the City and to support them in their commitment to improve safeguarding awareness and practice. A project group has been established and a Faith Project Coordinator funded to take forward this work into the 2022/23 year.

6.19 Our Quality Assurance sub-group, 'Quality, Impact and Outcomes', plays a vital role in our virtuous learning cycle. It leads on monitoring key performance information, testing the practice on the ground through audit and survey work, and providing exception reports to the Executive. The Board's Assurance Framework explicitly seeks to triangulate quantitive, qualitative and experiential data, not relying on a single source. Chairing of the Group this year has moved from the Director of Practice in BCT and Chief Nurse in the CCG, to the Assistant Director Safeguarding in BCT and Assistant Chief Nurse (Safeguarding) in the CCG.

6.20 The impact of the Quality, Impact and Outcomes sub-group has been demonstrated in the profile and progress made in reducing "exclusions" from schools, highlighting the negative impact of temporary accommodation on children and shining a light on the need for a practice focus and improved support in cases of neglect. That Neglect is now a priority for the Safeguarding Partnership is evidence of learning in practice.

6.21 This sub-group leads on considering the transferable learning from Inspections and Reviews elsewhere in the country. Clearly, the high-profile National Safeguarding Practice Review underway following the appalling murders of Arthur Labinjo-Hughes from Solihull and Star Hobson from Bradford, will be such cases. Because Arthur's early life was in Birmingham, colleagues have contributed to that review.

6.22 Already, the Joint Targeted Area Inspection (JTAI) of Solihull published in February 2022, is being used as a useful benchmarking tool by us in Birmingham. Additionally, I have asked that the Hackney Safeguarding Practice review in respect of "Child Q" is used to benchmark local practice in respect of schools concerns for possible drugs misuse by pupils.

6.23 Leadership and Learning remain keywords for our improvement agenda and it will be vital that new leaders within the Safeguarding system demonstrate their commitment to them, practiced in a spirit of openness and collaboration in pursuit of a joint purpose: Birmingham Children (should) Thrive.

7. Developing an effective multi-agency response to Child and Adolescent Neglect

7.1 This priority seems ever more timely as we hear about and experience the cost of living crisis besetting the country, and wider world. Already we are seeing the impact of neglect in a number of tragic serious cases, and the pressure on families is set to increase.

7.2 At the BSCP Executive in March, we received a valuable update on the work to develop the Neglect Strategy which is now ready for consultation, and its supporting tools for practice. This work ably led by a Neglect Lead Manager, Luisa Fraser, and supported by a partnership group, is making headway. Over two hundred professionals have been trained to use the

NSPCC licensed "Graded Care Profile 2" to support assessment and intervention. The links between this initiative, the Early Help agenda and EmpowerU Hub cannot be underestimated. Neglect impacts on babies, young children and adolescents and the strategy addresses this.

7.3 The active engagement of staff across housing, early years, schools and colleges, community and primary and secondary health, the voluntary and community sector and community policing, will be vital and makes this priority one that will continue into next year. Really, this is very much a work in progress. And it will require concerted Leadership to ensure that recognising and addressing neglect becomes everybody's business and is not the subject of "hand-off" from one professional or organisation to another. The connection with locality based Early Help, assessing the effectiveness of "Family Foundations", and strengthening communities is obvious.

8. Evaluating and addressing the consequences of Covid-19 on Safeguarding Children

8.1 Writing this report, two years on from the first "lockdown", little did I think that we would still be managing the impact of Covid-19 in March 2022.

8.2 For two years now, we have all adapted to the virtual world and the business of the Safeguarding Partnership, the meetings and groups I describe above, have been managed remotely.

8.3 We have learned a great deal about smart, remote working and many of the arrangements we have put in place will be sustained. We have agreed that Sub-Groups will continue to be convened remotely with occasional face to face development sessions. We expect the Board to possibly alternate remote and in-person meetings. That said, we have no final start date for the change.

8.4 Development – type sessions will be prioritised for in-person gatherings, to optimise creativity and support essential professional relationships based on trust, respect, openness and shared learning.

8.5 Our first planned face to face meeting at scale is the Safeguarding Leaders meeting at which this report is presented and I'm very much looking forward to meeting colleagues in person for the first time in ages.

