Windsor and Maidenhead
LOCAL SAFEGUARDING CHILDREN BOARD

Windsor and Maidenhead LSCB
Annual Report
April 2012 – March 2013

Working in partnership with

The Royal Borough Windsor & Maidenhead

THAMES VALLEY POLICE

NHS

NATIONAL PROBATION SERVICE

Cafcass

Foreword

The Safeguarding Children Board has worked with partner agencies to address issues of organisational change at a time of renewed national concern about the safeguarding of children and the greater knowledge about the sexual exploitation of children.

The Serious Case Review from 2011 is still awaiting publication due to delays in the court system, however we have continued to disseminate learning outcomes and good practice throughout the safeguarding consortium and have seen significant changes as a result. We have also learned from serious case reviews in other areas of the country and ensured learning has been distributed in a similar way.

The Board has prioritised activity in relation to Children in Care and in hearing the voices of children in the provision of services to safeguard them.

We experienced changes to our LCSB membership as a result of an NHS and police restructure, and replacements to some of the post-holders in our other partner agencies. We also had a nine-month vacancy period in the Business Manager post, which presented a real challenge to achieving some of our targets for the year. Unfortunately we were unable to host our usual Annual Conference last year, but we have scheduled an autumn conference for October 2013.

Finally, I would like to thank Board members, sub group members and all those involved in safeguarding children in the Borough for their hard work.

Donald McPhail
LSCB Independent Chair

1. The Royal Borough of Windsor and Maidenhead

1.1 The Royal Borough of Windsor & Maidenhead is situated 20 miles to the west of London at the beginning of the M4 corridor. The local government area is a small unitary authority created in 1998 from part of Berkshire County Council. The population is 144,560 with around 22% aged 0-19 (around 35,155 babies, children and young people).

1.2 There are three discrete centres of population – in Maidenhead, Windsor and Ascot with pockets of rural areas. The area is mainly affluent, with population census and other information sources showing that:

- 56.2% of RBWM residents are in managerial or professional roles (against a national average of 41.2%)[1].
- At an average of £342,742 (*August 2013*), house prices are the highest in the country outside of London[2].
- In spring 2013, 1,717 children were eligible for free school meals, which is relatively low, however this figure has significantly increased from 1,442 in 2012[3].
- Obesity rates of 7.4% for 4-5 year olds and 14.9% for 10-11 year olds in RBWM are significantly lower than England averages (National Child Measurement Programme[4]).
- Teenage pregnancy rates (last available figure indicated 31 conceptions) are consistently below the national average, and the number of young people not in employment, education or training (NEET), averaging at 4.7%, is also very low.
- 15% of RBWM residents are from minority ethnic groups. The proportion rises to 30% of the children and young people on roll in schools.
- The area has strong links with both the Crown and military service and Windsor contains two barracks with a number of military personnel living locally.

At the end of 2012/13 there were:

- 875 children who were considered in need and receiving support from Safeguarding and Specialist Services;
- 70 children subject to child protection plans;
- 110 children in the care of the Local Authority.

[1] **Office for National Statistics Neighbourhood Statistics**, Occupation, 2011
[2] **Land Registry House Price Index**, Average house price August 2013
[3] January 2013 School Census, RBWM records
[4] **National Child Measurement Programme Data 2011-12**, published Public Health England National Obesity Observatory

2. LSCB Membership and Attendance in 2012-2013

AGENCY	% ATTENDANCE	NOTES
LSCB Independent Chair	100	
RBWM LSCB Business Manager	100	Vacant Post June 12 to Feb 13
RBWM Safeguarding and Specialist Services (Children's Social Care)	86	
RBWM Lead Councillor for Children's Services	15	
RBWM Director of Children's Services	85	
RBWM Drug & Alcohol Team	40	
RBWM Youth Offending Services	57	
RBWM Head of Education and Schools (Children's Services)	85	
Chair – Prevention Sub Group	50	
Chair – Monitoring & Evaluation Subgroup	100	
Chair – Training Subgroup	30	
BHCT/Adult Services	42	
PCT/Designated Nurse	72	
Designated Doctor	66	
CAMHS	85	
Berkshire East Community Health Services	70	
NHS South Central SHA	15	
Lay Members	70 & 50	
Voluntary Sector Representative (Family Friends)	100	
Secondary School Head	50	
Primary School Head	50	
FE College Head / Safeguarding Lead	33	
CAFCASS	28	
Thames Valley Police	50	
Probation Service	86	

3. The Work of the LSCB

This section describes the work of the LSCB throughout the year of 2012/13 and identifies areas which required identified strengthening.

