West Sussex Safeguarding Children Board

Issue 4
Spring 2015

Newsletter

Welcome to the fourth edition of the West Sussex Safeguarding Children Board (WSSCB) Newsletter.

The aim of this newsletter is to provide information about safeguarding for people working with children and young people and their families in West Sussex.

The WSSCB is a multi-agency group of different organisations and agencies that work across West Sussex together as partners to ensure a united approach to looking out for the wellbeing of children in this county.

Contents

WSSCB Principle and Values

Following the WSSCB Development Day, the Board has refreshed the Principles and Values that underpin the WSSCB Vision.

OUR VISION IS TO KEEP CHILDREN AND YOUNG PEOPLE IN WEST SUSSEX SAFE BY:

- Coordinating our local safeguarding activity
- Being a driving force to improve local practice
- Ensuring that all agencies fulfil their safeguarding responsibilities effectively

OUR 'WORKING TOGETHER' AS A BOARD IN UNDERPINNED BY SIX NON-NEGOTIATBLE PRINCIPLES AND VALUES

- Honesty and respectful challenge of one another
- Active participation by everyone
- Always asking 'so what' is the impact?
- Being guided by the 'voice of the child' and our practitioners
- Sharing the responsibility and risk
- Holding one another to account for delivering

Latest News

UPDATED Working Together To Safeguard Children 2015

Working Together To Safeguard Children is statutory guidance which covers the legislative requirements and expectations on individual services to safeguard and promote the welfare of children, and provides a clear framework for LSCB's to monitor the effectiveness of local services.

The revisions include changes to:

- The referral of allegations of those who work with children
- Notifiable incidents involving the care of the child
- The definition of serious harm for the purposes of serious case reviews

A version of the guidance for young people and a separate version suitable for young children has also been made available.

To view the revised guidance and a summary of the changes visit the WSSCB website.

WSSCB Training

The WSSCB has recently undertaken a review of local multi agency safeguarding training provision and as a result some changes are being made to the core training core offer. For more information go to page 4.

Referral to WSSCB of a serious incident for consideration by the Case Review sub-group

The WSSCB Case Review sub-group has agreed a new process that will be used for professionals to make a referral of a serious incident to the sub-group through safeguarding leads in agencies and organisations. The reason for the referral form is to established a standard referral process across agencies and organisations to ensure that professionals working in operational, supervisory and support roles are aware of the process and able to access a standard way of bringing suitable cases to the attention of the WSSCB Case Review sub-group through their children's safeguarding leads. The referral form can be accessed via the WSSCB website.

Latest News

ChildLine Fight Against Porn Zombies (FAPZ) Campaign

ChildLine, part of the NSPCC, are running an awareness campaign aimed at young people aged 13-16 years, which highlights that online porn does not reflect real life and to build young people's resilience towards online porn. The FAPZ Campaign has been developed in consultation with young people and uses language and terminology to which they can relate. For more information about the campaign visit www.nspcc.org.uk news page. The NSPCC are also offering advice on how parents can talk to their child about the risks of online porn and sexually explicit material at www.nspcc.org.uk online porn page.

Keeping Children Safe in Education: statutory guidance for schools and colleges.

The Department of Education has published new guidance for schools and colleges on safeguarding and promoting the welfare of children, and on safer recruitment. This guidance replaces the 2014 guidance and can be viewed on the Department of Education website www.gov.uk

Information sharing guidance

The Department of Education has published advice for safeguarding professionals on information sharing. The advice helps practitioners and their managers decide when and how to share personal information legally and professionally. This advice replaces the 2008 guidance and can be viewed on the Department of Education website www.gov.uk

Advice for professionals on identifying and responding to child abuse

The Department of Education has published new advice for professionals on identifying and responding to child abuse; 'What to do if you're worried a child is being abused'. It explains the signs of abuse and neglect to look out for, and the action to take if you think a child is being abused or neglected. This guidance replaces the 2006 guidance and can be viewed on the Department of Education website www.gov.uk

WSSCB Training

The WSSCB has recently undertaken a review of local multi agency safeguarding training provision and as a result some changes are being made to the core training core offer.

