safeguarding children is everyone's business

Halton Safeguarding Children Board

Annual Report 2013-14

& Business Plan 2013-15


HALTON
Safeguarding Children Board
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Appendices

1. Independent Chair's Introduction

I am pleased to present to you the Halton Local Safeguarding Children Board (LSCB) Annual Report for 2013/14. I hope you will find it useful in understanding the way all services in Halton work together to safeguard children who are or may be at risk of harm. This report is intended to provide information for all involved in the work of, or who are interested in Safeguarding Children and Young People. The report sets out how the LSCB works; the structure and resources that support its work and the specific areas of work it must cover. These are important as all professionals need to work together to make sure we have a skilled workforce supported by strong and effective working arrangements.

The LSCB recognises that the work of partners to safeguard children and young people is continuing against a backdrop of a challenging economic environment and fundamental reshaping of public services. There have been significant changes to the structure of organisations and the move of commissioning (buying) of services to Clinical Commissioning Groups by local General Practitioners and other clinicians. This has brought a greater need for organisations and services to work even closer together. The audit and scrutiny work led by the LSCB ensures that safeguarding remains a priority for all partners.

The LSCB does not work in isolation and has strengthened its Governance and Accountability arrangements; with agreements in place for how we work with the Children's Trust Board, the Health and Wellbeing Board and the Adults Safeguarding Board. The LSCB has continued to develop its structure and membership to ensure that it can deliver effective scrutiny and challenge to promote improving safeguarding practice.
We have made changes to LSCB sub-groups; for example, forming a new Health Sub-group to bring together Health service Trusts and Providers working in Halton to improve oversight and consistency of safeguarding in Health services. We plan to recruit a young person and a parent member to the board in 2014-5.

A series of visits were undertaken by Board members to staff in all agencies working with children, young people and their families. This gave the Board opportunity to hear from staff in relation to what works well and what needs improving and importantly addresses a key focus of the board; to ensure that the views of children and young people are listened to. We also took the opportunity to talk to staff about the work of the Board and its key priorities.

The report provides information on how many children in Halton need protecting and require additional support and how agencies have worked together to provide this support. The report highlights the achievements of the LSCB and identifies priorities for future work. It shows how we continue to scrutinise and challenge the work of partner agencies and promote a culture of openness and learning. By doing this we seek to improve the safety and well being of the children of Halton.

Richard Strachan
Independent Chair
Halton Safeguarding Children Board

2. The Structure of the LSCB

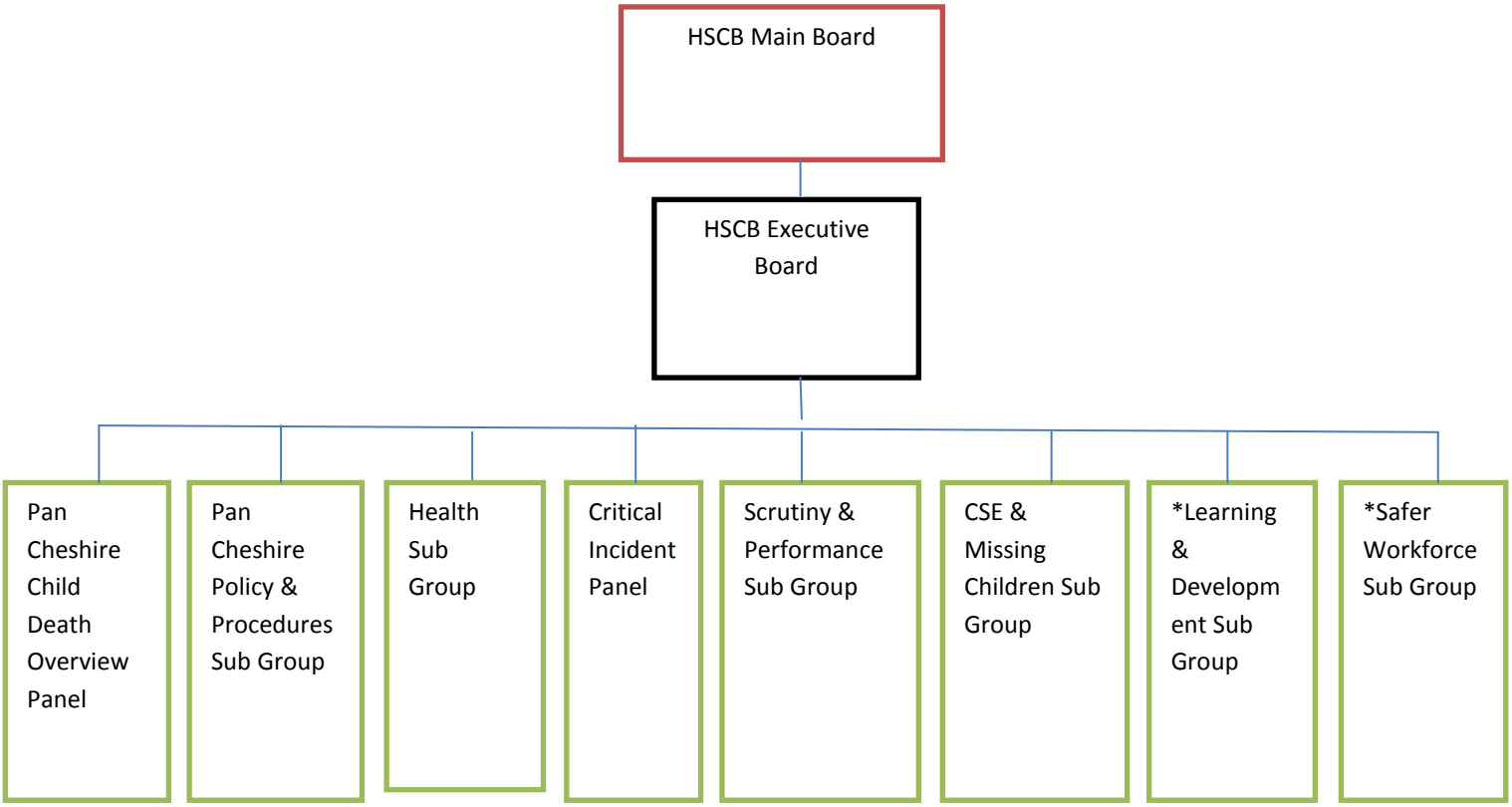
The Main Board is the overarching decision making body; the Executive and Sub Groups are accountable to the Board. The LSCB Executive Board drives the business on behalf of the Board, with the Sub Groups reporting directly to it.

During 2013-14 the LSCB considered research undertaken by the National Association of LSCB Chairs on effective Boards. Following consultation with Board members and a development session, it was agreed that membership of the Main Board was too large to undertake the Board's business effectively. A Health Sub Group would be developed to create a dedicated forum for oversight of safeguarding priorities in relation to the Health Sector. The Sub Group Chair, from one of the health Trusts, will represent the Sub Group on the Executive and Main Board. The arrangement is to be piloted, with a report to be presented to the Main Board later in the year on the effectiveness of the arrangements.

In order to manage business more effectively, and avoid duplication, the four Cheshire LSCBs agreed to set up a Pan Cheshire Policy and Procedures Sub Group. This was established in January 2014 with its priority action being to revise the Pan Cheshire Multi-Agency Safeguarding Children Procedures. The Pan Cheshire Child Death Overview Panel was established from April 2014. This provides a more effective way of reviewing child deaths across Cheshire. The broader footprint enables a range of expertise to be brought together to undertake reviews; for instance, thematic reviews for related deaths such as heart conditions or infections, where experts can attend the Panel to provide insight into the review. The Pan Cheshire arrangement also supports the four LSCBs to come together on awareness raising campaigns, sharing resources.

The LSCB has joint protocols in place with the Children's Trust and Health & Wellbeing Board, and Safeguarding Adults Board. This supports work on issues which overlap the strategic bodies, as well as ensuring that the LSCB can hold to account, and be held to account by, these strategic bodies.

HALTON SAFEGUARDING CHILDREN BOARD STRUCTURE



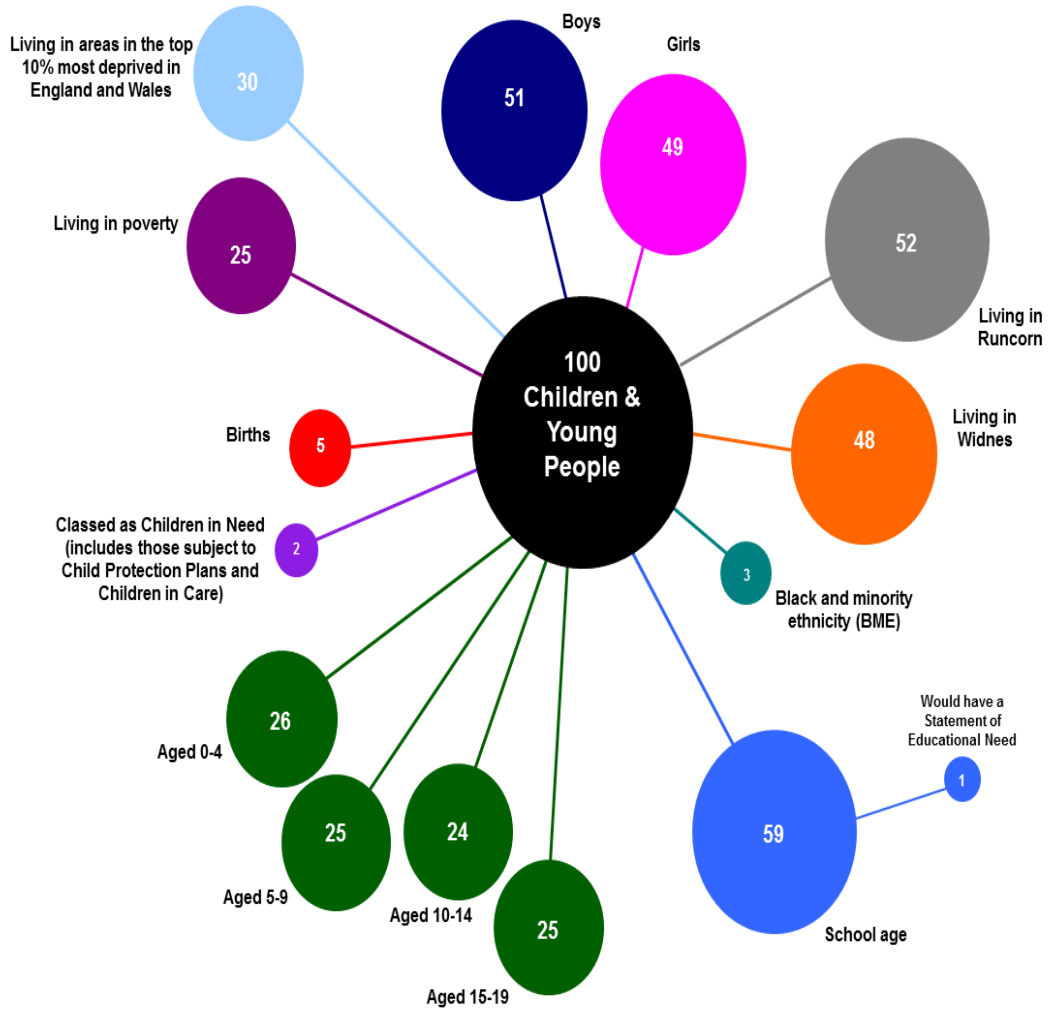
*Denotes joint Sub Group of the LSCB and Safeguarding Adults Board

3. Demographics of Halton

Halton has an estimated population of 125,700, of which approximately 31,200 children aged between 0-19 years are living in the borough. The population is largely white, with only 3.2% of the population identified as being from a minority ethnic group. (Source: 2011 Census)

Halton is the 27th most deprived local authority area in England out of 326. 26% of the population live in areas that fall in the top 10% most deprived nationally. In 2011-12 27.3% of children under 16 years were living in poverty.

