

# Dudley Safeguarding Children Board

'Working Together to Keep Children & Young People Safe'

# Dudley Safeguarding Children Board ANNUAL REPORT 2011-12

## EXECUTIVE SUMMARY

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## Introduction

The Board is the key statutory mechanism for agreeing how relevant organisations will co-operate and work together to safeguard and promote the welfare of children and young people in Dudley, and for ensuring the effectiveness of what they do.

Whilst the work of Dudley Safeguarding Children Board (DSCB) contributes to the wider goals of improving the well-being of all children, its core objectives are to safeguard and protect children, defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Understanding that role so as to enable those children to have optimum life chances and enter adulthood successfully

In order to achieve this Dudley Safeguarding Children Board (DSCB) will work to ensure that:

- *All* children and young people have safe environments to help promote their welfare and well-being
- Action is targeted at *vulnerable groups* such as disabled, children in care; *and*
- *Responses* to children who have been harmed to minimise lifelong impact are co-ordinated and effective

In accordance with statutory 'Working Together to Safeguard Children' guidance (2010), Local Safeguarding Children Boards are required to produce an Annual Report which includes:

- Providing a comprehensive analysis of the effectiveness of safeguarding arrangements in the local area, including the extent to which the functions of the LSCB are being effectively discharged including:
  - policies and procedures for the safer recruitment of frontline staff
  - assessment of single and inter-agency training on safeguarding
  - lessons learnt about the prevention of future child deaths
  - progress on priority issues
  - progress made in implementing actions from individual Serious Case Reviews and their impact
- Recognise achievements and progress and provide a realistic assessment of the key challenges that remain
- Challenge the work of the 'Children's Trust Board' and its partners to ensure that necessary overarching structures, processes and culture are put in place to ensure that children are safeguarded

## National Context

During 2011-12, there have been a number of key national developments across the safeguarding agenda. These include:

- Conclusion of the Munro Review of Child Protection arrangements and the government response to Munro
- Publication of Ofsted LSCB Good Practice guidance
- Conclusion of the Family Justice Review
- Publication of new guidance for the role of Director of Children's Services and Lead Member for Children's Services
- Publication of new guidance in respect of the management of allegations against staff working in schools
- Passage of the 'Protection of Freedoms Bill through Parliament and the establishment of the Disclosure and Barring Service (combination of Independent Safeguarding Authority and Criminal Records Bureau)

Brief summaries of key national developments are included within the DSCB 'SaFER' newsletter, along with electronic links to relevant information: for more information go to <http://safeguardingchildren.dudley.gov.uk/>

## Local Context

Since its inception in April 2005, Dudley Safeguarding Children Board has been working to 3 strategic objectives:

- promoting an understanding that safeguarding children & young people is everyone's and every organisation's responsibility;
- improving children, young people's and adults understanding of risks to children's safety, how they can safeguard children and what to do if they are worried about a child being abused; *and*
- developing safer services and employment practices across organisations who work or come into contact with children or young people



In addition, each year the Board agrees a small number of key priorities to focus on – these are outlined within the DSCB Business Plan & Work Programme for 2012-13.

The chairing of Dudley Safeguarding Children Board has been in a transitional arrangement since November 2011, when John Polychronakis, Chief Executive of Dudley MBC became the interim chair superseding Pauline Sharratt, Assistant Director of Children & Families.

## Achievements & Developments 2011-12

The LSCB has 5 key statutory functions (as outlined in Working Together, 2010). Some of these functions are specifically delegated to Sub-Groups to take a lead role in developments.