3.1 Focus on Children in Care

The Board prioritised consideration of the multi-agency support to children and young people in the care of the local authority. This was undertaken by all agencies reporting directly to the Board on their services to Children in Care.

To achieve this, dedicated time was made available at three sequential Board meetings to consider the level of demand for service for each agency, the capacity to meet that demand, the quality of service provided, the ability of agencies to listen to and take account of the voice of the child, to identify the needs of children placed out of Borough, and to identify challenges in the provision of services.

The review addressed issues of missing children and of those at risk of sexual exploitation.

Areas to Strengthen

While it was clear that there was good multi-agency understanding and cooperation in providing services to Children in Care, agencies were asked to address the following areas:

- The timeliness of initial health assessments of children and young placed out of Borough.
- The updating of information to the looked after health service when children move placements.
- Family group conferencing should take place as early as possible to ensure that all options for the child are identified as soon as possible.
- Increasing the number of foster placements available in the borough.
- Increasing the placement options for young people leaving care.
- Improving the monitoring of mental health provision for children placed out of Borough.
- The capacity to provide mental health support to Children and Young People in Care when the threshold for CAMHS services is not reached.

3.2 Ofsted inspection report and CQC inspection report

The outcome of these inspections was reported to the Board and it was agreed that the Business Planning of Board would focus primarily on the issues arising.

3.3 Updating of the Children and Young People Plan

The revised Children and Young People plan which had been reviewed to take account of issues arising from the inspection of children's services was presented to the Board for consultation. The Board supported the amendments to the plan.

3.4 Bullying Strategy

The Board was informed of a survey undertaken in local schools on the child's perception of the experience of bullying. The results indicated that the rates of bullying remained at the same level as in previous years, that cyber bullying was an increasing problem and that 48% of children were not satisfied with the support provided by schools.

Areas to Strengthen

Work is underway with the Young People's group and schools to formulate a support strategy and this will be reported to the Prevention Sub Committee.

3.5 MAPPA Annual Report

The annual report was presented to the Board. It was clarified that there was good multi-agency engagement with the MAPPA process and that the multi-agency engagement help identify safeguarding issues for children.

3.6 MARAC Annual Report

The annual report was presented to the Board and it demonstrates a consistent level in the reporting of domestic abuse situations. It was identified that agencies assess risk differently and use different categorisations.

Areas to Strengthen

The Board asked for the assessment process of agencies to be considered to establish if the understanding and communication of risk could be improved.

3.7 Domestic Homicide Protocol

The protocol on undertaking domestic homicide reviews was presented to the Board. The Board was satisfied that the protocol allowed for the efficient management of situations when there is a need for a domestic homicide review commissioned by the Community Safety Partnership and a serious case review commissioned by the Safeguarding Children Board.

3.8 Missing Children

Thames Valley Police provided an annual update on the effectiveness of the Missing Children Protocol.

Thames Valley Police reported that they were confident that the process was working well in Windsor and Maidenhead, with clear responsibilities for children's social care and community wardens to undertake return interviews to understand the reasons for young people going missing.

There is feed back to the Police from return interviews to ensue that any intelligence that can be gathered will assist a wider understanding of the risks associated with children going missing.

3.9 North Somerset Serious Case Review

The Children's Minister asked that this serious case review should be considered by all Safeguarding Children Boards. The case related to the sexual abuse of primary aged pupils by a teacher over many years, with opportunities to address concerning behaviours being overlooked within the school.

The Board identified the key issues for schools and wrote to them to ask them to assess their preparedness to identify and respond to the key issues, and report back to the Board.

3.10 Section 11 Audit Processes

Section 11 audits are carried out in order to monitor and evaluate compliance of the Local Authority and partner agencies with their specific and general duties in respect of safeguarding as defined in Section 11 of the Children Act 2004. The Windsor and Maidenhead audits were was undertaken in two stages;

Pan Berkshire S11 Panel

The agencies of the Windsor and Maidenhead Board that provide services in the area of more than one safeguarding board have a section 11 process undertaken on a pan Berkshire basis. The outcome of the section 11 audit process relating to those agencies was that they all met or exceeded the standards required.

Action plans were put in placed and are being monitored to further develop services.