If Halton was a village of 100 Children & Young People…



4. Safeguarding Activity 2013-14

How Safe are our Children and Young People in Halton?

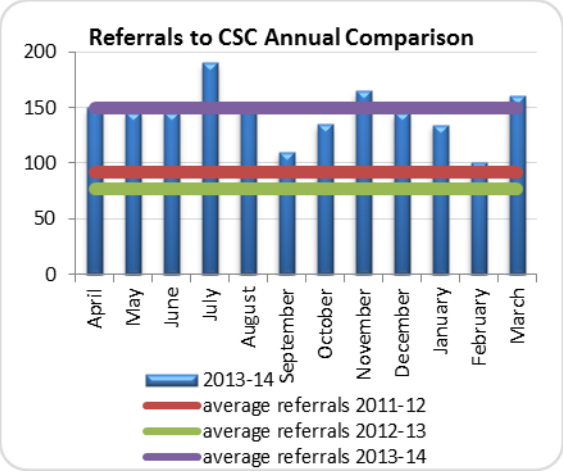
All services and the community in Halton need to be vigilant and have the confidence to report concerns where they think that a child may be at risk of harm. We also need to ensure that children have opportunities to speak out when they are at risk, or are being harmed. Specialist services such as Children's Social Care and the Police can only intervene to protect children if they are alerted to concerns. The LSCB promotes messages to both the public and practitioners of what to do if concerned about a child's welfare. In addition, specific campaigns are also promoted by the LSCB; such as recognising Child Sexual Exploitation, or how to keep safe using social media and the internet.

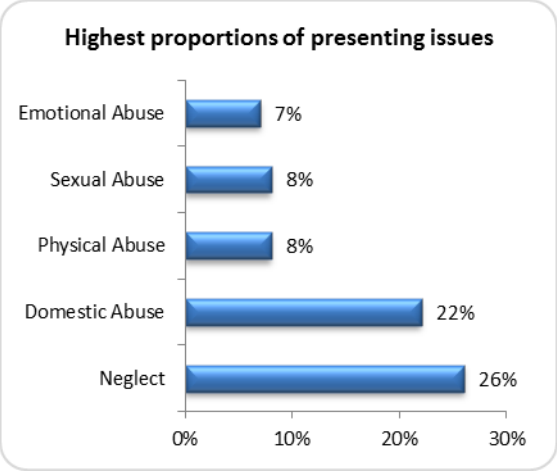
The following information is about children and young people in Halton who have been identified by the Local Authority and partner agencies as being in need of safeguarding.

The rate of Children in Need in Halton on 31st March 2014 is 410 per 10,000 population based on those children and young people who have been involved with Social Care across the Levels of Need Framework (see Appendix B Halton Levels of Need Framework). This includes those receiving an assessment, subject of Child Protection Plans, Children in Need and Care Leavers. The average for Halton's statistical neighbours is 456.2 per 10,000 population. Although Halton is still below statistical neighbours, there is a narrowing of the gap on previous years.

4.1 Referrals

A referral is information that has been received about a child which has led to a Social Work assessment.





The number of referrals to Children's Social Care has continued to increase. In 2013-14 there was an increase of 90% in comparison with 2011-12 and 128% in comparison with 2012-13. Halton's statistical neighbours are also experiencing growth in the rate of referrals. This indicates a greater understanding across the community and partnership of the impact of abuse and neglect on children, and the poorer outcomes if this is not addressed. The

LSCB plays a pivotal role in raising community and practitioner awareness about the impact of abuse and neglect on children.

This year has seen an increase in Child Protection Plans where sexual harm is identified. This is as a result of a consistent approach to the management of risk.

19 children moved in to Halton with Child Protection Plans in place from other local authorities and were given a temporary plan in Halton (one child had two occasions within the year of this happening). The majority returned to the area they came from. For all those children who remained resident in Halton a transfer conference was convened within the national timescale.

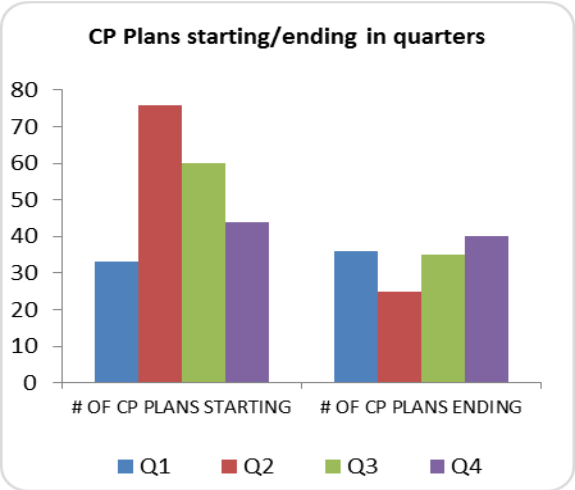
The LSCB receives quarterly information regarding agencies' attendance at, and reports provided to, Initial and Review Child Protection Conferences in line with the required standards. This is required as the provision of timely reports and attendance is important for children and families to contribute fully to the process, and for there to be informed decision making. In last year's Annual Report the LSCB noted that all agencies needed to ensure that these standards were recognised and adhered to. The increase in CP activity has further impacted upon this. Therefore the LSCB is undertaking work to scrutinise this further, and understand where the challenges are in the system in order to address.

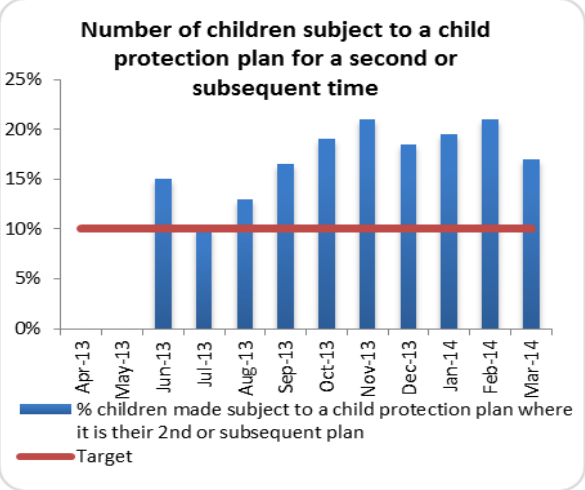
The Safeguarding Unit has addressed increased demand for conferences with plans to recruit to an additional Conference Chair during 2014-15.

4.2 Children Subject to Child Protection Plans:
Children become subject of a Child Protection Plan when it has been identified that they are in need of protection from either neglect, physical, sexual or emotional abuse. Only the most vulnerable children have child protection plans.

Last year's LSCB Annual Report identified low levels of Child Protection Plans and Children in Need as a priority area for improvement. The LSCB requested agencies to undertake specific analysis to test whether children were receiving services at the right level of the continuum of need. A range of work was undertaken and reported to the LSCB which included:

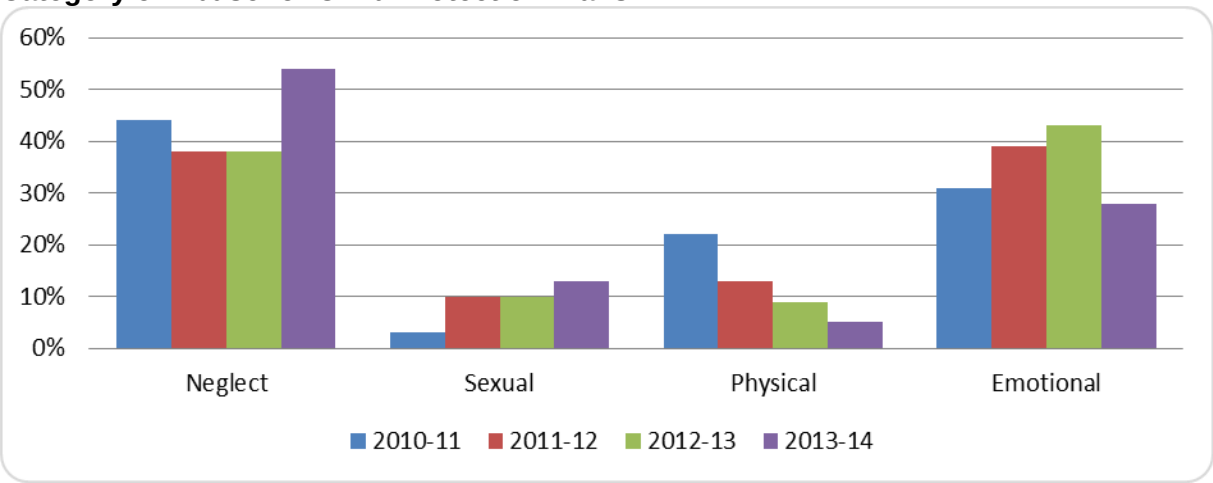
- Children's Social Care scrutinising contacts from partner agencies and the public and subsequent referrals.
- Revision of the contact and referral process, leading to implementation of a single point of entry for referrals to Children's Social Care – the Contact and Referral Team (CART).
- Children's Social Care managers and their Police counterparts in the Operational Public Protection Unit reviewing Child Protection investigations, specifically considering risk assessment, analysis and recording practices.
- Senior manager in Children's Social Care reviewing files to identify whether cases were being managed at the appropriate level.





214 Child Protection Plans were commenced in 2013-14. For **38 children this was a second or subsequent Child Protection Plan**. The number of plans has significantly increased, with the population at the end of the year more than doubling that seen last year. However, the number of families has not risen to the same extent, showing the impact of larger families entering the child protection process. The rate of children who were subject of a Child Protection Plan at 31st March 2014 per 10,000 population is 58.7 in Halton. The average for Halton's statistical neighbours is 63.5. This has brought us more in line with our statistical neighbours than in previous years. The LSCB recognises the significant impact the increase in child protection planning has across all agencies, and will be undertaking work to consider the reasons for the continuing rise in Child Protection Plans and outcomes for the children, alongside reporting on workforce capacity.

Category of Abuse for Child Protection Plans:



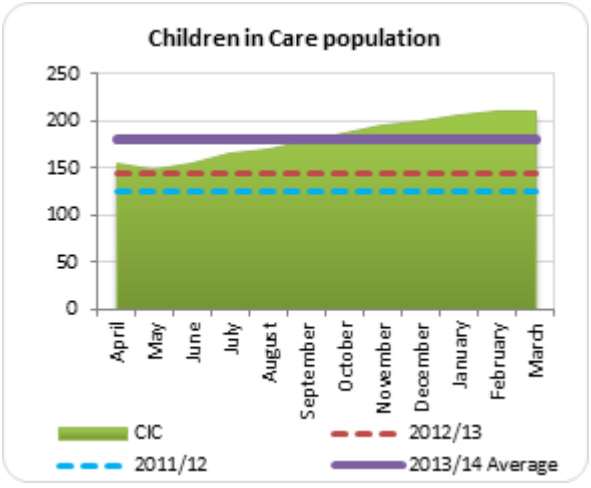
	2010-11	2011-12	2012-13	2013-14
Neglect	44%	38%	38%	54%
Sexual	3%	10%	10%	13%
Physical	22%	13%	9%	5%
Emotional	31%	39%	43%	28%

NB Children may change category of abuse during the course of the Plan and therefore may appear in more than one category.