The key achievements and developments during 2011-12 in relation to these are:

### ***Policies, Procedures & Protocols***

- Revision to a number of specialist safeguarding procedures within Section C of the safeguarding procedures manual
- Implementation of a new inter-agency thresholds framework for organisations working with children & young people - 'Right Services, Right Time, Right Place' – published in October 2011;
- Development of a Substance Misuse and Safeguarding Protocol

### ***Training and development***

- The Board provided multi-agency training for 1652 people during 2011-12, compared to 1705 during 2010-11 and 1894 the previous year, which represents a 13% decrease over 3 years
- The Board actively supported or provided face-to-face single-agency child protection training to 5151 people during 2011-12, a fall of 26% compared to the previous year;
- The Board facilitated 1166 people to complete one of the Virtual College e-learning programmes, a rise of 44% compared to the previous year;
- The Board delivered a total of 83 days of training (65 courses) during 2011-12
- The Board provided briefings for 460 people during the year

### ***Communicating and raising awareness***

- The Board supported a Regional Conference held by Stop it Now! as part of Safer Internet Day in February 2012, attended by over 50 people from a variety of agencies

- Dudley's Young People's Safeguarding Board (S4Kidz) has been less active during 2011-12. The group is currently in a period of transition as it combines with the N2N group of the Children & Young People's Partnership

### ***Monitoring and evaluation***

- Commissioned a Section 11 ('duty to safeguard') online audit tool – key member agencies were asked to complete the audit and a report presented to DSCB in September 2011 highlighting key themes. A scrutiny programme for 2012-13 was agreed in January 2011.
- Published a second QA Overview Report in June 2011, incorporating the themes from complaints and appeals in respect of child protection conferences and learning from case reviews
- Commissioned two Significant (Serious) Incident Learning Processes (SILPs), the first of which was reported to the Board in January 2012. The second one will be concluded by May 2012. The learning from both SILPs will be included in the Board's next QA Overview Report.
- Implementation of the key actions arising from the LADO (Local Authority Designated Officer) Annual Report in respect of the management of allegations against people who work with children, presented to the Board in May 2011;
- Up-dated Terms of Reference for DSCB and all sub-groups in line with *Working Together to Safeguard Children* (published March 2010);
- Chair of DSCB transferred to John Polychronakis, Chief Executive of Dudley MBC from November 2011 as an interim measure whilst the Board considered future options for chairing arrangements;
- Board agreed an action plan in respect of Munro Review, following the publication of her final report and subsequent government response;
- Board conducted a self-assessment of its arrangements against the good practice report published by Ofsted in March 2012, the findings from this are incorporated into DSCB's Work Programme for 2012-13;

### ***Participating in planning and commissioning***

- The Annual Report and Business Plan was presented to the Children's Services Select Committee and Dudley Children's Trust in 2011
- The Board contributed to the Service Improvement Review in respect of domestic abuse within the borough, primarily with a view to identifying current provision and gaps in service. An action plan is under development
- The Board used its core funding to directly commission 3 services in respect of safeguarding:
  - Specialist service to work with young people at risk of sexual exploitation (delivered by Street Teams and part funded by Comic Relief);
  - Young Runaways Pilot Project to identify the needs and gaps in respect of children who go missing from home or care (delivered by The Children's Society – ended July 2011);
  - Stop it Now! Black Country & Birmingham project in respect of the prevention of child sexual abuse (hosted by Barnardos Community Routes – ended October 2011)

### ***Functions relating to child deaths***

- During 2011-12, the Child Death Review Panel were notified in respect of 42 child deaths, of which 15 reviews were completed. The panel concluded that 2 of these 15 unexpected deaths had 'modifiable factors'

### ***Serious Case Reviews***

- DSCB initiated a serious case review in December 2011, which is not due for completion until at least the end of July 2012;

## Progress in respect of priority areas

DSCB agreed 3 key priority areas to focus its resources on to progress during 2011-12:

### **A strengthened leadership role in supporting multi-agency learning concerning child protection practice and joint investigations in respect of child abuse & neglect**

During 2011-12 we:

- concluded case reviews in respect of 2 children;
- concluded a Significant Incident Learning Process (SILP) in respect of 1 child
- initiated a SILP in respect of 1 child
- produced and disseminated 2 Overview Reports in respect of learning from case review, audit and complaints
- facilitated 3 learning events for front-line staff/managers
- facilitated 2 workshops in respect of 'working with highly resistant families (C4EO)
- conducted joint audit activity between police, social care and health
- conducted a review of the use of secure and residential placements
- strengthened Local Forum (extended to include health with new terms of reference)

