Alan Caton OBE
Independent Safeguarding Consultant

13 January 2025

Executive Leadership Group
Hillingdon Multi-Agency Safeguarding Arrangements
London Borough of Hillingdon
Hillingdon Council
Civic Centre
High Street
Uxbridge
Middlesex
UB8 1UW

Dear Tony, Jennifer and Jill,

Re: Independent Scrutiny of the London Borough of Hillingdon Safeguarding Arrangements

This letter summarises the findings from my independent review and scrutiny of safeguarding in the London Borough of Hillingdon in January 2025.

The focus of this year's scrutiny was to; seek assurance about safeguarding practice and scrutinise the effectiveness of the partnership arrangements with reference to:

- The effectiveness and impact of multiagency child safeguarding enquiries pursuant to s47 of the Children Act 1989.
- The effectiveness and impact of multiagency adult safeguarding enquiries pursuant to s42 of the Care Act 2014.

To facilitate this work, I reviewed in detail, 6 selected child cases and 6 selected adult cases. I examined each case, along with key partners, to assess the way threshold decisions were made, the effectiveness of multiagency working, how risk was analysed and what outcome was experienced for the respective adult or child.

I am an experienced safeguarding professional, having worked as an independent chair and scrutineer for both LSCB's, SAB's and Safeguarding Partnerships for the past 12 years. Prior to this I served as a police officer in Suffolk Constabulary for over 30 years and retired as the senior officer in charge of the Public Protection Directorate.

Working Together 2023 (WT 2023) clearly outlines the role of 'Independent Scrutiny' which I have also considered during this review. The relevant paragraphs from WT 2023 appertaining to Independent Scrutiny are attached at **Appendix 1.**

Review methodology

The review took place over a period of 6 days, during which time I looked specifically at the effectiveness of the partnership with a particular focus on the effectiveness and impact of both children's and adult's safeguarding enquiries.

This review is a snapshot of the current practice arrangements and is based on a small number of cases. The review took the form of reading relevant documentation, meeting key members of the partnership and facilitating multi agency round table discussions to examine those selected cases that had been subject to audit.

The full details of the Adult Audit of eighteen cases can be found in **Appendix 2**, 'Application of Section 42 Care Act 2014'. The full details of the Children's Audit of eighteen cases can be found in **Appendix 3** 'Application of Section 47 Children Act 1989'. The appendices should be read in conjunction with this letter.

I would like to thank all of those who contributed and gave open and honest feedback to inform the process. I would like to thank the Safeguarding Partnership Team who audited all the cases and coordinated the multiagency round table discussions.

All advice given, albeit experienced based, is in no way meant to be prescriptive and is given on the basis that Hillingdon Safeguarding Partnerships may or may not choose to act upon it.

Safeguarding Arrangements Key Findings

The Hillingdon Multi-Agency Safeguarding Arrangements for both children and adults comply with their statutory responsibilities. The arrangements for both children and adults are clear and have been published in accordance with statutory guidance.

I found that good relationships have been built between partners, both statutory and non-statutory, and that there is a real willingness for the safeguarding partners to work together to seek out vulnerable children and adults and to provide them with the best possible services. It is apparent that there is a strong sense of partnership across Hillingdon and a desire to continually improve services. There is a clear meeting structure and delivery model which is supported by multi-agency subgroups.

Strategic governance is provided by the Executive Leadership Group (ELG) who oversee the safeguarding arrangements for both children and adults. The ELG comprises of the Council Chief Executive and senior representatives from the ICB and police who form the three statutory safeguarding partners. There is joint and equal responsibility for the safeguarding of children and adults in Hillingdon which is recognised by the wider partnership. On speaking with senior leaders, it is apparent that they feel well supported by a very efficient Safeguarding Partnership Team which is led by a highly competent and effective manager.

It is very reassuring to see that the 'Areas for Consideration' following last years scrutiny have been considered by the partnership along with being actioned and progressed where necessary.

The safeguarding arrangements for both children and adults are well established and well understood by partners. Business plans drive the activity of the partnerships, which are well supported with a clear structure of meetings. The Executive Leadership Group, comprising of senior leaders from the three statutory partners have joint and equal responsibility for safeguarding in Hillingdon, their role is delivery oversight, challenge and governance.