8.6 In April, the Safeguarding system will see a return of in-person Child Protection Conferences, Reviews, and Core Groups and this will make renewed demands on partners' time, organisation and priorities. Whilst facilities for virtual attendance will be provided in exceptional circumstances, we know that real-time meetings will have benefits for the children and families whose needs and safety are being considered. Again, Leaders will need to be setting clear expectations for staff attendance and providing the right support to facilitate this.

8.7 As I did last year, I must pay tribute to all staff in all the organisations who have continued to serve the City and to support and protect vulnerable children. If anything, the pandemic has underlined the value and necessity for partnership working. At a senior operational level, it led to the establishment of the Partnership Operations Group. At a case level, the benefits of

joint work were highlighted by Consultant Paediatrician for Child death, Dr Jo Garstang, when she described the benefits of a shared paediatric visit with the Police following a sudden infant death.

8.8 One concrete outcome from the Partnership Operations Group, was the timely development of a home visiting protocol to ensure that children were seen during the period of the Pandemic and that was a vital development.

8.9 I acknowledge that with children prevented from attending school for long periods, the deprivation of opportunities to socialise or indeed to be seen, contributed to added pressures on families and added risks for children. And we know that the year saw a continued increase in incidents of Domestic violence and abuse.

8.10 So, the work to establish the Early Help offer in the 10 localities of the city was to meet a pressing need and it has had a real impact. At the March Practitioner Forum, we learnt that 37,000 individuals were helped by the locality Early Help teams and/or the Household Support Fund between April 2021 and February 2022. Its essential that the funding of this much needed support is made sustainable and recurrent.

8.11 The response to the pandemic has been impressive. And Covid-19 has not gone away. With the cost of living crisis, the war against Ukraine and the climate emergency, it will continue to provide a challenging backcloth to the work to enable Birmingham children to thrive.

8.12 Already we are adapting to new ways of working and we will not return to pre-2020 arrangements. The challenge is to take the best of the new practices, embracing technology, leaving "presentism" behind, whilst still finding time to establish sound relationships and a common purpose as the basis for collaborative working.

8.13 One aspiration that has been impacted by the pandemic is the direct engagement with children and young people to inform the work of the Safeguarding Partnership. And this is something that we have in our sights for next year.

9. Conclusions

9.1 This past year has been surprisingly more of the same in Covid-19 terms. That practitioners have sustained their commitment, creativity and energy to safeguarding children is evident and must be appreciated.

9.2 The culture of learning that we strive to embed is evident and must be sustained and celebrated.

9.3 Leadership is compromised by churn in the individuals holding accountable roles. There is a need for early identification of a key lead from Health to take their share of the accountability for the safeguarding system.

9.4 In my judgement, safeguarding arrangements in Birmingham are working effectively and progress in delivery of Partnership priorities is evident.

9.5 The development of the Birmingham Children's Partnership and prioritised Children's Plan are welcome and necessary. The progress in Early Help via a locality offer is encouraging.

9.6 The importance of strengthening arrangements to support best practice in Schools and in Health settings cannot be underestimated.

9.7 The new cast of police colleagues now charged with leading on Safeguarding in Birmingham, must be supported to develop open, respectful working relationships and effective practice arrangements.

9.8 I must end by thanking all the colleagues in all the organisations that make up the Birmingham Safeguarding Children Partnership for their support, and the confidence they have put in me to fulfil this awesome role – of convening, support, challenge, assurance and learning.

Penny Thompson CBE
Independent Chair
Birmingham Safeguarding Children Partnership

31st March 2022.

Appendices

Appendix 1: Role of BSCP Independent Chair – Leadership of Assurance, Learning, Partnering
Appendix 2: BSCP Structure Chart
Appendix 3: "Reachable Moments" Briefing Note
Appendix 4: "Unexplained Bruising" Briefing Note

Appendix 1

Role of BSCP Independent Chair – Leadership of Assurance, Learning, Partnering

Key Functions:

a) Independent convener of all those charged with the wellbeing, including safeguarding, of children and young people in Birmingham;

b) A champion for children and best practice;

c) Independent Chair of the Birmingham Safeguarding Children Partnership Executive Board and Safeguarding Leaders' Assembly;

d) Supporting and challenging the Birmingham leadership in their quest to achieve a sustainably safe city for children and young people, in the context of family, community and wellbeing;

e) Modelling openness, challenge, support, mutual respect, professionalism and learning for application by leaders in Birmingham;

f) Ensuring political and managerial leaders are demonstrably accountable for the resourcing and strategic priority given to the safeguarding and wellbeing of children and young people;