### **Improving inter-agency responses to children & young people who are vulnerable to experiencing sexual exploitation, internal trafficking and serious forms of bullying and violence**

In respect of child sexual exploitation (CSE) and internal trafficking, we have:

- Strengthened YPSE Panel
- Presented an annual report from Dudley Street Teams to DSCB (July 2011)
- Contributed to Bedford University research and completed self-assessment checklist for LSCBs
- Contributed to the development of a West Midlands (Police area) regional strategy and action plan

In respect of young runaways, we have:

- Concluded a 12-month pilot evaluation of need (Children's Society)
- Agreed development of internal service response for children who run away from home

In respect of bullying, we have:

- Contributed to development of new guidance
- Conducted learning event in respect of social networking (ABW)

In respect of domestic violence, we have:

- Completed DART evaluation & identified additional resource
- Contributed to Service Improvement Review

### **Improving inter-agency responses to children who are likely to, or who have, suffered emotional abuse and neglect**

During 2011-12, we have:

- Commissioned and delivered Signs of Safety training to Brierley Hill practitioners (initial pilot) and Halesowen practitioners
- Conducted some evaluation of the impact of Signs of Safety tools on frontline practice
- Reviewed the Neglect Strategy



## Summary of Safeguarding Activity

- During 2011-12, 465 common assessments were started of which 338 (73%) were completed in respect of vulnerable children and young people, a reduction of 39.5% compared to the previous year - 47.5% were started by schools; 17.2% by health professionals and 10.8% by children's centres;
- There has been a 77% increase in the number of Section 47 Strategy Discussions over the last 5 years – on average, 98.5% of all strategy discussions during 2011-12 resulted in a child protection investigation
- In 2011-12, just under 35% of all S47 Investigations resulted in an Initial Child Protection Conference, compared to 46% the previous year and an average conversion rate of 44% over the last 5 years – the fall may be linked to the continuing rise in the number of children becoming looked after by the local authority, who are not initially subject to child protection plans;
- There were 155 Initial Child Protection Conferences during 2011-12, 20 'Receiving-In' Conferences and 326 Review Conferences – the total of 312 children were the subject of an Initial Child Protection Conference during the year.
- There were 277 children subject to a Child Protection Plan during 2011-12, which represents a 6% fall compared to the previous year – on average, 89% of all Initial Child Protection Conferences result in a Child Protection Plan for one or more children;
- The number of new cases of emotional harm has increased by 160% over the 15 month period. In Quarter 4, 45% of children becoming the subject of a child protection plan were male, 44% were female and 11% were unborn
- 44% of all Child Protection Plans in 2011-12 were due to 'Neglect', with 31% due to emotional abuse – there has been a significant fall in the proportion of child protection plans relating to sexual abuse, from 19% in 2007-08 to just 6% in 2011-12 (although the rise in admissions to local authority care may in part explain this decline);
- 44 young people were referred to the Young People at Risk of Sexual Exploitation (YPSE) Panel during 2011-12, compared to 68 during the previous two years;
- There were 68 meetings in respect of 44 people who work with children & young people – a further 43 were referred to the Local Authority Designated Officer (LADO) for advice and support in respect of concerns or allegations about their employment suitability or potential risk of harm to children
- There were 682 children in care at the 31<sup>st</sup> March 2012, which represents a 11% increase from the end of previous year

## Effectiveness of Safeguarding Arrangements

### Safeguarding Inspection (an external view)

The announced inspection of Safeguarding & Looked After Children's Services took place in Dudley between 28 November and 9 December 2011. The 7 inspectors representing Ofsted and the Care Quality Commission met with a large number of practitioners and managers during the two weeks of fieldwork, facilitating interviews and focus groups.