The number of CP Plans open at the end of the year showed a 16% increase under the category of neglect. There are a number of reasons for this which include:

- Greater public and partnership awareness of the long term effects of neglect.
- The impact of learning from Serious Case Reviews nationally and locally.
- The impact of missing from home and poor school attendance is also reflected in CP Plans for older children.

4.3 Children in Care



At 31st March 2014 there were **214 Children in Care**. This was an increase of 47.5% from April 2013 to March 2014. Halton's statistical neighbours have also experienced an increase in their Children in Care populations. The rate of Halton's increase has brought the rate closer to that of statistical neighbours from a low starting point. In particular there has been a significant increase in the numbers of older children being admitted to care, aged 11 years or over, bringing the average age entering care up to 6.63 years. The LSCB requested the Children's Trust to undertake work in order to understand how early help services could identify older children in need of support. A revised early help model is to be implemented from the autumn of 2014.

The average length of time in care has decreased to 3.2 years from 3.4 years, ranging in time from 2 days to 17 years. This indicates that good permanency planning is in place for these children.

At 31st March 2014:

- 75% of Children in Care are placed within foster care and family settings.
- 25 young people were placed with external residential care providers.
- Of those 2 young people were placed within an independent children's home in Halton
- 17 were placed within 20 miles of the borough
- 6 were placed over 20 miles from the borough.
- 2 young people were placed within a secure welfare placement outside of the borough.

The LSCB receives reports on the quality of residential placements for Halton children. There is a clear process in place for reviewing any provision that falls below the Ofsted "good" judgement whilst a Halton child is placed there.

4.4 Children in Care of Other Local Authorities (CiCOLA)

Some children living in Halton are Children in Care of other local authorities; this means that they live in foster care placements, independent children's homes or within a Leaving Care/Semi Independent placement where the placement has been arranged by another local authority.

Each local authority is required to maintain a current list of the Children placed into its area.

For the past 2 years this function in Halton has been located in the Local Authority's Children's Commissioning Team. Notifications should come from the placing local authority. However as this has proven problematic, work has been completed to ensure that notifications are now received from Health (Children in Care Specialist Nurse) as well as all placement providers within the borough, and more recently from Education, with each party updating the other when a notification is received so that everyone's data is as current as possible

CICOLAs are a standing item on the Placement Provider Forum which meets quarterly to act as a reminder / prompt to the organisations. The Placement Provider Forum brings together both the local authority and independent providers working in the borough. The forum acts as a central point for dissemination of information and good practice, supporting the quality of placements in the borough.

On 31st March 2014 there were 163 young people on the CICOLA list - with over 30 local authorities placing young people into the borough of which only 4 local authorities have over 10 young people (Knowsley, Liverpool, St.Helens & Warrington). This represents a significant change in the make up of the local authorities that were placing young people into the borough when the list became located in the Commissioning Team. At that time significant numbers of young people were being placed from the London boroughs as well as boroughs in the North East and Ireland. One of the likely reasons for this change is that any issues of concern which lead to an Information Sharing alert being sent to all North West authorities are now shared with the Pan London group as well as the North East consortium so that their commissioning decisions are fully informed.

4.5 Private Fostering

Private fostering is an arrangement, usually made by a parent, for a child under 16 years (or under 18 years if they have a disability) to be cared for by someone other than a close relative (ie grandparent, brother, sister, aunt or uncle) for 28 days or more. It does not apply to children who are looked after by the Local Authority.

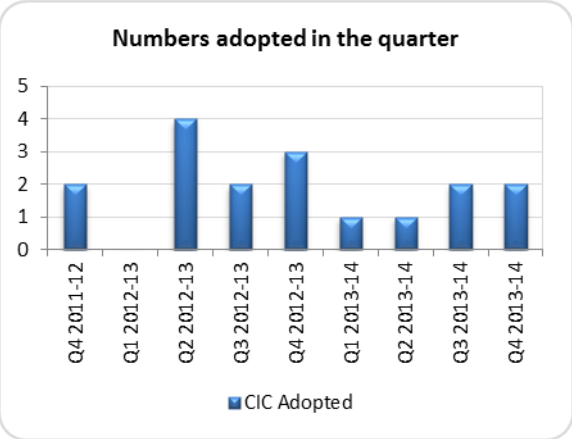
LSCBs are expected to ensure that effective processes are in place to promote the notification of private fostering arrangements in their local area. This includes raising awareness amongst staff and the public of what constitutes a private fostering arrangement, and the requirement to notify Children's Social Care. The local authority is required to provide an annual Private Fostering Report to the LSCB, which the LSCB reviews and responds to any findings as necessary.

During 2013-14 four private fostering notifications were received by the Local Authority. This was a reduction of two on 2012-13, and in line with previous years. All four arrangements ended in the year.

The following activity was undertaken to raise awareness of private fostering:

- Leaflets for parents/carers, children and practitioners were up-dated
- Packs were distributed across partner agencies to support delivery of awareness raising during team meetings
- Private fostering messages were distributed across school bulletins and governor briefings
- Early Years settings were targeted to distribute awareness raising materials

4.6 Children who are Adopted



2013-14 details

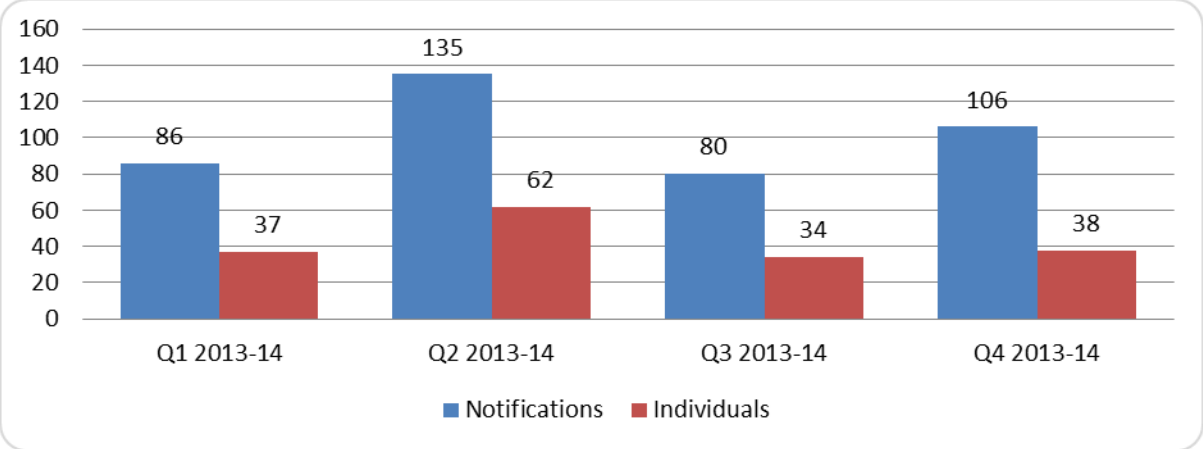
Age at adoption:	0-1 years	0
	1-2 years	67%
	3-4 years	22%
	5+ years	11%
Gender of adopted child:	Male	89%
	Female	11%
Ethnicity of adopted child:	White British	100%

The number of adoptions from care during the reporting period was 6. The average time (over three years performance) between a child entering care and moving in with their adoptive family was 538 days which is reduced from the previous year, but still better than the England average of 647 days and less than the threshold set by government.

4.7 Missing Children

New statutory guidance was published in January 2014 which led to a revision of the Pan-Cheshire Missing from Home & Care Protocol to include the definitions of: absent, missing and away from placement without authorisation. The new protocol defines agencies' roles and responsibilities including the collation and analysis of data to assist with trends around missing, and links to Child Sexual Exploitation and trafficking. A launch of the revised protocol across the workforce included the Children's Provider Forum.

Missing Children Data April 2013 – March 2014



The figures are similar to the previous year in that we have seen a spike each summer, during the school holidays. Individuals reported missing have been approximately 45% missing from home, and 55% being reported missing from care. Of the young people being reported missing from care, approximately 50% of those were Children in the Care of other Local Authorities (CiCOLAs).

Of those children reported missing, the largest cohort of young people were aged 14-16 years. Although at the beginning of the year there was a 50/50 split between males and females, from September – March females were most likely to be reported missing.

The local authority receives monthly "tracker" information from the police of all missing and absent children. This includes details of the type of placement they live in; the number of missing episodes over the last 6 months; the responsible local authority; any significant risks, including child sexual exploitation. This information is analysed along with Children's Social Care's information to ensure that all vulnerable children are identified and responded to appropriately. It is planned that during 2014-15 this data will also be compared with information on children missing from education and absent from education, in order to identify children vulnerable to multiple factors, ensuring they receive the appropriate services via the most appropriate plan.

Catch 22 is the commissioned service which has been providing the Missing from Home Service across Cheshire since 2012. Staff from Catch 22 work closely with the police Missing from Home Coordinator and other partners. They undertake return interviews and assessment, followed by direct intervention work as required. They also undertake return interviews with children in care, placed outside Cheshire, but living within a 30 mile radius. As the LSCB was concerned that this group of children may not be receiving the service, Catch 22 undertook work with the social work teams to raise awareness of the provision. This was reported to the CSE & Missing Children Sub Group.

4.8 Child Sexual Exploitation (CSE)

Sexual exploitation can happen to boys and girls from any background. Any child under the age of 18 may find themselves in a situation that makes them vulnerable to CSE. Perpetrators can be male or female, adults or other young people. We all need to be vigilant. In Halton we have an Operational Group that meets monthly to consider information about potential victims, perpetrators and areas where CSE may be taking place known as "hotspots". During the year 34 notifications were made to the Operational Group of young people at risk of CSE. 9 areas were identified as potential "hotspots", leading to targeted activity by the Police, YoungAddaction and Catch 22.

In addition a police operation was undertaken to:

- Safeguard and protect vulnerable children who were victims of and / or at risk of sexual exploitation or other abuse
- Investigate all incidents of child sexual exploitation (CSE) linked to the Widnes area to identify any criminal activity and bring offenders to justice.

The police worked closely with colleagues in Children's Social Care and other partner agencies. All the young people were safeguarded. 11 adults received a variety of enforcement actions.

Further detail of CSE work in Halton is set out in the section on the CSE & Missing Children Sub Group. Halton also sits on the Pan Cheshire Strategic Group which is chaired by the Police and reports to each of the 4 LSCBs.

4.9 Domestic Abuse

A high percentage of referrals are received about domestic abuse. Following challenge from the LSCB regarding a need for services to support families, Core Assets were commissioned to deliver the Domestic Abuse Family Service. The service is available to families where domestic abuse is taking place or has been within the last 12 months and/or there is an identified need that the family require both parenting and child safety planning support. The service has four key offers:

- Support to the non-abusing parent to enable them to understand the impact of domestic abuse on how they parent and how domestic abuse has an impact on children and young people's behaviour. This is delivered through parenting groups and/or one to one support.
- Direct work for children/young people focusing on safety planning, where the young person is still at risk from domestic abuse.

- Longer term recovery work where the perpetrator is no longer within the family home, delivered by a qualified art and play therapist.
- Support to Children's Social Care with pre-court proceedings work and providing information for assessments where required, with direct interventions and reports.