The Multi Agency Safeguarding Arrangements (MASA) for children were published in December 2024 in line with the requirements of Working Together 2023. The arrangements set out clearly how the safeguarding partners in Hillingdon coordinate their safeguarding services and how they will work together to safeguard and promote the welfare of children and adults with care and support needs.

I would like to highlight one area of partnership function that requires attention, review and progress. *Working Together 2023* outlines that the Lead Safeguarding Partners should agree on the level of funding needed to deliver effective multi agency safeguarding arrangements. This includes business and analytical support, independent scrutiny, infrastructure and core functions such as CSPRs, multi-agency training and learning events. Funding contributions from statutory safeguarding partners should be 'equitable', however in Hillingdon, funding arrangements appear to fall disproportionately on the local authority, with consistently low contributions from the police.

Area for Consideration 1 – ***For the LSPs to review the current funding arrangements for both children and adult safeguarding in Hillingdon to ensure joint and equitable funding contributions between the 3 statutory partners.***

During discussions it was noted that the Government are intending future legislation which will impact on multi-agency safeguarding. In the recently published document '**Keeping Children Safe, Helping Families Thrive**', the Government outlined their plans to change laws in order to keep families together and children safe, and to remove barriers to opportunity. Their key ambition is for a child protection system that is decisive and multi-agency with multidisciplinary skills. They are recommending, amongst other things, that multi-agency child protection units be established in every local authority area. The units will be integrated teams, staffed with multi-agency, experienced child protection practitioners from agencies working to protect children, including local authorities, police, health and education settings. These teams will be led by the local authority. Whilst this is not yet in legislation, it will be a significant change from current practice and could be happening at pace. I would suggest discussions should now be taking place at a strategic level between statutory partners and education to plan for the creation of a multi-agency child protection unit for Hillingdon.

Multi Agency Audit Findings

The focus of scrutiny this year was close examination of 6 cases out of the eighteen that were subject to audit, that reached the threshold for Section 47 enquiries for children and Section 42 enquiries for adults. The full breakdown, with analysis can be found in **Appendices 2 and 3**. I do not intend to go into the detail of each individual case in this letter as they are covered in the appendices. However, this review has led to identifying a small number of themes that the partnership may wish to seek further assurance on.

Adult Section 42 Enquiries Findings

Multi Agency Planning

Section 42 of the Care Act 2014 places a duty on local authorities to make safeguarding enquiries if they suspect an adult with care and support needs is experiencing or at risk of abuse and neglect and is unable to protect themselves. The small number of cases that were subject to audit did highlight that some of these enquiries failed to achieve good multi agency engagement. Several of the cases reviewed indicated insufficient multi agency planning meetings, which led to missed opportunities to gather relevant information. Safeguarding enquiries appeared to be treated as a task for adult social care rather than a multi-agency endeavour.

Area for Consideration 2 – ***For the Safeguarding Adult Board to seek assurance that multi-agency planning meetings are held at an early stage in Section 42 enquiries to ensure all relevant information is gathered and shared to enable better protection and outcomes for vulnerable adults.***

Section 68 Care Act 2014

Section 68 of the Care Act 2014 relates to independent advocacy in certain safeguarding situations. It is a duty placed on the local authority to arrange for an independent advocate to be available to represent and support an adult who is the subject of an adults safeguarding enquiry. It became evident in some of the cases audited that not all adults subject to an enquiry were adequately represented.

Area for Consideration 3 - ***For the Safeguarding Adult Board to seek assurance that adults at risk, who have difficulties participating in safeguarding enquiries have appropriate representation under Section 68 of the Care Act 2014. Also, the SAB to assure itself that there is adequate multi-agency safeguarding training on the role and importance of advocacy in safeguarding.***

Mental Capacity Act Assessments

The consideration of mental capacity is crucial at all stages of safeguarding adults' procedures as it provides a framework for decision making to balance independence and protection. Legislation underpinning practice in this area is guided by the application of the Mental Capacity Act 2005, which provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. This audit has highlighted that mental capacity was not appropriately considered in at least half of the reviewed cases. It is worth noting that the second National Analysis of Safeguarding Adult Reviews stated that shortcomings in mental capacity act assessments was a commonly noted failing.