The report was published on 25 January 2012 – a full copy is available to download at <http://www.ofsted.gov.uk/local-authorities/dudley> . It contains a total of 22 judgements (10 in respect of safeguarding and 12 in relation to services for looked after children. There are four key judgements - the table below provides a record of the main findings:

| <b>Safeguarding Services - Key Judgements</b>                               |          |
|---|----------|
| Overall effectiveness   | Adequate |
| Capacity for Improvement  | Good     |
| <b>Safeguarding outcomes for children &amp; young people</b>                |          |
| Children and young people are safe and feel safe                            | Adequate |
| Quality of provision  | Adequate |
| The contribution of health agencies to keeping children & young people safe | Adequate |

|  |             |
|--|-------------|
| Ambition and prioritisation  | Good        |
| Leadership and management  | Good        |
| Performance management and quality assurance                             | Adequate    |
| Partnership working  | Good        |
| Equality and diversity   | Good        |
| <b>Services for looked after children - Key Judgements</b>               |             |
| Overall effectiveness  | Good        |
| Capacity for Improvement   | Good        |
| <b>How good are outcomes for looked after children and care leavers?</b> |             |
| Being healthy  | Adequate    |
| Staying safe   | Good        |
| Enjoying and achieving   | Outstanding |
| Making a positive contribution, including user engagement                | Good        |
| Economic well-being  | Good        |
| Quality of provision   | Adequate    |
|  |             |
| Ambition and prioritisation  | Good        |
| Leadership and management  | Good        |
| Performance management and quality assurance                             | Adequate    |
| Equality and diversity   | Good        |

The report makes a total of 13 recommendations to be actioned within 3 or 6 months (see below) – Dudley Safeguarding Children Board will take a proactive approach in scrutinising and/or delivering improvements in respect of a number of these recommendations.

### **Areas for improvement – safeguarding**

| <b>Within three months</b>   |
|--|
| <ul style="list-style-type: none"> <li>Ensure the draft health action plan is agreed and fully support improvements in health provision, including case recording, health contribution to holistic assessments of need and risk, case planning and measurement of health outcomes and impact</li> </ul>                              |
| <ul style="list-style-type: none"> <li>NHS Dudley and NHS providers ensure timely access to emotional and mental health services for women who require additional support prior to and following the birth of their children</li> </ul>  |
| <ul style="list-style-type: none"> <li>Develop explicit joint protocols between children's services, health and adult social care to ensure that older young people and those at points of transition receive appropriate, timely and continuous services to meet their assessed needs</li> </ul>                                    |
| <ul style="list-style-type: none"> <li>Establish joint and agreed quality standards for safeguarding practice across the partnership and implement a joint quality assurance and performance framework underpinned by efficient information systems</li> </ul>   |
| <ul style="list-style-type: none"> <li>Extend audit processes to routinely monitor the consistency and quality of practice</li> </ul>  |
| <ul style="list-style-type: none"> <li>Ensure MARAC is fully operational and effective leadership is in place in order to meet the level of demand for such arrangements</li> </ul>  |
| <b>Within six months</b>   |
| <ul style="list-style-type: none"> <li>Ensure the electronic recording system in children's social care is fully operational and embedded to support effective case recording, captures the views of service users and collate data and information in a way that is immediately useful to front line and senior managers</li> </ul> |
| <ul style="list-style-type: none"> <li>Develop explicit arrangements for the use of the CAF within strategies for early intervention and family support to ensure that all agencies are assuming responsibility for being lead professionals in suitable cases</li> </ul>  |

### **LSCB Self-Assessment**

DSCB conducted a self-assessment of its own effectiveness using the Ofsted Good Practice Checklist (published in September 2011). A summary of the Board's self-assessment against the 5 key areas is outlined below:

| <b>Good Practice Area</b>  | <b>Self-Assessment</b> |
|--|------------------------|
| Governance arrangements  | Satisfactory           |
| Partnership working  | Good                   |
| Engagement with children and young people                            | Satisfactory           |
| Business planning and relationship with Children's Trust/Partnership | Satisfactory           |
| Quality Assurance  | Poor                   |

## Section 11 Audits

During 2011-12, key partner agencies undertook an audit of their Section 11 compliance using an online tool provided by Virtual College e-safeguarding children academy. It contains 11 standards and 45 sub-criteria - a summary of the audit outcomes is below:

### Overall Compliance

- The **average compliance** score against all of the criteria within the standards for all organisations/agencies is **81.8%**

