

2022-23

# ANNUAL IMPACT REPORT



Suffolk  
Safeguarding  
Partnership

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# About Us

Safeguarding Partnerships were established by the Care Act (2014) for adults and the Children and Social Work Act (2017) for children. The Care Act requires the Safeguarding Adults Board (SAB) to publish an Annual Report, and Working Together to Safeguard Children (2018) requires safeguarding partners to publish a report at least once in every 12-month period. The report should cover what has been done during the year to achieve the Partnership's main objectives and to implement its strategic plan, what each member has done to play their part in collective improvement, and how effective our work has been in practice, including how well we have implemented the learning from safeguarding practice reviews.

The Suffolk Safeguarding Partnership (SSP) is headed up by an Independent Chair, and collectively we are made up of three statutory partners: health, police, and social care, as well as a large number of non-statutory partners, such as Education, district and borough councils, housing providers, probation, the voluntary and community sector, and more.

The SSPs core objectives are to:



Be the lead voice for safeguarding adults, young people, and children at risk in Suffolk



Scrutinise organisations on how well they are carrying out their duties to safeguarding people at risk



Uncover vital learning from serious incidents and deaths of people at risk in order to keep people safe in the future

# A Message from Our Independent Chair

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Wouldn't it be great if we could have the abuse, neglect, and exploitation equivalent of a Smokefree2030?

Unfortunately, the triggers for family and community violence are still with us. This is why we have to keep fighting to keep people safe. Victims are easily lost sight of. Sometimes they are hidden in plain sight. Part of our role in the Partnership is to raise awareness of what people in Suffolk are sometimes going through around us, not a thousand miles away but upstairs, next door, on the other side of the street.

Our Impact Report describes what we did this year. Please help us to do the same or better next year.



**"...we have  
to keep  
fighting to  
keep  
people  
safe."**

A handwritten signature in black ink that reads "Anthony".

Anthony Douglas CBE

# Delivery on 22-23 priorities

## 01. Supporting Increased Partnership Working

- Accomplished further development of our commitment to co-production
- Re-established the Training & Development Sub-Group looking at the safeguarding training offer across Suffolk to identify gaps and opportunities for multi-agency offers
- Invested in alternative methods for embedding learning from reviews
- Supported the integration of current safeguarding provision into the new Integrated Care System structure

## 02. Developing a Partnership Wide Trauma Informed Approach to Practice

- Offered support in the dissemination of the Trauma Informed Practice Model through the Health and Wellbeing Board
- Increased awareness of safeguarding during key transitions for people at risk through delivery of learning from case reviews

## 03. Responding to the Mental Health Crisis

- Increased awareness of emotional health challenges through our social channels, webinars, and conferences
- Provided scrutiny and challenge to the delivery and commissioning of mental and emotional wellbeing services for Suffolk, and made recommendations based upon lived experiences we have heard directly to the Mental Health Committee

## 04. Focusing on Preventative Interventions

- Disseminated learning materials about the impact of coercive control on adults and children via a well-attended conference
- Deepened our links with the Suicide Prevention Steering Group, sharing learning from cases where suicide was prevalent to widen the reach for learning and to inform strategy development/commissioning of services
- Developed an audit tool to measure the effectiveness of interventions for exploitation and county lines jointly with the Community Safety Partnership
- Invested in time spent presenting to the voluntary and community sector, attending Annual Conferences and community events to engage them in the work of the partnership and deliver vital safeguarding updates
- Continued to invest grant funding into Inclusion Quality Marks for schools across Suffolk