Areas to Strengthen

The following areas were common themes of development for a number of statutory partner agencies:

a) ensuring that there is shared responsibility for safeguarding in senior leadership teams i.e. moving from a focus on one lead individual for safeguarding to a corporate responsibility for safeguarding;

b) Ensuring that safer workforce checks and processes are fully embedded in organisations, including making sure that staff and volunteers know when to contact the LADO.

c) Ensuring compliance with Information Sharing agreements, and making sure that frontline staff and volunteers receive training on information exchange (in the context of the pan-Berkshire Information Sharing and Assessment agreements).

d) Ensuring that beyond adherence to minimum standards for safeguarding training, organisations clarify which staff/volunteers should attend targeted or specialist safeguarding (Working Together Groups 3-8) training.

Action plans were put in place and will be monitored and reviewed by the Pan Berkshire Section 11 Group in 2013/14.

Windsor and Maidenhead Section 11 Panel

To complement the section 11 audit undertaken across Berkshire, the Windsor and Maidenhead Safeguarding Children Board undertook a specific section 11 audit process of the local authority services that engage with children and young people. Each service identified as having contact with children and young people was asked to prepare a section 11 audit template and attend a scrutiny meeting with board members, led by the LSCB Chair.

Areas to Strengthen

Development points were identified for each service and all services have been asked to report on progress in addressing these points.

Youth Offending Service

- The youth offending service to present its volunteer policy to the Board.
- To ensure that the safeguarding commissioning standards of the Board are adhered to.
- A protocol for reporting major incidents needs to be put in place.
- To consider introducing an audit of supervisions in line with the new Reflective Supervision process.
- Safer Workforce training to be arranged for recruiting staff.
- LSCB Cue Cards to be issued to all staff and volunteers.
- Training on Informed Consent and Information Sharing.

Central Business Services

- LSCB to be provided with assurance that Customer Service Centre staff are dealing with contacts from the public appropriately in relation to children.
- Need to establish a policy on Safeguarding Training and refresher training and provide evidence of this to the LSCB.

Public Protection Unit

- Trading Standards to present to the LSCB on their interaction and issues with children and young people.

Procurement & Strategic HR

- LSCB Commissioning Standards to be included in any agreements issued in relations to services for children.
- To check and review what is in place for commissioning with particular focus on safeguarding of both children and adults.
- To confirm safeguarding content of induction programme.

Highways - home to school transport

- To provide confirmation of the process used to check contractors / operators and the safeguarding clauses in their contract documents.

Leisure

- To check Berkshire CP Procedures mentioned in corporate policy and e-induction package.
- To develop Volunteer Handbook.

Adult Services

- To clarify use of B&B accommodation for families and young people.
- To demonstrate the process for identifying the needs of children when families make themselves deliberately homeless.
- To ensure a robust understanding of the pathway for any child perceived or suspected of being in need.
- To check wording on current SLA's in respect of safeguarding commissioning standards
- The Volunteers policy to be referred to HR and checked to ensure all key clauses included and alignment with other RBWM Volunteer documentation.
- To ensure that all staff are aware of and know how to access the Berkshire Child Protection Procedures online and that hard copies of any previous versions are destroyed.
- To refer to DAAT Manager the issue of SMART not attending CP conferences and Core Group meetings when invited, and also failing to provide reports or contribute to the process.

Children Services

- To review the audit programme and identify any audits to be reported to the M&E subgroup.
- To ensure that S11 and Working Together clauses are included when contracts are being put out to tender.
- To check Corporate Commissioning Standards include WT and S11 references.
- To check RBWM Volunteering Policy and establish whether this is relevant / appropriate and if it is in use across the unit.
- To ensure that there are mechanisms in place to enable the views of young people to feed into service development and change.
- To report to LSCB via the Monitoring and Evaluation Subgroup regarding supervision standards and associated audits and concerns around recording of training.
- CiB final report to be presented to LSCB
- To liaise with the Head of Sensory Consortium Service to arrange a presentation to the board.
- To provide Training Needs Analysis and Training Reports to LSCB.

A review of progress on implementation in these areas will be undertaken during 2013/14.

3.11 The Recruitment of the Business Manager to the Board

The local authority was unwilling to replace the full time Business Manager with a full time post, and although this was robustly challenged by the Board the funding to the Board from the local authority was reduced for the forthcoming year by 50%. The funding only permitted a part time post and recruitment was pursued on that basis. There was however considerable delay in replacing the Business Manager which impacted on the pace and continuity of board business.