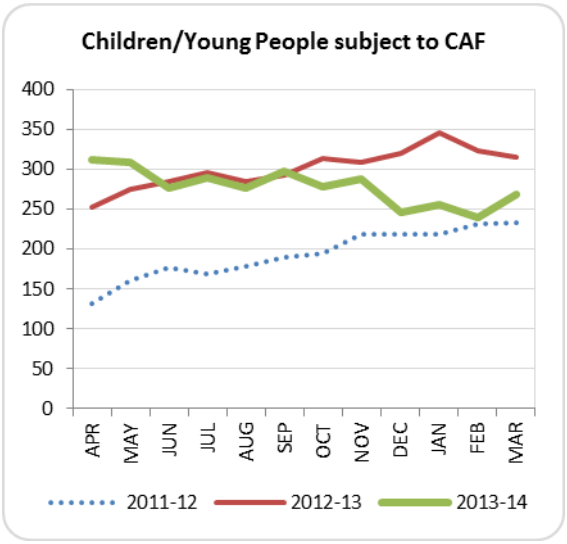
Halton has also appointed a Young People's Violence Advisor whose role is to:

- Improve early identification and intervention for teenagers experiencing, or at risk of, serious violence and abuse.
- Improve and co-ordinate effective, flexible local support and reduce risks.
- Use data collected by practitioners to inform service delivery locally and policy development nationally.

Since coming into post the Young People's Violence Advisor has:

- Developed a MARAC pathway for 16- 17 year olds
- Updated the DASH and MARAC process training
- Co-ordinated white ribbon events for young people to help raise awareness of domestic abuse.
- Supported the hidden harm agenda in particular around CSE.

4.10 Early Help and Support



Lead Professional Organisation Q4 2013-14	Count	%
Primary School	82	30%
Halton Borough Council	63	23%
Children's Centres	27	10%
PCT	24	9%
Secondary School	18	7%
Nursery school	13	5%
NHS Bridgewater	10	4%
Special School	9	3%
Family Work Service	7	3%
Not recorded	6	2%
Academy	3	1%
Post 16 education	2	1%
NHS Health Visiting	2	1%
Woodview	2	1%
NHS	1	0%
Total	**269**	

In some instances children may have additional needs which are not child protection related, or which if addressed at an early stage will prevent the need to refer to Children's Social Care at a later point. The child and family may need a range of supportive services to address these additional needs. The Common Assessment Framework (CAF) is a voluntary process, requiring informed consent of the family or young person, dependent upon age and understanding, whereby the child's needs can be assessed holistically, services delivered in a coordinated manner and reviewed regularly.

At the end of 2013-14 there were 269 open CAFs in Halton. Over the year there has been an approximate 15% decrease in the number of CAFs. The majority of Lead Professionals were from Children's Services or Primary Schools. The LSCB Chair wrote to all partners to reinforce the expectation that they participate fully in the CAF process, including initiating CAFs and undertaking the Lead Professional role. The LSCB also asked the Children's Trust's to undertake analysis of the low number of CAFs and engagement by partners in the CAF process. Initial findings from this work appear to indicate the under reporting of early help assessments.

5. The Work of the Sub Groups

5.1 Scrutiny and Performance Sub Group

The role of this Sub Group is central to the monitoring and evaluation function of the LSCB. The Sub Group oversees actions from a programme of audit activity across the Levels of Need Framework including the Common Assessment Framework, Child in Need and Child Protection Plans, Children in Care and Care Leavers. The LSCB is beginning to receive reports on the outcomes of audits undertaken by partners, but recognises that this needs to be developed further.

During 2013-14 the LSCB coordinated three Multi-Agency audits and from this has identified areas for improvement including:

- Inconsistent challenge between practitioners and limited use of the escalation process when there are differences of opinion about at which level children should receive services
- The need to proactively engage children and families more in the audit process to ensure that their views influence practice
- The improvement of IT to ensure secure information sharing between health and social care
- Reports being shared with families prior to conference by all agencies
- Minutes of Child Protection Conferences being circulated in a timely way
- Chronologies being completed consistently by social workers
- Effective engagement with Adult Social Care in a “think family” approach

An action plan is in place to address learning identified from the audit process which is overseen by the Scrutiny & Performance Sub Group.

Areas of good practice were also identified and reported back to frontline staff. These included evidence of good multi-agency working and improved outcomes for children. Also there was evidence of children being central to the planning process and their voices being heard.

The Sub Group has been further developing the LSCB Performance Framework, including additional reporting on indicators from Board partners. Further work will take place over the coming year to ensure that the performance reporting received by the Board is multi-agency, is meaningful and outcome focussed.
Priorities for 2014-15 include:

- Undertaking Section 11 audits of LSCB partner agencies to demonstrate the effectiveness of their safeguarding arrangements
- Regular reporting of audit activity undertaken by partner agencies and the impact of this

5.2 Child Sexual Exploitation and Missing Children Sub Group

During 2013-14 the Child Sexual Exploitation Sub Group broadened its scope to include oversight of children missing from home, care and education, recognising how missing children are particularly vulnerable to risk of harm through sexual exploitation. Bringing oversight of these vulnerable groups of children under the remit of one Sub Group recognises the LSCB's aim to overlay information so that children at risk due to a range of risks can be considered together.

The 5 key strands to Halton's CSE action plan overseen by the Sub Group are:

- Raising awareness
- Understanding what is happening locally for potential victims, locations and perpetrators
- Developing a strategic response
- Supporting victims
- Facilitating policing and prosecution of perpetrators

Key achievements:

- Revision of the Pan-Cheshire Missing from Home and Care Protocol
- Producing CSE Practice Guidance
- Identifying CSE Champions across partner organisations
- Delivering CSE training to frontline staff
- Partners' engagement in the first phase of the Pan-Cheshire CSE awareness raising campaign, aimed at young people – "The more you know, the more you see"
- Joint Cheshire & Merseyside CSE event for strategic and frontline staff

Priorities for 2014-15 include:

- Developing and delivering an Advanced CSE course for practitioners working with young people identified as being at risk of, or suffering from, CSE.
- Engagement in the next phase of the Pan-Cheshire CSE awareness raising campaign, targeting businesses.
- Raising awareness of CSE amongst parents and carers.
- Rolling out "Risking It All" interactive theatre presentation to all Year 9 & 10 pupils across Halton.
- Overlay of CSE and Missing Children information.
- Broaden the remit of the Sub Group to include Trafficked Children.

5.3 Health Sub Group

As part of the LSCB's revision of its membership and structures, it was agreed to pilot establishment of a Health Sub Group. The purpose of the Sub Group is to create a dedicated forum for oversight of safeguarding priorities in relation to the Health Sector. This is then reported to the Executive and Main Board, with the Health Sub Group Chair sitting on the Executive and Main Board, representing all of the Health provider Trusts. Health partners in Halton have shown openness and expressed commitment to undertaking their Board functions via the Sub Group.

The Sub Group is in its early stages of development, with priorities including:

- Review of Named GP functions.
- Review of Designated Doctor functions.
- Health assessments of Children in Care.

5.4 Learning & Development Sub Group

The Learning & Development Sub Group jointly sits under both the Safeguarding Adults Board and the LSCB. The Sub Group coordinates a joint Safeguarding Training Needs Analysis, and considers opportunities to jointly deliver training.

The Sub Group oversees the LSCB Training Programme and the evaluation of the impact of training on improved outcomes for service users. Examples of this can be seen in the Training Activity section of this report.

Key achievements:

- Developing an LSCB Learning & Development Strategy
- Developing a local Learning & Improvement Framework to sit alongside the North West framework
- Revising the Training Needs Analysis
- Delivering joint safeguarding training to elected members
- Undertaking impact evaluation of training

Priorities for 2014-15 include:

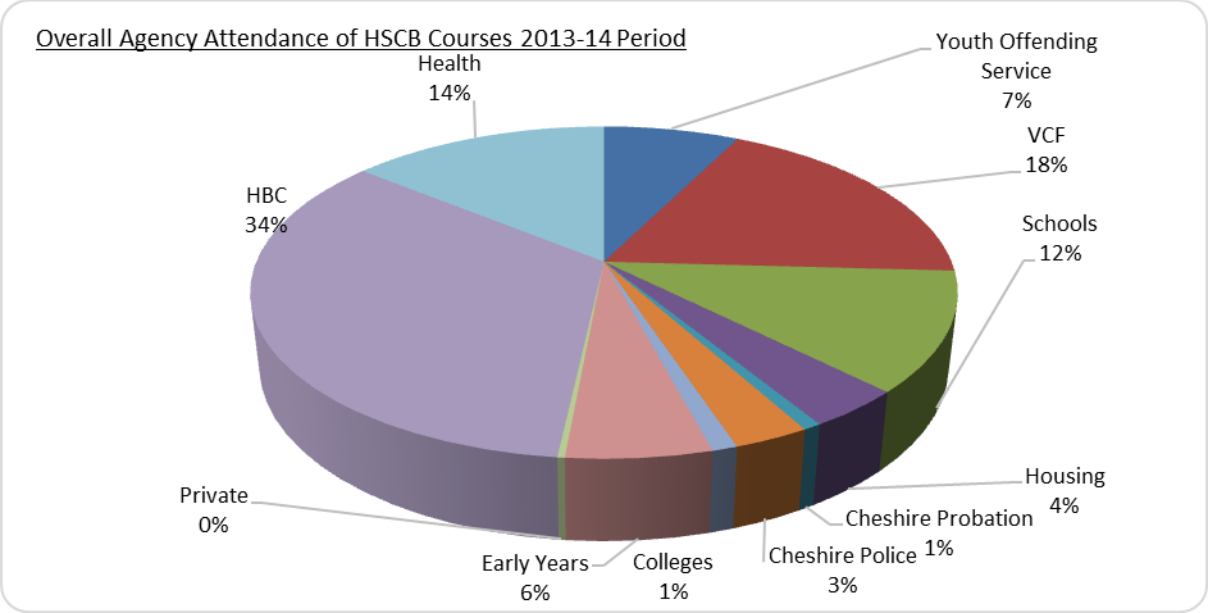
- Ensuring the appropriate multi-agency level 3 training is available to staff.

5.5 Training Activity 2013-14

The LSCB has a responsibility to ensure that appropriate safeguarding training is available to the workforce across the borough. It does this by undertaking an annual Training Needs Analysis; quality assuring single agency safeguarding training packages; and delivering multi-agency training. This work is led by the Learning & Development Sub Group.
The 2012-13 training programme saw 32 courses delivered with 906 places accessed. The LSCB also promoted a range of local and national e-learning.

Overall Agency Attendance on HSCB Courses 2013-14

Between 1st April and 31st of March 2014 13 different courses were offered in the HSCB Training Programme. Delivery ranged from lunchtime sessions to four day courses. The graph below indicates the overall distribution of training places by agency and across sectors.



Due to the LSCB Training Officer taking up a post elsewhere, the LSCB was without a Training Officer for much of the year. The Training Programme continued to be delivered via members of the LSCB Training Pool and external facilitators. However, we were unable to undertake the post course follow up of impact of training at 3 months due to lack of capacity within the team. Resources were focussed instead on the 12+ months telephone interviews. These are undertaken by members of the Learning & Development Sub Group and provide an opportunity for reflective interviews to take place with course participants in order to identify how learning from courses has made a difference to their day to day practice with children and families.

Examples of how training had made a difference to practice include:

- A Social Worker who reflected on a case and identified a hidden male who was a cause for concern in the family. She assessed him and this helped the mum to recognise that he posed a risk of harm to the children, and to work with the Social Worker to ensure he was no longer in that home.
- A Support Worker who recognised after training that a family he was working with were using strategies to make it look like they were complying with the plan of work, when no real changes were being made . As a result he consulted with CART, then reminded the family of the expectations and engaged them in the plan.