# Partner Reflections

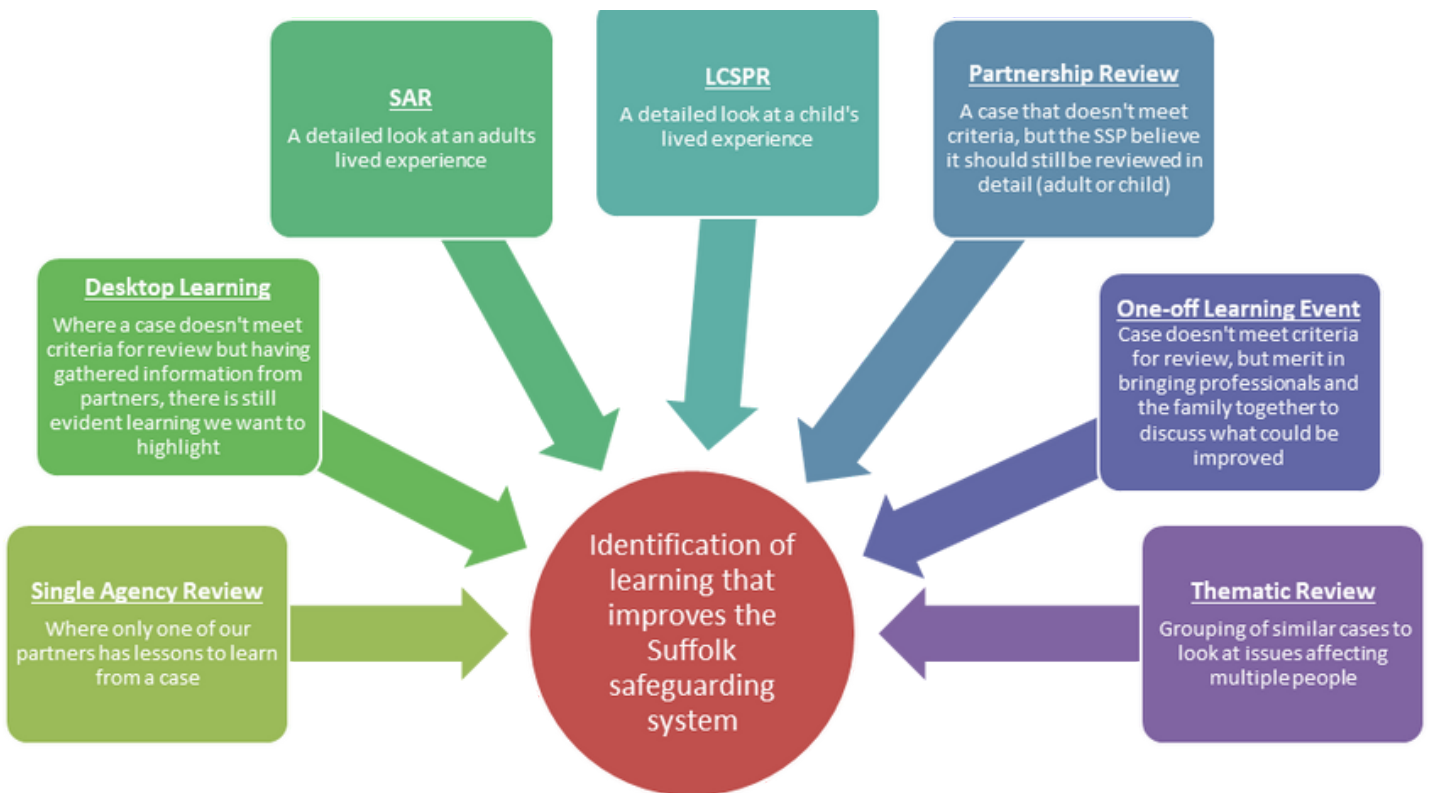
## Police

Towards the end of this year, Suffolk Constabulary had its Child Protection Inspection. The findings showed a number of strengths in the force, such as a committed workforce that hears the voice of the child, our ability to immediately protect children who are involved in serious incidents, and good multi-agency management of sex offenders, to name just a few. Of course, there are areas that we need to strengthen in the coming year, and a huge benefit of being part of the SSP is that we can collaboratively review our risk management processes for the most vulnerable children at risk of exploitation, domestic abuse, and missing from home.

In regards to adult protection, this is an area we are continuously improving on. This year we embedded learning from Joe Pooley's review, which had a significant impact on all partners. We remain challenged by the increasing complexities of adults presenting to us daily but we have a dedicated workforce and strong multi-agency partnerships here in Suffolk to try and find the right placement or support for a person as they present to us.