3.12 The LSCB e-safety website

A specific e-safety section on the board website was commissioned and presented to the Board. The Board was satisfied that there was important targeted information for children and young people of different ages, for parents, and for professionals. This was considered as an important step in providing key information to assist in promoting safety in the use of computers and other electronic devices.

3.13 Lay Members Forum

The lay members of the board now attend the South East Lay Members forum and this provides them with development opportunities and support from colleagues to understand their role on the Board. The Board agenda will always include the opportunity for lay members to feedback on issues emerging from the forum.

3.14 Children detained in Police cells

Nationally, the issue of young people being detained in Police cells raised and the position for young people in Windsor and Maidenhead was reviewed.

Thames Valley Police, the Children and Adolescent Mental Health Service, and the Youth Offending Service all reported on their experience of children being held in Police custody.

It was established that the Appropriate Adult service worked well with the Youth Offending Service and the Emergency Duty Team being able to access appropriate adults when required. There were a limited number of instances when there was a delay in accessing a mental health assessment for young people held under section 136 of the Mental Health Act. It was clear that the service to provide a mental health assessment was well established, but the timing of the request, during the night, meant that there was a delay in accessing the assessment.

Areas to Strengthen

The Board has asked for information on any incidents where young people have been detained in Police custody to be reported to the Board to keep this under review.

3.15 Disabled Children's Task Group

It was agreed that the Windsor and Maidenhead Safeguarding Board would be a member of the Pan Berkshire Disabled Children (Time Limited) Task Group. This group will be chaired by Rebecca Lacey who will be able to inform the Board of key strategic issues emerging.

3.16 Review of Health Visiting Services

The Board received a presentation, over two Board meetings, on the Health Visiting service in the Borough.

This established that the service is responding to between 1,800 and 2,000 births a year and that not all families choose to engage with the Health Visiting service after their first contact. It is recognised that within this group of families there may be children who are more vulnerable and a project has been undertaken to target this particular group. The targeting and assessing of this group is seen as a key element in the early help offer within the Borough.

The service reported capacity issues which prevented them from achieving the 14 day contact standard. This was an issue of recruitment rather than budget, and initiatives are being taken to achieve the required recruitment levels.

The Board was informed that learning from recent cases, including a serious case review undertaken within the Borough, has been incorporated into health visiting assessment and supervision processes. In particular, further training has been provided to Health Visitors on their response to minor bruising, including the management of concerns by family members when asked to seek a paediatric opinion.

Once identified, high risk families are targeted for extra services and Health Visitors recognise their important role in communicating needs to other agencies. The number of Common Assessment Framework assessments has increased.

There has been a strengthen response to the identification of drug and alcohol issues within families, and it was clarified that DAAT would inform midwifery if they became aware that a service user was pregnant.

Areas to Strengthen

To establish mechanisms to ensure regular reporting of Health Visitors case load and capacity to the LSCB.

3.17 Review of Midwifery Services

The Board received a presentation on the Midwifery Service in the Borough. This indicated that all midwifes and obstetricians has now completed level 2 safeguarding training and that any child or family that is identified as vulnerable is referred to the Crystal Team for an enhanced service.

The Board recommended that any family choosing not to engage with the Crystal Team will have their circumstances reviewed to ensure that the Health Visitor is made aware of the family's position and to consider if there is a need for referral to any other agency.

In the course of the presentation documentation was presented to the Board that indicated that two key features from a recent serious case review had been incorporated into the assessment processes by midwives: the role of fathers, and the implications of a concealed pregnancy.

3.18 Review of attendance at child protection conferences

The Board was informed that overall there is good attendance at child protection conferences and good submission of reports.

The child protection coordinator raises issues with agencies if they do not attended, and the Board requested that non attendance issues be raised with agency managers rather than the professional directly involved.

Areas to Strengthen

There will be regular reporting of attendance and submission of reports to the Monitoring and Evaluation Sub-Committee.

3.19 Sexual Exploitation

The Board reviewed the activity undertaken by the Board and the Children's Trust to ensure that there is a good awareness of sexual exploitation issues by front line staff and that there is a process for the strategic overview of sexual exploitation in the Borough.

The Thames Valley Police strategy on sexual exploitation was agreed by the Board, supported by an action plan for implementation.