- A Social Worker who used the Missing from Home & Care Protocol more effectively in her work. When she took over a case from another worker she identified that there should have been a Strategy Meeting called due to the number of missing episodes. This was arranged, and the young person referred to the Missing Service.
- A Nursery Manager who now ensures that the nursery provides free childcare when parents are attending Child Protection Conferences as the course led her to reflect upon the difficulties faced by families in the child protection process.
- A Nursery Worker who was able to confidently deal with a disclosure made by a child following training.
- A Teacher who challenged decisions by Children's Social Care to step down cases from Child in Need, leading to cases remaining at Child in Need due to ongoing concerns and impact on the children; prior to attendance on the training the teacher felt that she would not have challenged Children's Social Care.
- A CAMHS worker who networked with GPs on the course and continued to develop relationships afterwards which led to a GP contacting them for advice on a case, leading to a referral to CAMHS.

We achieved last year's training priorities by:

- Revising all courses to ensure they were compliant with Working Together 2013 and changes to practice such as implementation of the Single Assessment and introduction of the CART.
- Developing Domestic Abuse training to focus upon the impact on children.
- Embedding Child Sexual Exploitation training within the programme.
- Delivering Lessons from Practice training as part of the Learning & Improvement Framework, and embedding learning from Serious Case Reviews across the training programme.
- Working with neighbouring LSCBs across Cheshire and Merseyside to develop and deliver sessions for frontline and strategic staff.

During 2013-14 the LSCB will be recruiting to the vacant Training Officer post in a joint arrangement with Cheshire West & Chester LSCB. This will enable both LSCBs to develop their training programmes, and encourage further collaboration on joint training initiatives. Priorities for the 2013-14 training programme include:

- Developing a Pan Cheshire Advanced CSE course
- Rolling out training on the Graded Care Profile to support the Neglect Strategy
- Further delivery of Pan Cheshire training on topics such as Female Genital Mutilation

5.6 Safer Workforce Sub Group

The Safer Workforce Sub Group also reports to both Safeguarding Boards in Halton. During the year the Sub Group had lost momentum; therefore a meeting was held to review membership, revise terms of reference and review its priorities. In addition, a new Chair will take over for 2014-15.

Priorities for 2014-15 include:

- Revising Safer Recruitment training, delivering the Safer Recruitment Consortium package.
- Seeking the views of frontline staff on their experience of supervision as part of scrutiny of supervision practices across partners.

5.7 Local Authority Designated Officer (LADO)

Each local authority has a Local Authority Designated Officer (LADO). The LADO must be informed of all allegations relating to adults who work with children whether they are a paid member of staff, foster carer or volunteer, where there is concern or an allegation that the person has:

- Behaved in a way that has harmed, or may have harmed, a child.
- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Working Together 2013 amended the role of the LADO and issues of suitability were removed from the LADO's remit. The LADO is no longer responsible for:

- Where an employee is being investigated for an offence against an adult; or
- Their behaviour in their personal lives brings into question their suitability to work with children.

The exception to this is where Children's Social Care deems that their actions have harmed a child and as a consequence the threshold for LADO involvement is met.

The LADO's role includes providing advice and guidance to employers and voluntary agencies; management and oversight of individual cases; monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process. This is part of the process of ensuring that safer workforce practices are in place to safeguard children from individuals and practices which may be harmful. This process also safeguards staff by ensuring that malicious or unfounded allegations are thoroughly investigated and resolved in a timely manner.

32 allegations were reported to the LADO during 2013-14 that resulted in strategy meetings, this compares with 39 in the previous year.

Following on from last year's Annual Report which identified an increasing number of consultations and allegations made against professionals using Facebook and other social media sites to make contact with young people. The LSCB advised all agencies to ensure that staff, including volunteers, were made aware of expectations of behaviour at the point of induction and regularly thereafter. A good practice policy developed for use in early years settings was also circulated.

The LADO made the following recommendations to the LSCB in their annual report which will be actioned during the forthcoming year. These are:

i. Confirm the legal position in respect of retaining data on professionals when the LADO threshold is not met.
ii. Relay to the unions the impact of delay on all parties involved in the LADO process

5.8 Policy & Procedures Sub Group

The Sub Group continued to review single agency safeguarding related policies and procedures. It also revised the LSCB's Practice Guidance to ensure compliance with Working Together 2013.

Following discussions across the four Cheshire LSCBs it was agreed to move to a Pan-Cheshire Sub Group from January 2014. The initial focus for the Sub Group has been a revision of the Pan Cheshire Multi-Agency Safeguarding Children Procedures in a web enabled format. Initial feedback from practitioners has been positive, finding the format easier to navigate, and having access to procedures, guidance and research all in one place.

5.9 Child Death Overview Panel (CDOP)

A Pan Cheshire CDOP was formed in April 2013 in order to bring together an understanding of recommendations and learning from child deaths across Cheshire. The first Annual Report of the Cheshire CDOP can be viewed at Appendix C.

6. LSCB Challenge

The LSCB has provided challenge in respect of a number of issues over the year. This has included:

- The Safeguarding Unit approached the LSCB Chair raising concerns about the impact of frequent changes of social workers on children and families. The LSCB Chair requested the Safeguarding Unit to undertake additional scrutiny by auditing a random selection of 30 cases across Runcorn and Widnes. No children were identified as being at immediate risk of harm and areas of good practice were identified. Areas for improvement were identified.
- The Scrutiny & Performance Sub Group identified concerns regarding the reduction in the number of CAFs being undertaken, and an over representation of Lead Professionals from Children's Services and Primary Schools. The LSCB Chair wrote to all partners outlining expectations regarding involvement in the CAF process. The Board subsequently raised this further with the Children's Trust who have undertaken a piece of work across all agencies that has subsequently informed the revised early help model.
- The Board, in considering the proposed Service Level Agreement for the School Health Service, raised concerns with the Director of Public Health regarding the lack of reference to safeguarding throughout the document. The proposals were subsequently revised in consultation with NHS Halton Clinical Commissioning Group (CCG).

7. Learning and Improvement

During this period there were no Serious Case Reviews undertaken by the LSCB. A number of national Serious Case Reviews were considered by the LSCB with partners considering the implications within their own agencies as appropriate. These included the reports on the deaths of Daniel Pelka and Hamzah Khan, and the North Somerset and East Sussex reports relating to the teachers Nigel Leat and Jeremy Forrest. The LSCB disseminated learning from Serious Case Reviews by embedding learning across a range of courses, as well as via the Lessons from Practice workshop. The LSCB's newsletters identify recent cases and signpost staff to these reports, as well as the thematic reports published via the NSPCC's portal. A link is provided to the NSPCC portal via the Serious Case Review page of the LSCB's website.

The recommendations in the thematic report "What about the children?" and the learning from the Manchester Serious Case Review report on the death of Child U were considered by the LSCB. An action plan has been drawn up which focuses upon the relationship between Adult Substance Misuse & Mental Health Services and Children's Services. Progress of the action plan will be reported during 2014-15.

An audit schedule including the CAF, Children & Families Services and the Multi-Agency practice audits continued.

Category of Case	Number of Cases Audited	Number of Cases	% of Cohort Audited
Adoption & Fostering	2	4	50%
Children in Care	23	179	13%
Children In Need	41	628	7%
Child Protection	29	128	23%
Family Support	30	103	29%
CAF	24	285	8%

The LSCB jointly commissioned a piece of work with Cheshire West & Chester and Telford & Wrekin LSCBs to improve the impact of the voice of the child during the Child Protection process. Multi-disciplinary practitioners developed two templates to be used during Child Protection Conferences during a series of action learning sets, led by Prof. Jan Horwath from Sheffield University. The process was piloted with Widnes CiN Team neglect cases at Initial Child Protection Conferences. A researcher from Sheffield University is collating the findings which will be presented December 2014.

8. Key Priorities 2014-15:

The LSCB's five strategic priorities are set out in our Business Plan 2013-15. From this, the following vulnerable groups requiring particular focus have been identified for 2014-15:

- Early Intervention – The LSCB is to further develop reporting from all agencies on the impact of Early Intervention.
- Neglect – The LSCB will scrutinise impact of the Neglect Strategy.
- CSE & Missing Children – The LSCB will continue to scrutinise incidents of Missing Children and children at risk of, or who are being, sexually exploited. This will include more focus upon police disruption and prosecution activity and licensing. The LSCB will also ensure that the CSE Communication Plan is embedded and makes a difference to children & families in Halton.
- Children in Care & Care Leavers – The LSCB will undertake work to understand the reasons behind the increase in Children in Care, and the impact this is having on all partner agencies and service delivery.
- Domestic Abuse – The LSCB will consider the impact of the commissioned service, Core Assets and the role of the Young People's Violence Advisor. There will also be a pilot of Operation Encompass whereby Cheshire Police will share information of domestic abuse incidents with a named contact in each school in Widnes in order to ensure children are provided with support in a timely manner.

9. LSCB Business Plan 2013-15

1.0 PRIORITY: Identify and prevent children suffering harm RATIONALE: An effective LSCB monitors and understands the application of thresholds locally. The need for support is identified in a timely manner and services appropriate to the child's needs are available.

	What needs to happen?	What difference will this make?	Reporting arrangements	Timescale
1.1	LSCB has Performance Framework in place and receives regular quantitative, qualitative & stakeholder information.	Early identification of areas for improvement and further scrutiny.	Scrutiny + Performance Sub Group	December 2013
1.2	Ensure thresholds are being applied in line with the Halton Levels of Need Framework on a multi-agency basis through: AudIts that include children & families Training of frontline staff on thresholds and identified specific issues and specific vulnerable groups. Revision of Neglect Strategy	Right children at right level of need. Improve understanding of neglect amongst frontline staff. More timely interventions for children at risk of neglect.	Scrutiny + Performance Sub Group Learning & Development Sub Group Executive	June 2014 June 2014 March 2014
1.3	S11 Audits of Police, LA, YOS, Health Trusts, Probation (NPS & CRC), Housing Providers.	Frontline staff are supported to undertake their roles & responsibilities effectively to safeguard children.	Executive	July 2014

	S175/157 Audits of schools		Executive	December 2013
	S11 Audits of Children's Commissioned Services		Executive	March 2014
	Safeguarding audits of Childcare providers and Childminders		Executive	March 2014
	GP Practice Safeguarding Audits to be developed by NHS England (Merseyside).		Executive	Sept 2014
	Voluntary Sector S11 Audits to be developed.		Executive	Sept 2014
1.4	Children missing, including those missing from education or school roll, or at risk of CSE are identified and their needs met through appropriate services, through: Awareness raising & training of frontline staff. LSCB support of Pan Cheshire Strategic Group LSCB continues to prioritise this area. Operational Group identifies potential victims, perpetrators and hotspot activity. Continue to support cross border arrangements between Cheshire & Merseyside.	Children who are missing and at risk of CSE are effectively safeguarded. LSCB can demonstrate it is carrying out its responsibilities in relation to these children.	CSE & Missing Children Sub Group	January 2014

1.5	LSCB needs to be assured that CiC & Care Leavers receive effective, safe services through: IRM Report Annual Private Fostering Report Reports from Children's Trust Reports on children placed out of borough by Halton & those placed in Halton by other local authorities Views from CiC Council and Care Leavers Strengthen Board's engagement with CiC and Care Leavers.	Cic and Care Leavers receive effective, safer services.	Scrutiny + Performance Sub Group	June 2014
1.6	Support Pan Cheshire CDOP arrangements and ensure actions from Child Death reviews are implemented through Critical Incident Panel.	Children are effectively safeguarded. Staff learn the lessons from Child Death Reviews.	Critical Incident Panel	January 2014

2.0 PRIORITY: Protect children who are suffering or at risk of suffering harm

RATIONALE:
An effective LSCB is one where partners hold each other to account for their contribution to the safety and protection of children, including those Children in Care placed in Halton from other local authorities.