### Standards

- The **strongest areas** of compliance (on average) relate to:
  - Safe recruitment (9)
  - Senior management commitment to the importance of safeguarding children (1)
  - Service development takes account of the need to safeguard and promote welfare (**4**)
- The **weakest areas** of compliance (on average) relates to:
  - Service development is informed by the views of children and families (5)
  - Effective inter-agency working and information sharing in order to ensure safeguarding and promoting children's welfare (11)
  - Effective inter-agency working to safeguard and promote the welfare of children (10)
- The range of compliance against most standards is significant, with at least one organisation scoring 100% against 9 of the 11 standards
- Each organisation will need to decide its priorities for action in respect of standards they have scored less well, for example, below 70%, although improvement activity should not necessarily exclusively relate to such areas of poorer compliance. There may be some standards where the ambition of the organisation is to improve to 100%, even from a relatively good position

### Criteria

- The **strongest areas** of compliance across all the audits relate to:
  - the organisation has a recruitment policy in effect which ensures professional and character references are always taken up (9.1)
  - there is a named senior manager who champions safeguarding throughout your organisation (1.1)
  - the organisations written policies and procedure for safeguarding & protecting children are mandatory for staff and volunteers (2.10)
  - appropriate staff and volunteers who work or who have contact with children & families receive training on their professional roles and responsibilities and those of their organisation (8.2)
  - where appropriate enhanced or standard CRB checks are completed on all those staff and volunteers who work primarily or directly with children & young people... (9.4)
  - face-to-face interviews are carried out (9.5)
- The **weakest areas** of compliance across all the audits relate to:
  - contractors to the organisation who work with children are who delivering statutory services are Section 11 compliant and have been audited (10.6)
  - as a minimum the organisation evaluates outcomes from the perspective of the child or young person (11.3)
  - the organisation has identified principles of working with children and their families for all staff who work with them (10.1)
- There are 4 criteria which are red (25% compliance) – these were across two partner organisations

During 2011-12, each of the partner organisations will present a summary of their safeguarding self-assessment, highlighting areas of strength and areas for improvement – this forms part of the DSCB scrutiny programme to provide 'support and challenge' in respect of safeguarding effectiveness.



## **Lessons learnt from serious case reviews and child deaths and progress in implementing actions**

### **Serious Case Reviews**

The implementation of actions plans in respect of previous serious case reviews are monitored by the Serious Case Review Sub-Committee. During 2011-12, DSCB initiated a Serious Case Review in respect of Child C, which is still underway – it is envisaged that this will be concluded by September 2012 and subsequently published on the DSCB website.

### **Significant Incident Learning Processes**

The Board also undertook two Significant Incident Learning Processes (SILPs), a new process involving an independent facilitator and the active engagement of the practitioners and managers in a structured learning approach. The first of these was concluded in November 2011 – it identified the need for improvements in relation to:

- child protection conferences and child protection plans
- family and parenting assessments
- administrative support for child in need meetings and core groups
- child death processes and the aftermath for professionals
- cross-boundary working
- practice for the 'team around the child' (whether informally or formally constituted)

*The executive summary from the second SILP will be presented to DSCB in July 2012.*

### **Child Death Reviews**

During 2011-12, the Child Death Review Panel completed 15 reviews of child deaths and assessed two of these deaths as having modifiable factors. It also completed a more in-depth 'Root Cause Analysis' review of an asthma related child death. The reviews identified the need for improvements in respect of:

- Asthma management between key agencies such as GP, school health advisor, school and parent
- Impact of missed appointments
- Discharge planning, recording and follow-up
- Impact of change of agency thresholds
- Communication and information-sharing between agencies
- Impact of difficult relationships between professionals and parents

### **Key improvements identified through quality assurance activity**

Quality assurance and audit activity occurs at a single agency level and through multi-agency processes. During 2011-12, the Board has been revising its Quality Assurance Framework, which is due to be launched in June 2012. The framework will include new inter-agency child protection standards and audit tools.