Areas to Strengthen

It was established that there is a need for an operational group to be set up by the agencies providing services to children who may be sexually exploited, but it was felt that the strategic overview may be better established in conjunction with neighbouring Boards. This will be taken forward in the forthcoming business plan.

3.20 Protocol with Heatherwood and Wrexham Park Hospital

A protocol was agreed with Heatherwood and Wrexham Park Hospital which recognises that their main link with a Safeguarding Board is with Slough, but that communication with the Windsor and Maidenhead Board will be maintained when required.

3.21 Workshop on Styles of Serious Case Reviews

With three other Safeguarding Children Boards, the Windsor and Maidenhead Safeguarding Children Board participated in a workshop to examine different models of conducting serious case reviews to address the issues raised by Professor Munro in incorporating the SCIE 'systems' thinking into the review process. The workshop clarified principles for conducting future reviews, but established that no-one model would service the needs of all cases.

3.22 Engagement with the Clinical Commissioning Group

In recognition of the significance of the change to organisational arrangements within the Health sector, the engagement with the Clinical Commissioning Group became a regular item for reporting throughout this year.

In particular, there was a particular focus on ensuring that there was sufficient capacity in the designated doctor and designated nurse roles to support safeguarding children in the Borough.

3.23 Monitoring and Evaluation Sub group

A self audit process was established for schools to evaluate their ability to deal with the safeguarding issues raised by the North Somerset Serious Case Review. The sub-group worked to achieve responses from all schools in the borough and ultimately only a few did not submit a return. The issues raised in the audit helpfully re-focused schools on the need to address concerns about behaviour of adults in relation to children.

In the absence of a Board Business Manager, the chair of the sub-committee agreed to commission the four audits from the NSPCC agreed in the business plan:

- To what extent are men in parenting roles involved when assessments are carried out?
- How do LSCB partners ensure individual practitioner effectiveness and performance in relation to safeguarding children?
- Do children know what to do if they or a friend are being abused?
- Do those who work directly with adults recognise when children need a referral to social care?

Quarterly deep dive audits of multi-agency safeguarding cases were undertaken. The audits in general demonstrated good quality interagency working, but some key development points were identified.

These resulted in:

- a protocol being developed with SMART to improve the submission of reports to, and attendance at, child protection conferences and core groups;
- individual cases of not school attendance being pursued by the chair of the conference;
- a revision of the template for use by GP's submitting reports to conferences;
- Family Friends being asked to inform social care if families do not engage with services;
- while there was improvement in the engagement with fathers, there was a reminder to staff to include all relevant adults in child protection plans;
- a review of the audit template to focus more closely on the child's journey;
- a need for midwives and CAMHS to be invited to, and attend, relevant child protection conferences and core groups;
- a reminder to all agencies to ensure that reports for child protection conferences are available for parents to read before their attendance at the meeting;
- a step down approach from child protection plans to child in need being established;
- a reminder to professionals to make plans more outcomes focused.

The data presented to the board on child protection conferences was amended to capture the appropriate attendance of professionals at child protection conferences.

An audit of Core Groups also found improved engagement with male carers, but identified the need for closer cooperation with SMART.

The data presented to the Monitoring and Evaluation sub committee requires more analysis by individual agencies to ensure that the Board is more able to identify qualitative aspects of service delivery.

It was identified that there appears to be an overrepresentation of BME children with child protection plans, and that a future audit will seek to establish the factors behind this.

3.24 Standing items on the Board Agenda

The following are issues raised under standing items on the Board agenda:

- **Safeguarding Issues from Inspections**

A school received an inspection report that raised concerns about safeguarding. The Business Manager of the Board joined with the Assistant Director to visit the school to provide advice and support. It was then reported that following an Ofsted monitoring visit the school had been upgraded to good.

- **Issues from MAPPA**

Probation reported that there had been a change in arrangements for the management of a unit in the area that provides accommodation for high risk offenders. These are manly offenders from other areas who are accommodated in the unit.

Social workers are attending the MAPPA board to familiarise themselves with the work of the MAPPA board.

- **Issues from MARAC**

The issue of SMART not attending MARAC meeting was raised and action taken by the Board to achieve attendance.

Probation reported that Windsor and Maidenhead cases that had been discussed at MARAC had addressed the needs of children well.