The existing Module 1 & Module 2 training days are being replaced by a one day training module called **Working Together To Safeguard Children** from April 2015; this course is especially relevant for all professionals working with children and families, and particularly those with a designated safeguarding role. This course is now available for booking via the WSSCB training calendar.

Additional courses covering subjects such as SEND, Child Sexual Exploitation, E-Safety, Alcohol and Substance Misuse, Child Abuse, Mental Health and Neglect will be externally commissioned within the next financial year.

Other courses delivered by social care colleagues such as Signs of Safety, Child Protection Conference and Core Group Working, Understanding Thresholds, Safer Recruitment and Allegations Management will be uploaded to the WSSCB website once it is confirmed that they have been made available on the West Sussex Learning and Development Gateway.

E-learning courses are still available for Safeguarding Children, Child Sexual Exploitation, Domestic Abuse, FGM, Child Trafficking and Safer Recruitment via the WSSCB E-learning page.

For training for Designated Safeguarding Leads in schools or colleges please contact Joanne Steer via joanne.steer@westsussex.gov.uk or 0330 222 8223.

For information regarding allocation of places, courses fees, cancellation charges, non-attendance on the day and course evaluations visit the WSSCB training page.

If you have any queries regarding course availability or booking onto a course please contact the West Sussex Learning and Development Gateway via learninganddevelopment@westsussex.gov.uk or 01243 756 834.

*Although training is free, a non-attendance/late notice cancellation charge applies.

Multi-Agency Audits

Young People Who Self Harm—November 2014

Agencies that participated in this audit: Sussex Police (CPT); LAC Nurses; CSC –Intensive Family Support Team x 2; CAMHS; Lioncare School, North Hill House School, GPs, West Sussex Hospital Foundation Trust, Young Persons Service; Cardinal Newman School; Sussex Community Trust (School Nurses).

The questions that were asked in this audit were based around the Pan Sussex Procedures 8.29 Self-Harm and Suicidal Behaviour which outlines how different agencies should respond when a child presents behaviours related to: self-harm, self-mutilation, eating disorders, suicide threats and other gestures. The questions also focused on one of the positive triggers for change identified by young people who self-harm and the charities that support them, which is to have someone who will listen to them and understand their own unique situation.

Some Issues raised by audit:

- Record keeping and maintaining a detailed set of key documents and chronology of events on FWi was an issue in most cases .
- Ensuring that self-harming behaviours are appropriately addressed within care plans and strategy discussions, even if they are seen as a low risk factor at the time a plan should be in place in case the behaviour escalates in future. Self-harming behaviour is often one of a number of factors related to the on-going safety and stability of a child and it can be overlooked in favour by other factors when it comes to holding strategy discussions, assessing risks and planning care pathways.
- The phrase 'self-harm' is used to describe a wide range of behaviours. When recording "self-harm" within documents and case notes the specific type of self-harm is not mentioned in many cases. As there is a broad range of self-harming behaviours it would be helpful to know the specifics for each case (e.g. cutting, drugs, alcohol, eating disorders, burning etc)

Good practice identified during this audit included:

- This is a complex and challenging case that has involved input from many agencies and has benefited from good communication throughout. In particular a great deal of care and sensitivity has been evident in the way that the care plan for this young person has been finely balanced to ensure that placements have not been too restricting whilst ensuring that the young person is kept safe at all times and levels of anxiety are kept to a minimum where possible.
- This is another challenging case that has been well managed with appropriate and timely referrals being made between agencies (CSC / CAMHS/School/Police) in West Sussex and across borders with Brighton and Hove. More recently this young person has been reduced from high to low risk and a full package of support is being provided.