In June 2011, the Board published two key reports, the first entitled 'The Child's Voice' provided an overview of key messages from serious case reviews, learning from DSCB complaints panel, Key feedback from service users and professionals in respect of child protection conferences, and learning from local case reviews; the second report highlighted 12 cases identified by local practitioners as demonstrating good practice, particularly in respect of partnership working. Practitioners were also asked to identify areas for improvement in respect of multi-agency working. These were:

Both reports can be downloaded from the DSCB website – <http://safeguardingchildren.dudley.gov.uk/>

### **DSCB Complaints**

During 2011-12, DSCB held 1 Complaints Panel in respect of appeals concerning the outcomes of child protection conferences, compared to 6 Panels during the previous year. The key issues identified from this Panel was the effect of lack of available resources on social care and partner agencies in conducting important pieces of specialist work such as parenting assessments and work to consider the impact of domestic abuse on children.

*The learning from case reviews, complaints and audit will be outlined in greater depth within an overview report due to be published in June 2012 – for more information contact [graham.tilby@dudley.gov.uk](mailto:graham.tilby@dudley.gov.uk)*

## Key Challenges for the future

To some extent the very nature of safeguarding children will always present challenges across the professional landscape, both nationally and locally – what then are the key ones for Dudley?

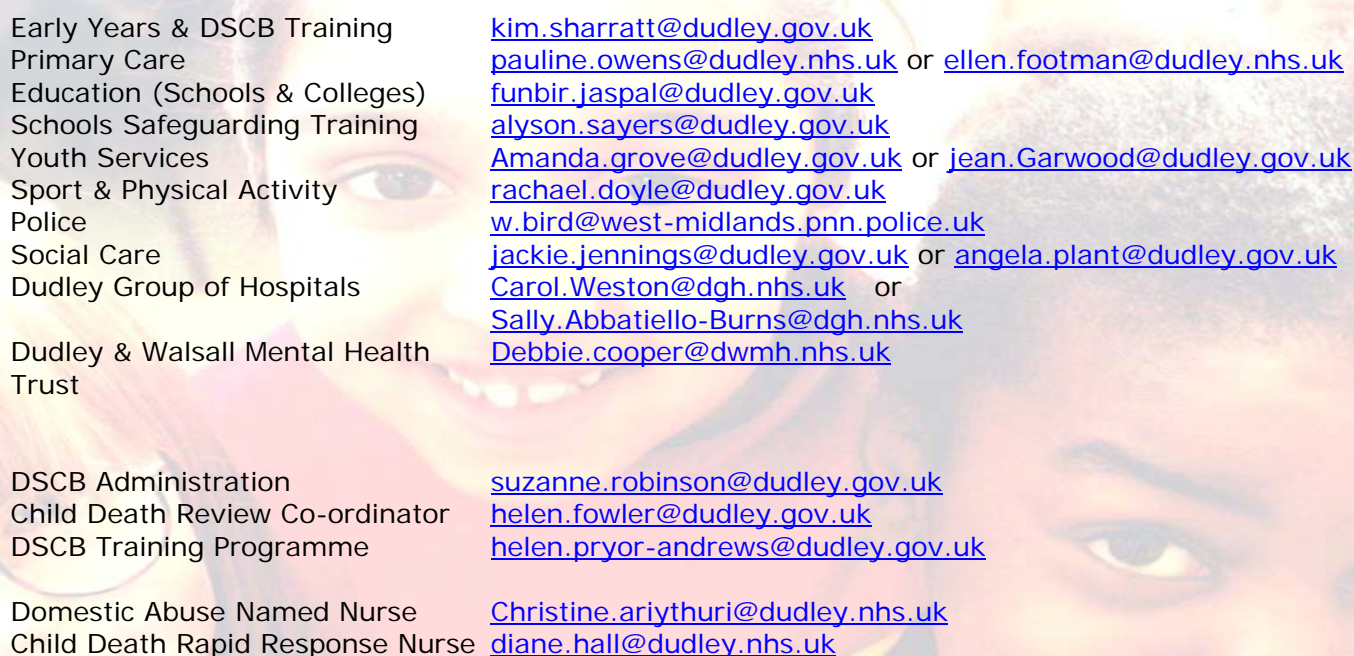
- capacity of front-line services to respond to demand and complexity of child protection work, notably at a time of recession where the impact of poverty is likely to increase pressures within some families;
- the impact on frontline practice of continued organisational change and reform within health and police;
- the impact of the Family Justice Review in terms of capacity to adhere to timescales and additional requirements with family court proceedings, particularly in view of the increasing complexity of the circumstances of some children who are subject to care proceedings;
- the impact of cuts within public sector and to voluntary sector services on the provision of early intervention and some areas of more specialist assessment and intervention;