Area for Consideration 4 - ***For the Safeguarding Adult Board to seek assurance that mental capacity assessments are considered and used appropriately and to be assured that all professionals conducting assessments are thoroughly trained in the Mental Capacity Act 2005 principles and the assessment process.***

Children's Section 47 Enquiries Findings

Again, as like the adult's scrutiny, eighteen child cases were subject to analysis and audit. Following this, 6 cases were selected for a multi-agency round table discussion, which I facilitated. There was good representation from the partnership involving colleagues from the police, local authority children's services and education, ICB and health providers. This section of the letter will look at the themes emerging from the audit rather than going into the detail of individual cases and should be read in conjunction with '**Appendix 3'**.

Representation at Strategy Discussions
Strategy discussions should be convened whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm. As a minimum, at each strategy discussion, there should be representation from the police, health practitioners and a local authority social worker. In addition, any other agency with relevant information should be invited. The audit showed that all strategy discussions were convened appropriately.

There were several examples where health and education professionals were not in attendance at strategy discussions. Further exploration of this non-attendance identified that health colleagues were not available due to staff shortages, also, because these strategy discussions were convened during school holidays, no education colleagues were made available. Whilst this is not acceptable, it is noted that where education and health professionals did not attend in person, information was subsequently gathered through the Section 47 Enquiry and/or the Child and Family Assessment.

I did note that the partnership quickly identified the lack of resources available in health to attend strategy discussions. This was raised as a risk with the Executive Leadership Group and action was taken by health to recruit additional resources. This has now been resolved, and health are regularly attending all strategy discussions.

Area for Consideration 5 – ***For the Hillingdon Safeguarding Children Partnership (HSCP) to be assured that processes are in place to enable school attendance at strategy discussions during school holiday periods.***

Area for Consideration 6 – ***For the HSCP to regularly review and monitor strategy discussions to ensure appropriate attendance from safeguarding partners.***

Child Protection Medicals
Child protection medical examinations should be undertaken to assess a child's health and development, identify any injuries or harm and provide appropriate treatment. Child protection medicals are necessary when there is suspicion of abuse, where there has been a disclosure and where forensic evidence needs to be secured.

One particular case highlighted this as an issue, where there was an absence of a child protection medical even though there was clear disclosure of physical chastisement.

Area for Consideration 7 – ***For the HSCP to be assured there are clear and consistent arrangements, processes and guidelines in place to ensure child protection medical examinations are conducted appropriately. Also, for CNWL to provide assurance to the partnership that a child***

protection medical will be undertaken if requested to do so following a strategy discussion and/or Section 47 enquiry.

Domestic Abuse

Domestic Abuse was a feature in a number of cases. Domestic abuse is any type of controlling, threatening behaviour violence or abuse between people who are, or who have been in a relationship, regardless of gender or sexuality. It can also happen between adults who are related to one another. Domestic abuse always has an impact on children. Being exposed to domestic abuse in childhood is child abuse. Children and young people may experience domestic abuse both directly and indirectly. The definition of significant harm was amended in the Children's Act 2002 to encompass the experiences of children who witness domestic violence or are aware of domestic violence within their home environment. Children who are exposed to domestic abuse should be treated as victims regardless of whether they were present during violent incidents.

Area for Consideration 8 – *For the HSCP to be assured that frontline practitioners understand the impact of coercive control and that there is wide recognition that children who are exposed to domestic abuse should be considered formally as victims in their own right. In such cases, strategy discussions should consider joint investigations which recognise children as victims.*

Child Protection Plan v Child in Need Plan

One particular case raised this issue, it was a complex case surrounding a child with very challenging needs who was at significant risk of harm outside of the home. This child was judged at being at risk of significant harm and the case was transferred to the Adolescent Team for specialist support under a Child in Need Plan. Whilst I have every confidence that this child is receiving the very best possible support, I hold the view that it should be held under a Child Protection Plan and not a Child in Need Plan.