Article Written by: Maggie Pugh (WSSCB Quality Assurance Officer) March 2015

Multi-Agency Audits

Neglect of Disabled Children—January 2015

Agencies that participated in this audit: Children's Social Care; Child Disability Team (CSC); Sussex Police; Schools (Palatine School, Jigsaw School, Herons Dale School); LAC Nurses; Sussex Community Trust (School Nurses); GPs, Continence Advisory Service and East Surrey Hospital.

This MAFAG was designed to investigate our multi-agency approach to identifying and protecting disabled children who are at risk of neglect within West Sussex and to revisit the use of the Neglect Identification and Measurement Tool (NIMT) & Graded Care Profile (GCP) that was originally audited in November 2012. The main **recommendation** resulting from this audit was that:

The NIMT and GCP are generic tools that do not take additional factors related to Disabled Children into consideration and as a result the NIMT and GCP are not currently being used. As a result the Neglect Steering Group are now reviewing and adapting these tools so that can be used effectively to identify the neglect of disabled children.

Good practice identified during this audit included:

- The group were impressed with the work of the Child Community Nurses in a number of cases
- Members of LAC teams usually have a Health Visitor background. What was notable in one case was that the appointed member of the LAC team had a background in working with children with Learning Disabilities which enabled her to give more specialist support and care in this. It was recognised by the group that having a wider range of skills and experiences within the LAC team does help the team to deliver a higher quality, specialist service.
- Tenacity of the Continence Team to make sure the child was seen and provided with the support it needed when faced with parental obstruction.
- Good Multi agency engagement and working throughout most cases

Article Written by: Maggie Pugh (WSSCB Quality Assurance Officer) March 2015

Child Protection Audits

These audits are carried out every 2 months and review practices and records that are kept at the key stages of the Child Protection process; Referral, Strategy Discussion, S47 enquiries, Initial Child Protection Conference and RCPC. 30 audits were completed in December / January and of these 11 were considered GOOD, 15 ADEQUATE and 4 cases graded as INADEQUATE .

The main reasons for cases being graded as INADEQUATE were:

- Lack of risk assessment in relation to all the children in the household and lack of clarity as to actions and management sign off (Referral only audit)

- Information missing concerning the children's personal details as well as outline information regarding previous exposure to domestic violence and inappropriate care from an uncle. More detail is needed. (Referral only audit)

- Poor record keeping: e.g. Core Group Minutes not available for the alleged 3 core groups held. Records appear very confused. No CPP available for the timescale being audited. Notes made on Fwi were comprehensive but clearly not distributed to members of Core Group (Core Group, CPP Plan and RCPC audit)

- Some significant co9ncerns such as: core groups poorly attended; CPP not discussed at core groups; no further actions from core groups; no contingency plan; SW report doesn't include observations of attachment; SW report doesn't include all the CPP objectives (Core Group, CPP Plan and RCPC audit)

Another aspect of the Child Protection process that is being monitored closely by the LSCB is the involvement of key agencies in Strategy Discussions and in particular the involvement of representatives from Health and Education. The lack of involvement of these agencies remained an issue in the December audit, but it is hoped that a briefing session that was delivered to staff in December will start to influence a positive improvement in this area in February's audit.

Child Death Overview Panel

Safe Sleeping

Safe Sleeping remains one of the top two modifiable factors identified in child deaths here in West Sussex (the other being Smoking by the Mother during Pregnancy) and there has been a great deal of work undertaken this year to raise awareness of how to reduce the risk of Sudden Infant Death Syndrome (SIDS). 16th-23rd March was "Safer Sleep Week" a national campaign to raise awareness of SIDS that was put together by the charity The Lullaby Trust.

In preparation for Safer Sleep Week our Specialist Nurse Safeguarding Children, Annette Lawrence-Owen, delivered training to 100 members of staff and further training has been planned. There was also a press release issued and safer sleep posters distributed to all children and family centres, GP's and libraries. WSCC has also provided £1,000 funding for room thermometers and cot cards to be used in hospitals. To hear Jenny Ward the Director of Services at The Lullaby Trust talking on Spirit FM about SIDS here in West Sussex, click here and then scroll to the bottom of the page.

