

**Report to:** East Sussex Health and Wellbeing Board

**Date of meeting:** 13 December 2022

**By:** Chris Robson, East Sussex Safeguarding Children Partnership Independent Chair

**Title:** East Sussex Safeguarding Children Partnership Annual Report 2021/22

**Purpose:** To advise Board Members of the multi-agency arrangements in place to safeguard children in East Sussex.

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## **RECOMMENDATIONS**

**The Board is recommended to receive and consider the East Sussex Safeguarding Children Partnership Annual Report for 2021-2022.**

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### **1. Background**

- 1.1 [Working Together to Safeguard Children](#) 2018 sets out the arrangements for cooperation between organisations and agencies to improve the wellbeing of children. This places a duty on police, clinical commissioning groups (*NHS Sussex as of July 2022*) and the local authority to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area. The partnership arrangements are set out in section 4 (page 8) of the report.
- 1.2 In order to bring transparency for children, families and all practitioners about the activity undertaken by the Children's Safeguarding Partnership, Working Together 2018 sets out that the safeguarding partners must publish a report at least once in every 12-month period. The report must set out what they have done as a result of the arrangements, including child safeguarding practice reviews, and how effective these arrangements have been in practice.
- 1.3 The 2021/22 ESSCP Annual Report focuses on partnership learning, impact, evidence and assurance.

### **2. Supporting information**

- 2.1 The ESSCP Annual Report 2021/22 outlines the work undertaken by the partnership, highlighting key learning and achievements in section 2 (page 6), which includes:
  - 8 multi-agency Rapid Reviews conducted and 4 completed Local Child Safeguarding Practice Reviews (LSCPR).
  - 869 multi-agency staff attended 61 virtual training courses. 98% of evaluations rated the course as Excellent or Good, which is a 2% increase on last year.
  - Three multi-agency audits held: non-accidental injuries in under 2s, step-up step-down from early help, and a regular case file audit.
  - New Independent Chair recruited and ESSCP Development Action Plan created.
  - Strengthened partnership focus on learning, impact and pan-Sussex working.

- Four additional safeguarding projects covering: harmful sexual behaviour in education settings, reducing parental conflict, elective home education (EHE) and a focus on Safeguarding under 1s.
- 2.2 The ESSCP Annual Report 2021/22 will be published on the ESSCP website, and a copy of the published report shared with the Child Safeguarding Practice Review Panel and the What Works Centre for Children's Social Care as per chapter 3 of Working Together 2018.
- 2.3 The national review into the death of Arthur Labinjo-Hughes and Star Hobson was published in May 2022, after the period the ESSCP annual report focuses on. Arthur Labinjo-Hughes, 6, and Star Hobson, 16 months, were both murdered in 2020 as a result of sustained abuse and neglect by their caregivers. A summary of the learning from this review and the initial ESSCP response is provided below:
- 2.4 In analysing what happened to Arthur and Star and how their local public agencies responded, the review identified a set of issues which hindered professionals' understanding of what was happening to Arthur and Star. These were:
- Weaknesses in information sharing and seeking within and between agencies.
  - A lack of robust critical thinking and challenge within and between agencies, compounded by a failure to trigger statutory multi-agency child protection processes at a number of key moments.
  - A lack of specialist child protection skills and expertise, especially in relation to complex risk assessment and decision making; engaging reluctant parents; understanding the daily life of children; and domestic abuse.
  - A lack of effective leadership and management which has a powerful enabling impact on child protection practice and creates and protects the optimum organisational context for undertaking this complex activity.
- 2.5 The national review identifies a number of key messages for *all* Safeguarding Partners:
- Robust multi-agency strategy discussions are always being held whenever it is suspected a child may be at risk of suffering significant harm.
  - Sufficient resources are in place from across all agencies to allow for the necessary multi-agency engagement in child protection processes e.g., strategy discussions, section 47 enquiries, Initial Child Protection Conferences.
  - There are robust information sharing arrangements and protocols in place across the Partnership.
  - Referrals are not deemed malicious without a full and thorough multi-agency assessment, including talking with the referrer, and agreement with the appropriate manager.
- 2.6 The ESSCP Independent Chair wrote to the safeguarding leads (police, NHS Sussex and the local authority) in July 2022 to seek assurances with regards to the learning outlined above. The response to this, along with a multi-agency deep dive audit / mock joint targeted area inspection (JTAI) of the multi-agency response to identification of initial need and risk, will be discussed at the ESSCP Steering Group in December. Therefore the 2022/23 ESSCP annual report will include this piece of work.

### **3. Conclusion and reasons for recommendations**

3.1 An effective Safeguarding Children Partnership is in place in East Sussex.

3.2 The Health and Wellbeing Board is requested to receive and consider the ESSCP Annual Report 2021/22 and to note the continuing partnership priorities for 2020-2023:

- Education Safeguarding
- Child Exploitation
- Embedding a Learning Culture
- Safeguarding under 5s

### **CHRIS ROBSON**

Independent Chair ESSCP

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