# Reviews

This year, we further built on our dynamic approach to reviewing, which meant that, as well as continuing to meet our statutory responsibilities in undertaking Safeguarding Adults Reviews (SARs) and Local Child Safeguarding Practice Review (LCSPRs), we enhanced our ability to look at more cases that perhaps didn't always meet threshold criteria for review to draw out the best systems wide learning possible. These flexible approaches also enable us to apply learning in real time to have the biggest impact possible for people accessing services today and tomorrow. The below image shows each of the reviews we undertake and their purpose.



20

**CASES REVIEWED USING ONE OF THE ABOVE  
PROCESSES IN 22-23**

**SUFFOLK SAFEGUARDING PARTNERSHIP  
ANNUAL IMPACT REPORT 22-23**

# Published Reviews

Click on the links below to read the life experiences and learning from the cases we published this year. Each case has bullet point headlines of what you can expect to find (if you're reading a paper version of this, head to our website: [www.suffolksp.org.uk](http://www.suffolksp.org.uk)).

Adult

## [Nigel](#)

- 
- Learning Disability
  - Hospital discharge
  - Section 42 Enquiry

Young Adult

## [Joe Pooley](#)

- 
- Transitions
  - Trauma informed
  - Housing

Children

## [Molly, Isobel, & Sophie](#)

- 
- Language barriers
  - Spotting risks
  - Pre-birth assessments

Teen

## [Anika](#)

- 
- LD & Autism
  - Black heritage
  - Managing complex health needs

Children

## [Babies L, M, & N](#)

- 
- Pre-birth assessments
  - Safer sleep
  - Trauma informed

Teen

## [Jake](#)

- 
- Out of education
  - Learning disabilities
  - Parenting

Child

## [Luke](#)

- 
- Non-accidental injury
  - Parenting
  - Multi-agency working



# Themes

Although we consider and learn lessons from individual terrible incidents, we also take a bird's eye view of what's happening nationally and in Suffolk to identify 'themed' issues. This enables us to think proactively about how to help people before something bad happens. Here are four of the many themes we identified this year.



## 01. Traumatic Childhoods

Parents of babies who died from overlay often had **traumatic childhoods** themselves, which impacted their ability to parent. Professionals need to consider trauma-informed practice in every contact.



## 02. Professional Curiosity

The best and worst cases we saw either highlighted exceptional curiosity or complete lack of it from professionals, and this dramatically changed how safe a person was. To be professionally curious means to see past the surface and be inquisitive about what else may be happening that puts someone at risk.



## 03. Capacity

Consideration for a person with fluctuating capacity (sometimes they can make decisions and other times they can't) is often missing from assessments. This means people who make bad decisions because they are mentally unable to care for themselves can end up in harm's way.



## 04. Sharing Information

Gaps in sharing vital information can mean that those professionals working closely with a person or family don't have the full picture to manage risks adequately or that someone slips through the net of help entirely.



“

After my dad's death, the Suffolk Safeguarding Partnership reviewed his care to see where there may be learning. I was involved throughout the whole process and able to challenge decision-makers directly about how to improve services. I felt listened to and pleased that things are happening as a result. I've also posed a challenge back to the Partnership as I think successes should be celebrated more.

-Lloydie James Lloyd”

“

I've not had the best experiences with services, particularly social services, but things were different working with the Suffolk Safeguarding Partnership. I felt like they listened to me, and I was given a platform to share learning about my son Joe who was murdered. I hope this learning saves other young adults from having the same life as Joe did.

-Sam Nicholls”



Image credit: BBC News

# Partner Reflections

## Adult and Community Services

We are proud of our workforce's understanding and commitment to address the abuse and neglect of adults at risk in Suffolk. During early 2023, this commitment was recognised during our Local Government Peer Challenge, which highlighted the genuine strength of our workforce, along with good relationships with our providers and excellent relationships with our partners. It is these relationships that enable us to work together in listening to the voices of the people who use our services to deliver the best possible safeguarding outcomes.

During the last year we have seen great improvements in understanding of roles and responsibilities with health partners, which has improved joint working to safeguard adults at risk. This was supported by a review of the health Standard Operating Procedure, which galvanised understanding and forged greater partnership working, an example of which can be seen in our collaborative efforts to review the sad death of Nigel. The review provides a great insight into how health and social care agencies have learnt together to improve outcomes for people like Nigel and take action to improve partnership working going forward.