Article Written by: Maggie Pugh (WSSCB CDOP Officer) March 2015

NSPPC ChildLine Schools Service

According to our research, on average two children in every primary school classroom have experienced some form of abuse or neglect. But, either through fear or a lack of information, most children don't seek help or tell anyone what's happening until they're much older. We know this because the majority of children who contact our ChildLine helpline for advice or support are over 11 years of age and they report that the abuse started many months or even years before this.

Imagine if you could reach these children when they are much younger, potentially even before the abuse has started. Imagine that you could give these children the knowledge to understand that what they're experiencing is abuse, and the courage to speak out and get help.

This is why we began the NSPCC Schools Service – to empower children at a much earlier age to understand that they have the right to be happy and safe, and to teach them that help is out there if they ask for it.

The NSPCC Schools Service is a **free** service, delivered by fully trained volunteers. Through an assembly and interactive workshop, they educate 9 – 11 year olds about the different forms of abuse, such as bullying and neglect, and teach them who to go to for help. They learn about 'trusted adults' that you can ask for help; such as a parent, carer or teacher. And they also learn how to contact ChildLine – either over the phone or online. The sessions are tailored to the age of the children of the children in the group and topics are covered in a way that is easy to understand, without being graphic.

We started delivering the service to schools in West Sussex in October 2012 and since then our team of 30 volunteers has carried out almost 100 school visits and spoken to more than 6,500. That's 6,500 children in West Sussex who now know how to keep themselves safe, and who to ask for help should they ever need it. And that's 6,500 children whose parents now know how easy it is to have a conversation with them about abuse.

The service has so many benefits for schools – it creates a safe space for children to discuss their understanding of what can be complex, difficult and very sensitive issues. It also safeguards them by encouraging them to identify extended sources of support should they need it now or in the future.

It links in with the PSHE and Citizenship curriculum and it helps create a strong safeguarding culture within the school. It's also a great way of providing evidence against the OFSTED Inspection Framework 2012 including the recent updates.

We want to take the NSPCC Schools Service into every primary school across West Sussex. It couldn't be easier and it's completely free. To find out more or to book your visit, contact me at amanda.rocca@nspcc.org.uk or visit visit http://www.nspcc.org.uk/fighting-for-childhood/our-services/services-for-children-and-families/childline-school-service/contact-childline-schools-service/

Article Written by: Amanda Rocca (ChildLine Schools Service Area Coordinator for West Sussex) March 2015

Multi-Agency Public Protection Arrangements (MAPPA)

MAPPA are a set of arrangements to manage the risk posed by the most serious sexual and violent offenders (MAPPA-eligible offenders) under the provisions of sections 325 and 327B of the Criminal Justice Act 2003.

They bring together the Police, Probation, and Prison Services in each of the 42 Areas in England and Wales into what is known as the MAPPA Responsible Authority. MAPPA–eligible offenders are identified and information about them is shared by the agencies in order to inform the risk assessments and risk management plans of those managing and supervising them.

The Secure & Forensic Services within Sussex Partnership NHS Foundation trust and the Surrey & Sussex Probation Trust (now the National probation Service) have secured funding to work in partnership to deliver a new and innovative approach to working with high risk, high harm personality disordered offenders. This is modelled on pilot Pathway Projects that support the work of probation to ensure that their management of offenders with Personality Disorder (PD) is psychologically informed. Psychologists have joined the Offender Manager Delivery Unit in West Sussex to provide training, case consultation and formulation skills to support pathway management for this challenging group of offenders.

Following a successful pilot of polygraph testing for sexual offenders in East and West Midlands Probation Regions over the period 2009-2012, Ministers stated that they intended to makl polygraph testing available for inclusion in certain sexual offenders' licences. A Statutory Instrument to allow testing in England and Wales was passed in July 2013 and came into force in 2014.