## Key Priorities for 2012-13

The key priorities for 2012-13 are:

- Improve the consistency and quality of inter-agency child protection practice
- Provide support and challenge to embed common assessment and deliver early support to vulnerable children, young people and their families
- Improve inter-agency responses to children & young people at risk, or who have suffered, sexual exploitation or abuse

For further information go to the DSCB website and download the Board's Business Plan and Work Programme for 2012-12 or contact [graham.tilby@dudley.gov.uk](mailto:graham.tilby@dudley.gov.uk)



|                                      |  |
|--------------------------------------|--|
| Early Years & DSCB Training          | <a href="mailto:kim.sharratt@dudley.gov.uk">kim.sharratt@dudley.gov.uk</a>   |
| Primary Care                         | <a href="mailto:pauline.owens@dudley.nhs.uk">pauline.owens@dudley.nhs.uk</a> or <a href="mailto:ellen.footman@dudley.nhs.uk">ellen.footman@dudley.nhs.uk</a>     |
| Education (Schools & Colleges)       | <a href="mailto:funbir.jaspal@dudley.gov.uk">funbir.jaspal@dudley.gov.uk</a>   |
| Schools Safeguarding Training        | <a href="mailto:alyson.sayers@dudley.gov.uk">alyson.sayers@dudley.gov.uk</a>   |
| Youth Services                       | <a href="mailto:Amanda.grove@dudley.gov.uk">Amanda.grove@dudley.gov.uk</a> or <a href="mailto:jean.Garwood@dudley.gov.uk">jean.Garwood@dudley.gov.uk</a>         |
| Sport & Physical Activity            | <a href="mailto:rachael.doyle@dudley.gov.uk">rachael.doyle@dudley.gov.uk</a>   |
| Police                               | <a href="mailto:w.bird@west-midlands.pnn.police.uk">w.bird@west-midlands.pnn.police.uk</a>   |
| Social Care                          | <a href="mailto:jackie.jennings@dudley.gov.uk">jackie.jennings@dudley.gov.uk</a> or <a href="mailto:angela.plant@dudley.gov.uk">angela.plant@dudley.gov.uk</a>   |
| Dudley Group of Hospitals            | <a href="mailto:Carol.Weston@dgh.nhs.uk">Carol.Weston@dgh.nhs.uk</a> or <a href="mailto:Sally.Abbatiello-Burns@dgh.nhs.uk">Sally.Abbatiello-Burns@dgh.nhs.uk</a> |
| Dudley & Walsall Mental Health Trust | <a href="mailto:Debbie.cooper@dwmh.nhs.uk">Debbie.cooper@dwmh.nhs.uk</a>   |
| DSCB Administration                  | <a href="mailto:suzanne.robinson@dudley.gov.uk">suzanne.robinson@dudley.gov.uk</a>   |
| Child Death Review Co-ordinator      | <a href="mailto:helen.fowler@dudley.gov.uk">helen.fowler@dudley.gov.uk</a>   |
| DSCB Training Programme              | <a href="mailto:helen.pryor-andrews@dudley.gov.uk">helen.pryor-andrews@dudley.gov.uk</a>   |
| Domestic Abuse Named Nurse           | <a href="mailto:Christine.ariythuri@dudley.nhs.uk">Christine.ariythuri@dudley.nhs.uk</a>   |
| Child Death Rapid Response Nurse     | <a href="mailto:diane.hall@dudley.nhs.uk">diane.hall@dudley.nhs.uk</a>   |