# Celebrating Success

As wisely recommended by Lloydie (page 8), we are showcasing just a tiny percent of the good practice we see day to day in safeguarding adults and children. The professionals, volunteers, and charities working to keep people safe from abuse and neglect are true heroes. They work under immense pressure, often with budgetary constraints and facing ever increasing complexities and demand.

## So we want to say **THANK YOU**

When we say we see SO many examples of good practice, we really mean it! Situations such as hospital staff risk-assessing people in ambulances when there are delays, police stepping outside of their remit to safeguard someone who may not have specialist support to hand, and social care staff who visit those they're working with outside office hours to mitigate harm. But we wanted to go one step further than a generic nod to good practice. Below is an example of a real-life case where a housing provider stepped up to the mark to help a young woman.

### **Anya**

Anya is 21 years old. She is living a chaotic lifestyle, drinking excessively and ending up in risky situations. She has reported over 250 allegations of sexual assault to police over just 2 years. Anya is incredibly vulnerable with complex needs; she regularly self-harms and her flat is covered in blood. Social care are in the process of applying to the Court of Protection to safeguard Anya and get her the right support. Her living conditions are unclean, and her housing provider has begun the eviction process. After a multi-disciplinary discussion, they have agreed to extend Anya's tenancy to allow for the court process to complete. Thanks to their collaboration with partners, Anya will remain in stable housing, avoiding street homelessness and further risky situations.

# Transforming Services

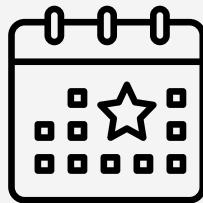
Our Partnership prides itself on disseminating good quality learning materials in new and innovative ways to help transform services for people. We do this in a number of ways, by targeting messaging to professionals and the public, so that safeguarding becomes everybody's business.

**1199**



**professionals  
attended our  
webinars**

**39**



**events that our  
team presented  
at across the  
county**

**291**



**people attended our  
hybrid Annual  
Conference**

“It’s helpful to hear national learning from this case [Star and Arthur], and I would like to see more webinars in the future.”

“Hearing learning from each agencies' perspective is helpful.”

“This was excellent and so helpful for reflection of practice.”

# Learning From Reviews

Webinars have proved hugely popular in a post-COVID world, so we've adapted our offer to suit whilst still retaining some in-person events. Aside from the webinars and events we've hosted from reviews in Suffolk (which is our standard offer), we've also covered some high-profile national cases where there is relevant learning for our county, such as **Star Hobson and Arthur Labinjo-Hughes**, two children who were murdered, and **Child Q**, a black female teen who was strip searched.

Our team regularly get out and about to share vital safeguarding updates. This year we went to and worked with:

- Suffolk Football Association
- Care Fair
- Learning From Child Deaths Annual Conference
- Safeguarding Trainers Forum
- Latitude
- Community Action Suffolk's Annual Conference
- Safeguarding Champions Network Seminars
- Safeguarding Locality Forums

**96%**

increase in uptake of webinars

**1000+**

people targeted through our outreach

“

It really was a fantastic opportunity to find out what is going on in Suffolk, what all the services look like, and the support that you can all offer. The knowledge and experience you shared along with the subject matter was pitched perfectly.

”

“

Aside from the detail and wisdom offered, it will have raised awareness and confidence amongst the Club Welfare Officers that they are part of a wider multi-agency safeguarding network which we are plugged in to and that their issues will be addressed appropriately when raised, and it has given a broader idea of what the young people in their club could be being exposed to. Thank you again; your ongoing partnership is crucial to us.

”

# Our Year in Numbers

**59,000**

website user sessions



**36,000**

of which were unique viewers



**47**

Instagram

new followers

**316**

people reached



**10,000**

Knife crime posters sent to young people via sports booklets

twitter



**1982**

people reached

**69**

partners



# Partner Reflections

## Health

In the past year, Health has contributed, in collaboration with our partners, to ensure that those most vulnerable are kept safe. This collaboration and working across systems and spaces within Suffolk will be enhanced and improved as we now work within the Integrated Care Boards.