	What needs to happen?	What difference will this make?	Reporting arrangements	Timescale
2.1	Partners to challenge each other where there is professional disagreement regarding the child's level of need.	Children receive services that meet their needs. Strengthen partnership accountabilities.	Safeguarding Unit Meeting	January 2014

2.2	Assurance for the Board that children in need of protection are receiving the services they need.	Help the Board to understand the reason for this and address blockages to ensure that children in need of protection are subject to Child Protection Plans.	Scrutiny + Performance Sub Group	June 2014
2.3	Scrutiny of Domestic Abuse services for children and families to evaluate impact.	Children and families receive services that meet their needs.	Scrutiny + Performance Sub Group	October 2014

3.0 PRIORITY: Ensure that children are receiving effective early help and support.

RATIONALE:
An effective LSCB monitors the effectiveness of early help. Early help and support ensures better outcomes for children; reduces the risk of harm; and prevents children being taken into care.

	What needs to happen?	What difference will this make?	Reporting arrangements	Timescale
3.1	Improve and strengthen the engagement in CAF process by all partners through: Audit Increased reporting from Children's Trust Continued training Relevant LSCB members ensuring improvements within their agencies	Increase in number of CAFs. Increase in number of Lead Professionals from partner agencies. Increase in number of referrals to CSC where there is evidence of early help.	Executive	June 2014
3.2	Ensure that older children are receiving co-ordinated multi-agency early help and support.	Reduce the number of older children coming into care without any previous involvement with CSC.	Executive	June 2014
3.3	Development of revised Early Help Model	Children receive early help and support that meets their needs.	Executive	September 2014

4.0 PRIORITY: Support the development of a safe and informed workforce, including volunteers

RATIONALE:
All LSCBs have statutory functions relating to learning and improvement, training and safer workforce. Opportunities for learning should be effective and engage all partners. Training should impact on improving frontline practice and the experiences of children, families and carers.

	What needs to happen?	What difference will it make?	Reporting arrangements	Timescale
4.1	Local Learning & Improvement Framework in place.	Supports the workforce in receiving learning from all review and audit related activity to inform practice.	Learning + Development Sub	July 2014
4.2	HSCB Training Strategy in place.	Provides framework to ensure HSCB learning & development activity is planned in order to meet local need, and evaluated with regards to impact on outcomes for children & families.	Learning + Development Sub	December 2013
4.3	Evaluate impact of safeguarding training	Frontline staff are competent and confident practitioners. Children are effectively safeguarded.	Learning + Development Sub	May 2014
4.4	Revise Board's approach to multi-agency learning & development activity.	Provide opportunities for staff to access multi-agency safeguarding learning and development opportunities to develop their practice.	Main Board	April - September 2014
4.5	Revise Pan-Cheshire Multi-Agency Safeguarding Children Procedures	Provide an easy to use set of procedures that will support the workforce in identifying and acting appropriately to safeguard children.	Pan-Cheshire Policy + Procedures Sub	April 2014
4.6	Partners ensure staff receive induction, supervision and access to continuous professional development., through: S11 Audits S175 Audits	Frontline staff are competent and confident practitioners.	Executive	January – September 2014
4.7	Frontline visits by LSCB members Frontline event in partnership with	Increase profile of Board across workforce. Increased ownership of Board members in their role on the Board.	Executive	March 2014

	Children's Trust	Provide opportunity for Board members to increase their understanding of the role of staff in partner agencies. Provide workforce with opportunity to influence the work of the Board. Enable frontline staff to increase their understanding of the role of the Board and encourage staff to influence the work of the Board.	Learning + Development Sub	May 2014
4.8	HSCB & SAB to develop engagement with the Faith Sector.	Increase profile of Board across Faith Sector.	Main Board	December 2014

5.0 PRIORITY: Engage with Children and Young People, their Families and Communities in developing and raising awareness of Safeguarding.

RATIONALE:
All LSCBs have statutory functions that include awareness raising. Listening to children, families and the community enables LSCBs to identify local safeguarding concerns and work with partners to develop more responsive services. Safeguarding children is everyone's business.

	What needs to happen?	What difference will it make?	Reporting arrangements	Timescale
5.1	Campaign to raise awareness of CSE	Encourage reporting.	Pan-Cheshire CSE & Missing Strategic Group	January 2014
5.2	Public feel confident to report safeguarding concerns and know who to report to.	Encourage reporting.	Safeguarding Unit Meeting	March 2014
5.3	Strengthen links with the following groups: Children with Disabilities Young Carers CiC Council	Improve LSCB's scrutiny of vulnerable groups.	Main Board	September 2014
5.4	Support E-Safety events.	Improve parent/carer awareness of e-safety issues, and support them in	Main Board	February 2014

		speaking to their children.		
5.5	Support Crucial Crew event.	Provide Year 5 children with opportunities to discuss their safeguarding concerns and provide safeguarding messages.	Learning + Development Sub	March 2014
5.6	Support Relationship Awareness for Teens (RAFT): Introduction of pilot roadshow events to raise awareness of teen relationship domestic abuse	Provide targeted groups of young people aged 14-18 years opportunities around: • Increased awareness of the dynamics and characteristics of healthy, unhealthy and abusive relationships amongst teens (14+) • Increased ability to recognise the key indicators of abusive behaviours in relationships • Increased knowledge and ability to support/signpost others in abusive relationships	Executive	December 2014

1. Budget Information

Income 2013-14	
HBC – Children & Enterprise Directorate	45, 817
HBC - Schools	32, 000
NHS Merseyside Halton CCG	45, 817
Cheshire Constabulary	20, 000
Cheshire Probation	3, 230
Cafcass NW	550
Training Income	3891
Carry Forward 2012-13	161, 703
Total Income:	313, 008

Expenditure 2013-14	
Staffing	102, 517
Multi-Agency Training	12, 994
Supplies & Services	38,307
Support Services	20, 950
Premises	2, 300
Total:	177, 068
Carry Forward:	137,206
Total:	314,274

Appendix A
Halton Safeguarding Children Board Membership & Attendance 2013-2014

Attendance Log			Meetings 2013-2014			
			09.07.2013	17.09.2013	10.12.2013	25.03.2014
Independent and Overseeing Members	Richard Strachan, Independent Chair		✓*	✓*	✓*	✓
	Cllr Ged Philbin, Lead Member Children & Young People (Participant Observer)		✓	A	✓	✓
Lay Members	Marjorie Constantine, Lay Member		✓	✓	A	✓
Local Authority	Gerald Meehan, Strategic Director, Children & Enterprise		✓	✓	✓	✓
	Steve Nyakatawa, Operational Director, Learning & Achievement		✓	✓	✓	✓
	Tracey Coffey, Operational Director, Children & Families		✓	✓	✓	✓
	Paula St Aubyn, Divisional Manager, Safeguarding Quality & Assurance, HBC		✓	R	✓	✓
	Lindsay Smith, Divisional Manager, Mental Health, Communities Directorate		A	✓	✓	R
	Eileen O'Meara, Director of Public Health		A	✓	✓	✓
	Helen Rimmer, Solicitor, Legal Services		✓	A	A	A
Health	Suprio Bhattacharyya, Designated Doctor for Child Protection, Bridgewater Community Healthcare Trust		✓	✓	A	A
	Kate Fallon, CEO, Bridgewater Community Healthcare Trust		R*	✓*	✓*	R
	Michelle Creed, NHS England (Merseyside)		✓	A	R	D
	Gary O'Hare, Clinical Lead Children's Safeguarding, Halton CCG		✓	✓	A	✓
	Ann Dunne, Designated Nurse, Safeguarding Children, Halton CCG		R	✓	✓	✓
	Jan Snoddon, Chief Nurse, Halton CCG		✓	A	✓	A

Attendance Log			Meetings 2013-2014			
			09.07.2013	17.09.2013	10.12.2013	25.03.2014
Police	Martin Cleworth, Superintendent Northern BCU, Cheshire Police		R	✓	A	✓
	Nigel Wenham, DCI Strategic Public Protection Unit, Cheshire Police		✓	✓	✓	A
Criminal Justice Services	John Davidson, Assistant Chief Executive, Cheshire Probation		R	✓	R	A
	Gareth Jones, Head of Service, CWHW YOS		✓	A	A	✓
CAFCASS	Tom Cheadle, Service Manager		✓	✓	A	A
Schools and Colleges	Dee Denton, Head Teacher, Lunts Heath Primary, Primary Headteacher Rep		✓	✓	A	A
	Andrew Keeley, Headteacher, St Chad's, Secondary Headteacher Representative		A	✓	✓	R
	Joanne Tringham, Halton Association Governors Rep		✓*	-*	-*	✓
	Paula Mitchell, Programme Manager, Riverside College		✓	✓	✓	✓
Housing Sector	Andy Williams, Liverpool Housing Trust		D*	D*	A	A
VCF Sector	Sue Thomas, Children England, Voluntary Sector Rep		-	-	✓	✓
HSCB	Tracey Holyhead, Manager		✓	✓	✓	✓
	Rhonda Saul, Quality Assurance & Safeguarding Development Officer		✓	✓	A	✓

*Denotes attendance of previous Board Member in this role
A = Apologies
R = Designated representative attended
D = Did not attend

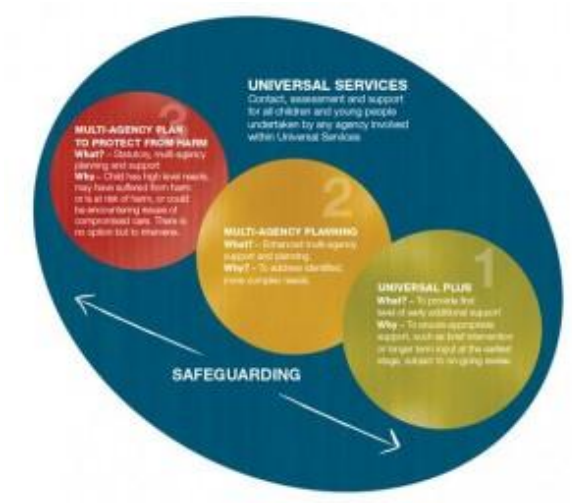
Appendix B

Halton Levels of Need Framework

The Halton Levels of Need Framework aims to support agencies to meet the needs of children, young people and their families to ensure the best possible outcomes. It aims to assist practitioners and managers in assessing and identifying a child's level of additional needs and how best to respond in order to meet those needs as early as possible to prevent needs escalating further.

Halton Levels of Need Framework was revised and launched in April 2013. The framework sets out three levels of additional needs above Universal Services that captures the full range of additional needs as they present. Universal Services remain at the heart of all work with children, young people and their families and are in place for all whether additional needs present themselves or not.

The fundamental relationship between Universal Services and the three levels of additional needs is captured in the diagram below:



The key principles of the Framework include:

- Safeguarding runs throughout all levels.
- Provide early help and support at the first possible stage and meet needs at the lowest possible level.
- The focus is on Halton's more vulnerable groups and directing service responses at preventing vulnerability.
- Builds on existing good multi-agency working and formalises shared responsibility for meeting all needs.
- Supports work of all agencies and is equally applicable to all agencies.
- Flexible and fluid, allows free movement between levels as additional needs increase or reduce.

- Clear and understandable
- Focus on the needs of the child and family to ensure the best outcomes for all.