Working Together 2023 states that '*where children may be experiencing extra-familial harm, children's social care assessments should determine whether a child is in need under section 17 of the Children's Act 1989 or whether to make enquiries under section 47 of the same Act following concerns that the child is suffering or likely to suffer significant harm'.*

My rationale for this view is that it would reflect the level of risk the child was facing. It should be noted that other partnership systems, such as the NHS Child Protection Information System (CPIS) does not allow for alerts to be added where a child is the subject of a Child in Need Plan. Therefore, should this child have presented at a hospital or health setting, these risks would not have been known. In addition, when children move across boundaries, there are clear processes for transferring children who are subject of a Child Protection Plan. This is not always the case for those children on a Child in Need Plan.

Area for Consideration 9 – *For the HSCP to seek assurance that all cases where children are experiencing extra-familial harm and are deemed to be at risk of suffering or likely to suffer significant harm, that they are subject to enquiries under Section 47 of the Children's Act 1989.*

<u>General Findings from the Round Table Discussions</u>

In general terms there was very good engagement from partners at these discussions. There was a recognition that all partners were well prepared and spoke openly about their findings putting forward suggestions for future improvement. The discussions were wide ranging and captured a number of areas that required further assurance and learning which I have captured in the main body of this letter.

During the discussions we identified a lot of good practice, we did also find a wide variation in both practice and record keeping. There were other areas discussed that would benefit from further scrutiny and assurance, these included exploring the experiences of children who are removed by the police using their powers of protection, particularly looking at the appropriateness of accommodation they are taken into and how the police and local authority work together in such cases.

We also briefly discussed school exclusions and the negative impact they have on children, recognising the increased risks such children face in the community and their exposure to contextual harm. This area would benefit from further scrutiny and multi-agency discussion to ensure all partners share the same vision and recognise that exclusion is really seen as a last resort when all avenues of support have expired to keep these children in a school setting.

Conclusion

In conclusion, there continues to be many strengths to the safeguarding arrangements for both children and adults across Hillingdon. I have found a strong partnership that is open to scrutiny and challenge and one that strives to continually learn and improve practice. As last year, I have not come across any areas of poor practice or weaknesses in service provision. The areas I have outlined for the partnership to further consider, are there to help the partnership on its journey to improve collaboration and coordination and therefore consequently, to improve outcomes for children, families and adults in Hillingdon.

There is strong leadership from the ELG and a clear sense of joint and equal responsibility from the three safeguarding partners. The partnership is one that is built on high support, high challenge and where difficult conversations are encouraged.

Finally, I would like to congratulate Hillingdon following their recent CQC Inspection of Adult Social Care. Achieving a ‘Good’ grade is testament to all the hard work of leaders, frontline staff and partners in delivering high quality services to improve outcomes for Hillingdon’s vulnerable adults. It was very pleasing to see that CQC recognised Hillingdon’s effective partnership. They stated in their report ‘The local authority had a clear understanding of the safeguarding risks and issues in the area. They worked with partners in respect of safeguarding to reduce risk and to prevent abuse and neglect from occurring’.

Next year’s independent scrutineer should consider the findings from this scrutiny report to assess progress against the ‘Areas for Consideration’.

Yours sincerely,

Alan C Caton OBE
Independent Safeguarding Consultant

Appendix 1

Functions of independent scrutiny role

- Provide safeguarding partners and relevant agencies with independent, rigorous, and effective support and challenge at both a strategic and operational level.
- Provide assurance to the whole system in judging the effectiveness of the multi-agency safeguarding arrangements through a range of scrutiny methods.
- Ensure that statutory duties are being fulfilled, quality assurance mechanisms are in place, and that local child safeguarding practice reviews and national reviews are analysed, with key learning areas identified and effectively implemented across the safeguarding system.
- Ensure that the voice of children and families is considered as part of scrutiny and that this is at the heart of arrangements through direct feedback, informing policy and practice.
- Be regarded as a 'critical friend' and provide opportunities for two-way discussion and reflection between frontline practitioners and leaders. This will encourage and enable strong, clear, strategic leadership.
- Provide independent advice when there are disagreements between agencies and safeguarding partners and facilitate escalation procedures.
- Evaluate and contribute to multi-agency safeguarding published arrangements and the annual report, alongside feeding into the wider accountability systems such as inspections.