The effective partnership between the Suffolk Child Death Review Team and the SSP is fundamental in identifying learning that will prevent future deaths of our most vulnerable children in Suffolk. This year has included in-depth learning around Sudden Infant Death Syndrome (SIDS) and suicide prevention.

Across adult and children's services we have promoted the Think Family approach to ensure no one is seen in isolation from their family/carers, whether an adult or child, and across health we have supported the SSP in promoting staff to be Trauma Informed and use Trauma Informed practice to support the conversations and work we do with families, adults, and children. To ensure lessons are learnt from case reviews, we have introduced a holistic model of evidencing impact of learning, which will support the SSP in gaining assurance that recommendations are implemented and making a difference.





## Equalities, Inclusion, & Co-Production

Healthwatch defines co-production as when people work equally with professionals and decision-makers to design, evaluate, and improve health and social care services. It is a meeting of minds coming together to find a shared solution. The approach is built on the principle that those who use a service are best placed to help design it. With this, we aspire to be equal partners and co-creators. The SSP recognises that our communities hold much wisdom and experience.

We pride ourselves in having an open-door policy where we welcome people into our Partnership to share their views and co-create services with us. This year we took the Healthwatch [#committocopro](#) pledge and have been developing more modern and engaging ways of hearing from our communities. Keep reading to hear from two Co-Pro Ambassadors who we are grateful to have worked with on our Openness Statement.

“ Working with the SSP Co-production group on the Openness Statement was a great experience. The team had not met up as a group before but we quickly felt free to question, suggest, etc., resulting in an Openness Statement that I am proud to have been a part of co-producing.

Sheila Warnes, Healthwatch  
Suffolk Co-production  
Ambassador ”



“ We worked on the Openness Statement together with the SSP and felt their hearts were truly focussed on co-production to ensure it was for everyone, not just professionals. Everything we suggested was taken on board, and we had lots of conversation about the look and feel of the statement. It felt good to be a part of something so important.

Claire Reeve, Healthwatch  
Suffolk Co-production  
Ambassador ”



“  
**County lines is a major worry; I worry about this effecting my family.**

**89%**  
felt they knew where to go for help

“  
**We need better access to mental health services.**

**Our outreach events in communities across Suffolk went down well, with local residents chatting to us about all things safeguarding. We spoke to almost 100 people over a few days. Here's what they told us ...**

**Top rated safeguarding issues:**

- Drugs & county lines
- Sexual assault
- Cyber bullying
- Knife crime
- Homelessness
- Mental health

**94%**  
felt they could trust services to help them when they needed it

# Partner Reflections

## Children & Young People's Services

This past year, CYPS have remained committed to working with our partners to safeguard children and young people at immediate risk of harm, as well as looking at the bigger picture to improve how we work together to improve services for long-term benefit.

We've formed part of a new Operational Oversight Group, which allows senior safeguarding leaders in Police, Health, and Social Care, to be connected to each other week on week to find solutions 'in real time' to some of our hardest safeguarding issues. A commendable example of this was our work with Police and Health to swiftly support a local school and families following a tragic event. The rapid sharing of information and a joined up approach meant families received support quickly and in a way that best helped them to deal with events. Safeguarding vulnerable young people transitioning between services continues to be of paramount importance, which was underpinned by the lessons from Joe Pooley's review.

We remain very grateful for the skilled and compassionate work done to protect children day in and day out by CYP staff and partners.

# With heartfelt thanks...

To all the individuals and families who shared their stories.



To the ambassadors and people with lived experiences who co-produced with us in order to make a difference for others.

To the dedicated professionals who continue to work tirelessly under immense pressures to safeguard the people of Suffolk.

## Find out more about the Suffolk Safeguarding Partnership

### Contact

Endeavour House  
8 Russell Road  
Ipswich  
IP1 2BX

[www.suffolksp.org.uk](http://www.suffolksp.org.uk)  
[enquiries@suffolksp.org.uk](mailto:enquiries@suffolksp.org.uk)



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