Going forward, a local MAPPA protocol will be developed to set out a clear process on how offenders convicted of Counter-Terrorist and Domestic Extremism offences will be managed under MAPPA. A staff commendation reward scheme will also be developed to reward those staff who have demonstrated great achievements through multi-agency collaboration across MAPPA agency teams.

For more information or to read Sussex MAPPA Annual Report (2013-2014) visit the Surrey and Sussex MAPPA website www.surreyandsussexmappa.com

Article taken from Sussex MAPPA Annual Report (2013-2014) written by James Bourke (HMP Lewes Governor Kent & Sussex Prisons), Giles York (Chief Constable Sussex Police), and Andrea Saunders (Assistant Director National Probation Service, Sussex).

Changes to Children Home Regulations 2015

In April 2015 revised Children's Homes Regulations and associated Guidance came into force. The revision to the Regulations is significant, which are now also described as Quality Standards, of which there are 9. Full versions of the regulations can be found at http://www.legislation.gov.uk/uksi/2015/541/pdfs/uksi_20150541_en.pdf and Guidance can be found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/410021/Guide_to_the_Children_s_Homes_Regulations_including_the_quality_standards.pdf

Whilst much of the new framework and guidance remains very similar to previous Regulation and Guidance, there is a marked change in emphasis, even evident in the language and titles of the Standards as described above. There are some key areas to note:

• A home's Statement of Purpose will be even more of a key document, and will be scrutinised to ensure that services offered are in line with what is described within the document.

• Business and staffing plans for homes are required to be much more 'active' – regularly reviewed and updated throughout the year as services change and develop

• The home's role in the wider care planning process for a child or young person has been strengthened, with emphasis on the introduction process, during their placement and transition process to new placements/provision. There is enhanced responsibility upon homes to ensure that concerns are raised and plans reviewed if young people present high levels of risk in placements.

• There is even greater emphasis on the child's voice being heard – both in terms of individual planning and service review/development.

• The requirements are qualifications for staff have been tightened – all staff now have to complete the relevant award with 2 years of starting their employment, rather than the previous requirement of commencing the qualification within 6 months.

• There are also some changes to Regulation numbers and requirements around monitoring and notifications:

• There is also now a requirement to send an annual summary of complaints and actions taken in response to them.

In response to the new Regulations, Ofsted have updated both their framework for inspection of children's homes https://www.gov.uk/government/publications/inspecting-childrens-homes-framework and their guidance for inspectors https://www.gov.uk/government/publications/inspecting-childrens-homes-guidance-for-inspectors

Article Written by: Phil Allen (Residential Service Manager, Children's Operations, Child Disability, WSCC) April 2015

National Serious Case Reviews

Summary of March 2015

For a list of all National Serious Case Reviews published in 2015 visit the National Serious Case Review page on the WSSCB website.

South East Wales Safeguarding Children Board

Chelsey and Mary

This review concerns the death of a 17-year-old girl and her 6-month-old daughter in a house fire started by the baby's father.

Issues identified include:

- Not recognising the father's predatory, controlling and abuse behaviour as sexual exploitation and domestic abuse

Recommendations include:

- Emphasising to agencies that child protection procedures must be followed in relation to all children, regardless of age, until they reach 18

Oxfordshire Safeguarding Children Board

From the experience of children A, B, C, D, E and F

This review concerns sexual exploitation of children in Oxfordshire from the experience of children A, B, C, D, E and F.

Issues identified include:

- Professionals lack of understanding of government guidance on the exploitation of children
- Insufficient investigation into what was happening and a tendency to see the victims as 'difficult girls make bad choices'

Recommendations include:

- OSCB to ensure that messages from the victims and their families given to the review are embedded in training

Leeds Safeguarding Children Board

Child V

This review concerns the death of a 17-year-old boy, as a result of hanging. He was found with a ligature around his neck in a cell in a Young Offender Institute; Coroner's inquest concluded accidental death.