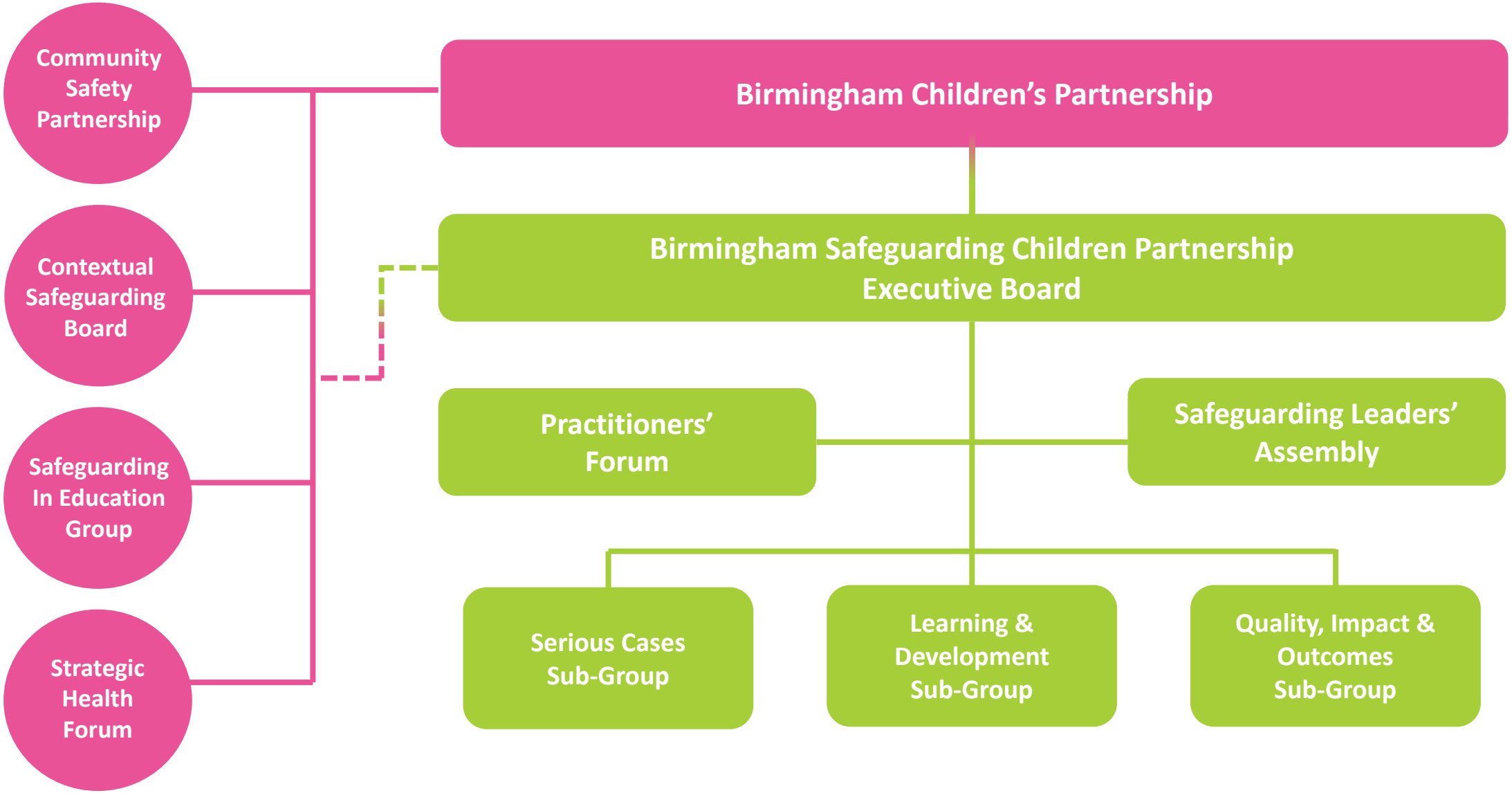
g) Ensuring the Safeguarding Partners' leadership role is understood, valued, respected and fulfilled;

h) Demonstrating a robust approach to evaluation, practice audit & research whose dissemination will support valuable learning for multi-agency leaders, managers and practitioners in their critical roles;

i) Through robust independent support and challenge, contribute to developing confidence of citizens and the state in the city of Birmingham.