Working Together 2013 seeks to ensure that all local areas have effective safeguarding systems in place and sets out two key principles that should underpin all safeguarding arrangements:
SAFEGUARDING IS EVERYONE'S RESPONSIBILITY: for services to be effective each professional and organisation should play their full part; and

A CHILD CENTRED APPROACH: for services to be effective they should be based on a clear understanding of the needs and views of children

The Halton Levels of Need Framework has been developed in line with this guidance and meets the requirement for the publication of a 'thresholds document' for Halton. It is based on a robust application of the Framework for the Assessment of Children (underpinned by the Children Act 1989), Team around the Family procedures and is consistent with LSCB procedures. The Halton Levels of Need Framework can be used as a central focal point to bring the right agencies together at the right level.

In terms of the **Children Act 1989**, our responsibilities include:

Where a child is accommodated under section 20 (when parents retain the parental responsibility for the child), the local authority has a statutory responsibility to assess the child's needs and draw up a care plan which sets out the services to be provided to meet the child's identified needs.

Under section 31A, where a child is the subject of an Interim Care Order or a Full Care Order, the local authority (who in these circumstances shares responsibilities, as a corporate parent, for the child and becomes the main contact around the child's every day needs) must assess the child's needs and draw up a care plan which sets out the services which will be provided to meet the child's identified needs.

Appendix C

Pan Cheshire Child Death Overview Panel (CDOP)

Encompassing the Local Safeguarding Children Boards for

Cheshire East

Cheshire West and Chester

Halton

Warrington

Annual report for Child Death Reviews

April 2013 – March 2014

Caryn L Cox
Director of Public Health, Cheshire West and Chester Council

Karen Newton
Pan Cheshire Child Death Co-ordinator, Cheshire East Council

July 2014

This report is provided to professionals working in the field of safeguarding children in the four LSCBs listed above

Cheshire East Local Safeguarding Children Board

The Local Safeguarding Children Board
Working to Keep West Cheshire's Children and Young People Safe

Contents

Acknowledgements

My thanks go to all the panel members – past and present who have made this report possible. Particular thanks are extended to Karen Newton, the Pan Cheshire CDOP Co-ordinator.

My thanks also extend to all those who have sat on the panel as subject experts and those who respond to child deaths, for their continued dedication and success in implementing the child death review process.

Thanks are extended to Eileen O'Meara, Director of Public Health at Halton Council who very kindly Chaired the first Pan Cheshire CDOP in July 2014.

Glossary

Term	Meaning
Child	A person aged 0-18th birthday
Expected death	A death that could have been reasonably predicted 24 hours before the death occurred or 24 hours before the immediate events leading to the death occurred
Infant	Aged less than 1 year of age
Modifiable factors	Factors associated with a death which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths
Neonatal period	From birth until 28 days of life
Perinatal period	From viable gestation (around 23 weeks of pregnancy) until 7 days following birth
Unexpected death	A death that could not have been reasonably foreseen 24 hours before it occurs – or where there was an unexpected collapse or precipitating events leading to the death

Abbreviations

CDOP – Child Death Overview Panel

SUDI – Sudden Unexplained Death in Infants

LSCB – Local Safeguarding Children Board

Foreword

I write the foreword to this report as Director of Public Health for Cheshire West and Chester Council and as the current Chair of the newly formed Pan-Cheshire Child Death Overview Panel (CDOP) – a sub-Committee of the four Local Safeguarding Boards of Cheshire East, Cheshire West and Chester, Halton and Warrington.

This report presents a summary of the work of the panel over the past year April 2013 – March 2014.

The panel undertakes a rigorous review of child deaths of those children ordinarily resident in one of the four areas and is a good example of effective multi-agency partnership. With the joining of the four panels we are able to provide a robust overview and insight into how child deaths can be prevented. The wide ranging experience and expertise of those who contribute to the panel either on a regular basis or through contributing as an expert in a particular field means that evidenced conclusions can be drawn to inform changes in policies, procedures and day to day practices to reduce the incidence of childhood death.

The work of the panel as demonstrated in this report should help to improve outcomes for children and young people across the four areas by identifying areas for reducing the risk of deaths where factors were identified that may have been modified to potentially prevent future deaths. This report will provide information to each of the Local Safeguarding Children Boards. It should serve as a powerful resource for driving public health improvement and promoting child safety and wellbeing.

Anonymity is a corner-stone for all data presented to CDOP, the LSCBs, shared regionally and nationally, to protect the identity of deceased children and their families. This report represents a summary of the full professional report. Numbers of deaths in individual areas and as a result of specific causes may not be reported as whole numbers where the number of incidents is less than 5, although the findings and outcomes of reviews will be included. This is for the protection of all those involved.

Caryn Cox
Chair – Pan Cheshire Child Death Overview Panel
and
Director of Public Health, Cheshire West and Chester Council

Executive Summary

'Working Together to Safeguard Children 2006, 2010 and 2013' specified that a mandatory multi-agency response and review process for all deaths in childhood (from birth up to 18th birthday) had to be implemented by April 2008 across England. The purpose of the process was to ensure all professionals responded to childhood deaths and reviewed each death in a uniform manner to identify lessons to be learnt and potentially prevent similar tragedies. The two key elements to this process are a "rapid response" and "child death overview".

This report brings together data from the first year that the newly formed Pan Cheshire panel has been meeting - since April 2013. The main report identifies the data relating to child deaths reviewed across the four LSCB areas; later annexes show the data for each specific LSCB area.

The report highlights the key data and findings of the panel.

- 58 child deaths were notified in the period April 2013 – March 2014
- 35 child deaths were reviewed by the panel from April 2013 - March 2014
- The Child Death Overview Panel met on five occasions over the year, four of these to review child deaths

Of those deaths reviewed

- 63% of the deaths occurred before the child reached one year of age (22 deaths)
- 63% of the deaths were male (22 deaths)
- Perinatal/Neonatal events accounted for 37% of deaths (13 deaths)
- 74% of deaths were classed as 'unexpected' (26 deaths)
- 31% of deaths reviewed had 'modifiable factors' (11 deaths)
- Recommendations/actions identified at case discussions and at the panel aimed at reducing risks and supporting families, have been taken forward.

When considering relatively rare events such as child deaths small variations in numbers can represent a large proportional difference. Therefore considering these figures together as a Pan Cheshire panel can help to establish a clearer representation of emerging trends or patterns but care must still be exercised.

Membership of the Pan Cheshire CDOP

Membership during 2013/14 has comprised the following

Position	Agency	Comments
Director of Public Health Chair of Panel	Cheshire West and Chester Council	
CDOP Co-ordinator		
Consultant Paediatrician (Designated Doctor)	Mid Cheshire Hospitals NHS Trust	
Specialist Nurse for the Child Death Overview Panel	East Cheshire Trust	
Specialist Nurse Safeguarding Children	Countess of Chester Hospital NHS Trust	
Inspector – Public Protection Unit	Cheshire Police	
Superintendent – Strategic Public Protection Unit	Cheshire Police	
Safeguarding Manager	Cheshire East Council	
Social Worker	Warrington Council	
Senior Midwife	Countess of Chester Hospital NHS Trust	Left the panel January 2014
Senior Midwife	Countess of Chester Hospital NHS Trust	
Designated Safeguarding Nurse	Warrington and Halton Hospitals NHSTrust	Left the panel October 2013
Designated Safeguarding Nurse	Warrington CCG	
Lay Member	Warrington	
Consultant Paediatrician	Warrington and Halton Hospitals NHS Trust	
Board Manager	Halton Safeguarding Children Board	
Head of Midwifery	Bridgewater Community Healthcare NHS Trust	
Consultant Community Paediatrician (Designated Doctor)	Countess of Chester Hospital NHS Trust	

Background to the Child Death Overview Processes

Since 1st April 2008 Local Safeguarding Children Boards (LSCBs) have held a statutory responsibility to review deaths of all children normally resident in their area. The criteria for a death to be reviewed is, any instance whereby a death certificate is issued for a person aged 0 - 18 years, with the exception of babies who are stillborn and planned terminations of pregnancy. In order to carry out this function the LSCB is required to appoint a committee known as the Child Death Overview Panel (CDOP). The CDOP is then required to report to the LSCB chair, in order that any findings can be used to inform planning on how best to safeguard and promote the wellbeing of children within the local area.

The CDOP committee carries out two inter-related processes, the 'rapid response' and the overview panel. Firstly, if the death of a child has been 'unexpected' a rapid response is completed. This involves a group of professionals meeting to determine the reasons that the child died, address the needs of any other children living in the household, and the needs of all family members and to address any public health issues that arise during the review. This rapid response is usually co-ordinated between the Police, a lead Paediatric Consultant (or other trained healthcare professional) and the LSCB senior team to ensure the necessary professionals are included and any information gathering can take place quickly following the death.

Secondly, the child death overview panel meet regularly to review all child deaths in the local authority area including those reviewed at rapid response. The panel has a fixed core membership and will include additional professional groups as necessary for the cases to be reviewed. The child death overview panel does not review child deaths until all investigations and criminal justice and inquest proceedings have been completed. Therefore, for unexpected child deaths, there may be a significant delay between the rapid response and the death being reviewed by the overview panel.

The purpose of the CDOP process is to gain insight into how and why children in the local area die, with the intention of protecting other children and helping to prevent future child deaths. This involves accurately establishing the cause of death, any emerging patterns of death and identifying any modifiable factors which may have contributed to a child's death. As part of this process the CDOP is required to decide if a child's death was precipitated by any modifiable factors. If modifiable factors are found, then a thorough consideration and action plan detailing how such deaths may be avoided in the future will be carried out by the CDOP. It is also a statutory requirement of the CDOP to collect local data for the Department for Education in order that regional and national data can be compiled.

Key data, April 2013 – March 2014

The child population estimates in each of the four LSCB areas is detailed in the following table.

LSCB area	Child population size* (0-17 years)
Cheshire East	74,998
Cheshire West & Chester	66,052
Halton	28,105
Warrington	44,103
Total	**213,258**

* Source: ONS Mid Year Population Estimates, 2012

The Pan Cheshire CDOP met on five occasions between April 2013 and March 2014.

The total number of child deaths notified across the Pan Cheshire footprint between April 2013 and March 2014 was 58.

The total number of child deaths reviewed by the panel between April 2013 and March 2014 was 35.

At the commencement of the new Pan Cheshire panel, there were a large number of cases (31 deaths) which were 'outstanding' from the four predecessor panels and passed through to the new Pan Cheshire panel for review.

During 2013/14 the panel considered a large number of these 'outstanding' cases (23 deaths). As of April 2014 there were still eight deaths from 2012/13 that had not yet been reviewed by the CDOP (of these three are ready for the panel and five are waiting for inquests to be completed).

There are, as of April 2014, 46 child deaths which were notified between April 2013 to March 2014 which are still to be reviewed (of these 10 are ready for the panel, 17 will require a themed panel and 27 are waiting for an inquest to be completed).

For any deaths where the review processes are not completed, even if the death occurred in 2013/14, these deaths are not included in any of the following analysis, except when considering number of deaths in each LSCB area, as they have enabled a crude death

rate to be calculated which can be compared with the death rates for England.

From the cumulative data the greatest proportion of deaths occurred during the neonatal period (0-27 days). The neonatal period accounts for 37% of all the child deaths reviewed, and 63% of all deaths occurred before the child reached one year of age. More than 77% of child deaths occurred before the child reached their fifth birthday.

Deaths by gender, April 2013 - March 2014

There is a higher mortality rate amongst male children, this reflects the data nationally. From April 2013 – March 2014 of the 35 child deaths reviewed by the CDOP, 13 were female and 22 were male.