Issues identified include:

- Focus of interventions on symptoms rather that causes of Child V's difficulties
- Failure to agree a multi-agency response that included contingency planning for repeated crises
- Failure to address frequent requests for contact with family members

Recommendations include:

- Corporate parenting responsibilities for promoting education, training and employment
- Provision of suitable accommodation for young people with high support needs

Kirklees Safeguarding Children Board

Subject Child

This review concerns the death of a 1-year-9-month-old child as the result of severe brain damage. Police were unable to establish how the subject child sustained the fatal head injuries however medical evidence indicated that they were inflicted non-accidentally.

Issues identified include:

- Maternal history of depression
- Concerns raised by father and paternal grandparents relating to an unexplained burn to subject child's hand and a bruise

Learning includes:

- A focus on parental behaviour sometimes diverting professional attention away from the child
- GPs treating episodes of maternal depression in isolation with insufficient attention to broader issues of family life, parenting capacity and wellbeing
- Need for professionals to remain alert to safeguarding issues and think critically and reflectively whilst performing routine professional activities

Oldham Safeguarding Children Board

Child D

This review concerns the death of a 7-week-old English/Polish child in January 2014, as the result of a severe head injury and multiple other injuries.

Findings include:

- Insufficient professional curiosity given the concealment or denial of mother's pregnancy
- The use of two different formats for inputting dates of birth onto an electronic systems contributing to an error that prevented sufficient sharing of information

Recommendations include:

- The use of genograms by community–based practitioners as a tool to gather information and to prompt practitioners to be inquisitive
- Simplification and consistency in data inputting formats and processes

Harrow Safeguarding Children Board

Child R

This review concerns the death of young man who died as a result of taking a combination of drugs after he had gone missing from a care placement.

Specific findings on service provision include:

- Shortcomings in health and education services for looked after children
- Mental health and substance misuse services
- Young people leave secure accommodation
- Children missing or absent from care placements
- Quality of local authority intervention services and targeted social work needed

Isle of Wight Safeguarding Children Board

Q Family

This review concerns the long term physical, emotional and sexual abuse and neglect of several children within a family.

Learning includes:

- The need for supervision and use of discretion in excluding hostile parents from child protection conferences

Recommendations include:

- Multi-agency meetings should be convened if any agency has major concerns
- Records should be easily accessible and processes should allow multi-agency discussion of chronic cases without a single trigger event

Haringey Safeguarding Children Board

Child D

This review concerns the serious injury of an 11-week-old baby.

Learning includes:

- Focus on targets led back to critical assessment and professional desensitisation of the environment of violence and criminal activity the baby was growing up in

Blackpool Safeguarding Children Board

Baby Q

This review concerns the serious unexplained head injury of an infant under 4 weeks old.

Learning includes:

- Importance of midwives and health visitors co-planning and coordinating responses and need to routinely and confidentially ask parents about domestic abuse, mental health and substance misuse

Recommendations include:

- Put in place a mechanism to reduce the risk of confusion caused by recording the same case under multiple surnames and ensure there is full consultation with other agencies before a diagnosis is changed from non-accidental injury to medical cause

Key Contacts

West Sussex Safeguarding Children Board Team

Jimmy Doyle

Independent Chair of the WSSCB

Jimmy can be contacted via the WSSCB Project Support Officer

WSSCB Board Manager

This post has been newly appointed to and the new Board Manager, Helen Donelan, will take up post in June.

Jade Kilvington

WSSCB Project Support Officer

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Maggie Pugh

CDOP and QA Officer

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Interim Practice Development Manager

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Children's Access Point

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01403 229 900

Emergency Out of Hours

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0330 222 6664

If your organisation would like to contribute to future issues please contact WSSCB at lscb@westsussex.gov.uk