BIRMINGHAM Safeguarding Children PARTNERSHIP

Structure Chart



Appendix 3

Learning from Serious Cases

Briefing Note for Team Meetings

September 2021

Reachable Moments

Background

The Birmingham Safeguarding Children Partnership commissioned a Local Child Safeguarding Practice Review focusing on the fatal stabbing of a teenage boy, and two other young men who were with him at the time of the incident. The independent review considered all aspects of agency involvement in the lives of the boy, the young men and their families. The purpose of the review was to identify systemic learning and specific areas where we can continue to improve frontline practice to safeguard children and to prevent or reduce the risk of recurrence of similar incidents.

In January 2020, the boy and young men, who were all from Birmingham and believed to have been involved in an urban street gang, travelled to a small country town where the violent assault took place. The police investigation found that the purpose of their visit was linked to 'County Lines' and the illegal supply of controlled substances. The boy and young men were recognised as being victims of Child Criminal Exploitation (CCE). The perpetrator has been brought to justice, together with three individuals who have been convicted of perverting the course of justice. All four received substantive custodial sentences.

The key learning from the review focuses on circumstances when a child or young person is more likely to take up an offer of support - 'Reachable Moments'. Practitioners can capitalise on these to maximise the opportunity to connect with vulnerable young people to help change their lives.

Key Findings, Good Practice and Learning

- The review highlighted the quality of partnership arrangements and practitioners' knowledge, passion and commitment to make a difference for children at risk of criminal exploitation.
- The review endorsed the partnership approach in Birmingham to safeguarding exploited young people, seeing them as children and victims first, rather than just offenders. However, it was felt that understanding of the National Referral Mechanism (NRM) could be improved across agencies working with children at risk of CCE.
- The 'One Day One Conversation' (ODOC) and Disruption Planning meetings were seen as key to the effective co-ordination of partnership intervention for children at risk of criminal exploitation and disrupting perpetrators.
- The detrimental impact of school exclusion was again highlighted, along with the importance of a partnership approach to working with schools to intervene early to support and work with children at risk of expulsion and at risk of CCE.
- It is important that children who go missing have a Return Home Interview (RHI), especially where it is suspected CCE is involved. The timely sharing of information from RHIs not only helps to build a more holistic picture of the child's lived experience, but also provides vital intelligence about perpetrators to help inform the work of the EMPOWER U Hub.

Improving Practice

- When there has been a dramatic deterioration in a child's behaviour and wellbeing, when there is a risk of exclusion from school, when they receive medical treatment for an unexplained injury, when arrested and in police custody or when found having been missing, practitioners need to reach out and connect with the child to gain their trust and confidence, in order to make a difference. Practitioners need to seize these '***Reachable Moments***'.
- Practitioners should familiarise themselves with the National Referral Mechanism (NRM) guidance on safeguarding children from CCE.
- In educational settings early intervention is essential to find out why there is a deterioration in a child's behaviour at school, to focus support to prevent the need for exclusion where possible.
- Educating children about the dangers of knives and being involved in gangs and serious youth violence is key to preventing future exploitation. This should start from in the last years of primary school as well as continuing at secondary school.
- When practitioners carry out an RHI, they should maximise the opportunity to build trust and confidence with the child and ensure the timely sharing of information with the EMPOWER U Hub.

Next Steps – What you can do

a) Circulate this Briefing Note to all members of your team and discuss the case at your next team meeting or supervision session. Use the PowerPoint presentation to ensure everyone understands and is able to apply the learning.

b) Make sure you and your team understand that Criminal Exploitation is a form of child abuse (Working Together to Safeguard Children 2018).

c) Familiarise yourself with and use the screening tool to help assess risk for both criminal and sexual exploitation, which is available on the BSCP website - click here. The screening tool, once completed, must be attached to a Request for Support Form and submitted to the BCT Children's Advice & Support Service (CASS) via cass@birminghamchildrenstrust.co.uk. Further advice and information is available via the Child Exploitation and Missing Hub on 0121 464 7967.

d) Make sure your team are aware that the Right Help, Right Time (RHRT) guidance is currently being refreshed and will be available to download from the BSCP website before the end of September 2021. For a copy of the RHRT guidance – click here.

e) Visit the BSCP website (www.lscpbirmingham.org.uk) for details of free Multi-Agency Training on Child Exploitation and other safeguarding topics.