Ethnicity of child for all deaths, April 2013 – March 2014

From the national 2011Census data in England and Wales 19.5% of the population were not from the White English/Welsh/Scottish/ Northern Irish/British ethnic group.

The North West data shows that 12.9% of the population were not from the White English/Welsh/Scottish/ Northern Irish/British ethnic group.

Across the four LSCB areas 33 child deaths reviewed (94%) were in the White English/Scottish/Welsh/NorthernIrish/ British ethnic group, <5 deaths (6%) occurring in any other ethnic group

Deaths reviewed by CDOP with modifiable factors, April 2013 - March 2014

A key purpose of the CDOP review process is to identify any modifiable factors contributing to the death. Modifiable factors are defined as one or more factors, which may have contributed to the death of the child and which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths (DfE 2013).

For the period April 2013 – March 2014 of those cases reviewed, there were 11 child deaths (31%) with modifiable factors. This is higher than the average for England which is around 23%.

82% of child deaths where modifiable factors were identified were in children under the age of five years.

Category of death, April 2013 - March 2014

The most common category of death was a perinatal/neonatal event (37%). The second most common category was death due to an acute medical or surgical condition (17%),

followed by deaths categorised as due to a chronic medical condition or congential, genetic or chromosomal abnormalities. These four categories of death account for 77% of all child deaths.

36% of the deaths reviewed which had modifiable factors identified were perinatal/neonatal deaths. 31% of all deaths within this category were found to have modifiable factors.

One quarter of all deaths with modifiable factors were related to infection. 40% of all deaths categorised as infection were found to have modifiable factors; this is higher than the average across England which is currently 26%. However the numbers are small and therefore small fluctuations in numbers produces a large percentage change.

All deaths in the categories 'sudden, unexpected and unexplained deaths' and 'trauma and other external factors' were found to have modifiable factors.

Event that led to cause of death, April 2013 - March 2014

Over the period April 2013 to March 2014 neonatal deaths were the most common cause of death reported by CDOP, this accounted for 37% (n=13) of all deaths . The next most common causes of death were 'known life limiting condition' and sudden unexpected death in infancy' (each n=10) which presented each in 29% of all child deaths.

The most common cause of death with modifiable factors was sudden unexpected death in infancy.

Expected and unexpected deaths reviewed by CDOP, April 2013 - March 2014

An expected death refers to a death that could reasonably been foreseen by clinicians for a period of at least 24 hours before it occurred. An unexpected death is then defined as the death of an infant or child which was not anticipated as a significant possiblity 24 hours before the death or, where there was was an unexpected collapse or incident precipitating the events that led to that death.

Between April 2013 and March 2014 there were 26 deaths (74%) where the death was classified as 'unexpected'. Of the 11 deaths which were identified as having modifiable factors nine were unexpected deaths (82%).

Child protection, April 2013 - March 2014

There were no child deaths over the period April 2013 - March 2014 reviewed by CDOP in which a Child Protection Plan was in place at the time of the childs death.

Statutory orders, April 2013 - March 2014

There were no deaths reviewed by CDOP in which a Statutory Order had been in place at the time of the childs' death. Statutory Order, refers to section 31 of the Children Act 1989, (care orders).

Place of death, April 2013 – March 2014

During the period April 2013 – March 2014 the most common place of child death was within an acute hospital setting (83%) with the greatest number within a Neonatal Unit (31%). Five children (14%) died within their home of normal residence.

National annual statistical data

The LSCBs are required to collect a considerable amount of data following the death of every child and then submit an annual return to the Department for Education. The CDOP Co-ordinator is responsible for this function on behalf of each of the four LSCBs. The Department for Education, in turn, consolidates the returns and publishes a statistical release in July. This document is circulated to the members of CDOP as the national data "paints a picture" and can act as a "health check" as to how the CDOP is performing and compares to national data. The data is at a national level and in some parts at a regional level but it is not possible to compare individual LSCBs. The data can be found on the Department for Education website and is referenced in this document.

CDOP Recommendations and learning points, April 2013 - March 2014

Learning points identified following multiagency review of child deaths at the CDOP, including lessons identified at any internal reviews of the child death by individual agencies, were disseminated nationally where relevant, via the CDOP co-ordinators national network, to facilitate learning and improved quality of care.

The following summarises key themes from the recommendations, learning and action points gathered from CDOP meeting minutes. These themes are related to factors associated with all child deaths discussed.

Safe sleeping

One of the key areas that the CDOP identified from their considerations during the year was the number of deaths where unsafe sleeping positions or "co-sleeping" had been a modifiable factor. As a result of their considerations, the panel commenced a subgroup to review safe sleep (relating to deaths where co-sleeping or safe sleeping was raised as an issue). This group has joined with the Merseyside CDOP and are planning to run a joint campaign on safe sleep across the Cheshire and Merseyside footprint – to ensure

consistency of messages and to reduce duplication and costs.

Disengagement by families from services

The CDOP identified that there had been a number of cases where families had "disengaged" from health, social care or other related support services. The CDOP wrote to the Chairs of the LSCBs to highlight this issue and also to key agencies to request that they ensure a suitable pathway was in place to follow up with families who "did not attend" scheduled appointments to ensure they had not actively disengaged from services.

Suicide

The Panel identified that whilst numbers of deaths through suicides notified in the year it met were low, there was, what appeared to be an increased number within the Cheshire East LSCB area. Cheshire East Council advised the panel that it planned to undertake an in depth review of suicides in children over the past few years and would report back on the findings to the panel in due course.

Child death rapid response

The CDOP has identified that a "true rapid response process" is not undertaken for unexpected deaths across the Pan Cheshire footprint whereby a suitably trained health professional undertake a visit to the home where a child death occurred, alongside the police. A letter was sent to the six CCGs covering the four LSCBs advising them that this was identified within the guidance. Warrington CCG have agreed to take a lead with a view to commissioning and implementing a true rapid response process across the four LSCB areas. The panel will continue to monitor this to ensure this is undertaken.

Identifying deaths in hospital for children aged 16-18 years

When a child reaches the age of 16, in a healthcare setting they are treated as an adult and not placed on a children's ward or under the care of a paediatrician. As such if a child dies between the ages of 16 and 18 they are treated as an adult. It is possible therefore that some child deaths may not be notified to the CDOP Co-ordinator and therefore a review into the death of that child may not take place. Following a presentation by a Paediatric Consultant from a neighbouring area who had tackled this issue successfully in their own area, the CDOP contacted all the Acute Trusts to request that a similar notification system was put in place.

Smoking in pregnancy

The CDOP identified that there were a number of cases where the mother had smoked during pregnancy, smoking in pregnancy can lead to a range of health issues for newborns as well as premature births and underweight babies. The panel wrote to acute

trusts and Directors of Public Health requesting that reducing smoking in pregnancy remains a key priority through smoking cessation services and through specially trained midwives who work with mums to reduce the numbers smoking in pregnancy.

Medical advances - resuscitation

The Consultant Paediatricians cascaded to acute trusts the findings from a case of a failed newborn resuscitation that could potentially have been avoided through the use of a 'Meconium aspirator device' attached to the endotracheal tube, to enable suction of the airways during resuscitation. This led to enquiries from other hospitals in the country so they can procure the kit and incorporate into their practise.

Learning from child deaths – sharing widely to prevent future deaths

The CDOP wrote to one Acute Trust following a child death where a Root Cause Analysis (RCA), (an RCA is a systematic method for reviewing adverse incidents, ie a problem solving methodology for discovering the real, or root cause(s) of problems or difficulties) had been undertaken in the trust to request that the learning points from the RCA be shared across the Pan Cheshire footprint.

Administrative/support processes

Perinatal mortality and summary information - The CDOP wrote to each Acute Medical Director in NHS hospital trusts where Cheshire children may be admitted and subsequently die, to request that minutes from Perinatal Mortality meetings were submitted to the CDOP Co-ordinator so that any learning from these meetings can be reviewed as part of the panel considerations.

The panel also requested that the Acute Trusts send to the CDOP Co-ordinator, the 'Summary Letter' that is sent to GPs from the Paediatricians to aid the panel considerations.

Letters to families - The CDOP introduced a process whereby a letter is sent to the parents or guardians of a child following their death. The letter, sent some three to four weeks after the death, advises them of the child death overview process and also invites them to meet the Chair of the panel if they feel they have anything they wish to disclose to the panel to support the core aim of the panel in preventing future deaths. During 2013/14 only one family took up this offer.

Timely notification - The CDOP identified that some notifications were not made in a timely way - in particular those which had involved road traffic incidents where a child died. The Cheshire Police who are a member of the panel have liaised with relevant colleagues to ensure that notification is undertaken in a timely way. This is being monitored.

Missing data – a number of older forms have incomplete data on them – particularly in relation to the wider family and the father of the child. Key members of CDOP are working with partner and provider organisations to support them to understand the importance of having robust information to support the panel considerations and to improve the information that is supplied to the panel on the forms.

Ambulance Trust – CDOP identified that the Ambulance Trust were not following the established processes and protocols for child deaths. The panel wrote to the Ambulance Trust to ensure that they were aware of the protocols so that these could be followed.

Future work for the CDOP

CDOP Priority Action Plan

Priority	Action	Lead	Timescales	Outcome
Safe Sleep	1) Create a set of Pan Cheshire Integrated Working Guidelines	Janice Bleasdale	Dec 2014	Reduce the number of deaths where unsafe sleeping has been identified as a risk factor.
	2) Benchmarking advice to identify current practice of training for professionals and current practise for parental education.	Janice Bleasdale	Jan 2015	
	3) Implementation of guidelines by all LSCB Board members to be cascaded	All Board Members	Feb 2015	
	4) Dissemination of information and training	Board Sub-Groups and individual agencies	Oct 2015	
	5) Repeat exercise in 2) after Action Plan completed	Janice Bleasdale	Dec 2015	
Teenage Suicide	1) All LSCB's to have shared the learning from Cheshire Easts Thematic Review	Boards	12 months from publication	1) Improve the management of risk teenage suicide. 2) To ensure that all relevant

				practitioner and commissioners are aware of the learning and individual agencies implement relevant learning into their organisation.
Bereavement Services	1) CDOP to be assured of the provision of bereavement counselling from LSCB representatives 2) CDOP Task and Finish Group to be set up to work on Website and other avenues of dissemination of information	Boards CDOP	Dec 2014 Within the next 12 months	To improve the response to bereaved parents and siblings

During 2014/15 the panel will continue where feasible to review cases using a thematic process – themes planned for 2014/15 include – cardiac cases where a Consultant specialising in Paediatric Cardiology from Alder Hey will be invited to attend the panel as a subject expert to support the panel in their considerations. A further CDOP will focus on neonatal deaths.

However it must be borne in mind that reviews should not be overly delayed due to lack of sufficient number of deaths of similar nature.

The Panel are proposing to hold a half day professional development day for relevant health and social care professionals and academics who may work in areas where they respond or deal with child deaths.

The Pan Cheshire CDOP will continue to explore the potential of closer working with the Merseyside CDOP.

The CDOP will also during 2014/15 give consideration to the frequency of the meetings in order to assist progress in presenting cases to the CDOP in a timely fashion. The panel currently meet on a quarterly basis and for a whole day.

The panel through the CDOP Co-ordinator are looking to produce a set of Pan Cheshire CDOP webpages that can be embedded within each LSCB website.

References

(Accessed July 2014)

Department for Education (2013) Working together to safeguard children – A guide to inter-agency working to safeguard and promote the welfare of children http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children

Department for Education (2014) Statistical Release: Child Death reviews Year Ending March 2014 https://www.gov.uk/government/statistics/child-death-reviews-year-ending-march-2014