Appendix 4

Learning from Serious Cases

Briefing Note for Team Meetings

October 2021

Unexplained Bruising….

Background

This independent review focuses on the tragic death of a 21-month-old child in November 2017 as a result of catastrophic brain injuries following a violent assault. The child's mother suffered from drug addiction before and throughout the pregnancy, and the baby was born prematurely. There was a long history of agency intervention with the family, with the child's two older siblings living with their maternal grandmother since 2015 under a Special Guardianship Order (SGO). In March 2016, the child was placed with a relative under an SGO, following a positive assessment and endorsement by the Family Court. Children's services continued to offer support to the Special Guardian for a further 6 months.

In April 2017, the Special Guardian rekindled her relationship with the perpetrator who is now known to have a history of mental health problems and violence, which includes domestic abuse. At the time he was attending a domestic abuse perpetrators group work programme and disclosed that he had started a relationship with a woman with children. This important information was not shared by the Probation Service, with partner agencies.

During October and November 2017, the Special Guardian expressed concerns to nursery and healthcare professionals about the number of bruises sustained by the child. A medical review at hospital was undertaken a month prior to the fatal assault, but at that time no safeguarding concerns were identified. In November 2017, the child was admitted to hospital having been found unresponsive at her home address and sadly died three days later. In March 2021, the perpetrator was found guilty of the child's murder and sentenced to a minimum term of 20 years in prison. The review identifies important learning for front-line practitioners.

Improving Practice

- If you become aware of a new relationship and have concerns about the risk the individual poses to their new partner and/or children, share this information with other professionals working with the family in order for any risks to be identified and assessed, as set out in '*Right Help Right Time Delivering effective support for children and families in Birmingham'* guidance. If there are no professionals working with the family, refer your concerns to the Children's Advice and Support Service (CASS).
- When a parent/carer presents with a child with an unexplained bruise or bruising, be curious and seek a detailed explanation, particularly in non-mobile babies. Always be mindful that disguised compliance could be a factor. Following your discussion with the parent/carer, consult with your agency's senior safeguarding lead for advice and support on what action is required.

Good Practice and Learning

1. In this case, the post-placement support network was not clear and a multi-agency pathway with a named lead agency and clear expectations would have been helpful. All carers who now have an SGO granted in Birmingham are offered support via the SGO Support Team for a minimum of six months post Order with an allocated Social Worker. The SGO Support Plan is then reviewed on an annual basis. Special Guardians have also been provided with access to advice and guidance as and when required. They have access to continued training, support groups and dedicated support to assist with the child's education.
2. Enough time should always be given to assess the integration of the child within the family, the care of that child and the impact this has on all members of the family before the final SGO is made. Now nationally, Family Courts work in close collaboration with safeguarding agencies to ensure that children who achieve permanence through special guardianship receive appropriate levels of support and supervision following the Order.
3. The nursery and GP were unsure of what action to take when the child presented with significant bruising. In the intervening period regional guidance on the management of injuries in babies and children under two years of age was updated in August 2020, and training for health professionals around bruising in infants and children has been, and will continue to be, delivered.

Next Steps – What to do

a) Circulate this Briefing Note to all members of your team and discuss the case at your next team meeting or supervision session. Use the PowerPoint presentation to ensure everyone understands and is able to apply the learning.

b) Familiarise yourself with regional guidance about the management and referral of babies and children under the age of two years, particularly those who are not yet independently mobile, who have presented with an injury - **click here**

c) NSPCC provides useful guidance for professionals on how to identify bruises that may be the result of non-accidental injuries. To access the guidance, **click here**

d) Make sure your team are aware that the Right Help, Right Time (RHRT) guidance is currently being refreshed and will be available to download from the BSCP website. For a copy of the current RHRT guidance **click here**

e) Encourage your team to attend 'Learning Lessons from Serious Cases'. For more information on this training course and for future delivery dates **click here**