- **Capacity Issues and Organisational Change**
    - Probation reported some temporary capacity issues arsing from the departure of staff.
    - The Board member from the Voluntary sector is leaving and will be replaced by a part time manager in Family Friends.
    - It was reported that there had been a significant increase in the number of children requiring special schools in the Borough. There is still sufficient capacity to meet their needs at the present time.
    - Additional health visitors were recruited to improve the delivery of services.

- The local authority restructuring was reported to the Board.

- A proposed change to the terms and conditions of social workers has impacted on the ability to recruit permanently to social work posts.

- A new Police Commander for the Borough has been appointed and he agreed to become the vice chair of the Board.

- **Consultations**

The Board was informed of a consultation on the proposed change to the funding to schools for children with additional support needs.

The board supported agencies to respond to the consultation on the residential element of Manor Green School.

3.25 The Thames Valley Chairs and Business Managers Meeting

The Chairs and the Business Managers of the 9 Safeguarding Children Boards in the Thames Valley area meet four times a year to coordinate activity and address issues relating to agencies that span either Berkshire or Thames Valley.

Issues addressed were:

- Safer recruitment
- The engagement with Thames Valley Police
- Consideration of serious case reviews from other areas
- Amendment to the missing children protocol
- The involvement of the Police in MASH
- Working Together Consultation
- Child Sexual Exploitation
- Pan-Berkshire Section 11 process
- Future arrangement for the pan-Berkshire CDOP panel

3.26 Prevention Sub group

2012/2013 presented some significant challenges for the Preventing Harm sub group with a change in the chair and the loss of two business managers from the LSCB. This, combined with major organisational change in statutory partner organisations, has led to inconsistency in the membership and representation within the group. Despite these challenges however, the group has prioritised their work on identifying the very real current, and emerging threats to children. By identifying these threats, and the risk posed, we can respond together in preventing harm or further harm to children.

The group recognised that Child Sexual Exploitation (CSE) poses a real threat to children across the country and here within the Royal Borough. The group identified the need for CSE to be addressed as a key priority for multi agency and stakeholder response. The group pressed for a coherent and comprehensive strategy to tackle CSE - identification of the problem, mapping vulnerability, providing awareness training, protecting those vulnerable, initiating interventions and bringing offenders to justice only part of the wider strategic direction. This pressure contributed to the establishment of the newly formed multi agency CSE Strategic and Operational Group and plays a key part in this vital area of preventing harm. Members of this group sit on the CSE group and are playing a key part in providing safeguards that prevent harm.

Another priority area of business for the group is the ongoing risk to children within the home and schooling environment. Domestic abuse, and the impact upon children within the home, continues to be of significant concern. Consultation and discussion within the membership identified the need to ensure that we, as part of the wider LSCB board, were working with agencies in developing mechanisms to raise awareness, understand what intervention/service providers were doing and contribute in providing specialist support where appropriate. The establishment of the Domestic Abuse Executive Group within the Borough, consisting of key stakeholders, is very welcome and once again representatives from this sub group sit as part of that forum. This group will continue to play an important part in identifying the potential for serious harm to children as part of ongoing D.A within the home.

Raising awareness around the threats to children is a key component of this sub group and members continue to identify risks to our children within the community. By way of example, the exponential rise in affordable smart-phones and their accessibility to children brings risks when social media is abused. Inappropriate displaying of photographs, bullying, blackmail and sexual grooming continue to be seen across the country, with the most critical cases ending in children taking their own lives in response. The group has highlighted this and members work with their respective organisations in highlighting this, focusing on those most vulnerable. The group has also looked again at ‘e-safety’ and is pressing for a more user friendly, interactive source, that enables parents to access sources of information pertaining to the potential risks to children. The group recognised that there is an existing ‘handbook’ of parenting in place and work is ongoing to bring this up to date, ensuring it is both relevant and accessible to the widest available audience.

It is vital that the Prevention Sub Groups contribution is influencing, and pressing for, positive outcomes that safeguard children and prevent harm. A significant success of this

group is the sharing of information between key stakeholders, awareness raising and the identification of threats, harm and risk to children. By focusing on these threats and responding quickly we will be better placed to achieve this. A recent concern is that historically the group's action plan has focused on too many priorities. This in itself can impede swift action and progress on delivery.

As we move into 2014 this group will continue to focus on the most significant risk and harm; recognising the challenges but responding accordingly. A more streamlined, succinct plan that holds members to account will enable us to deliver this.

3.27 Serious Case Review Sub group

The Sub-group finalised overseeing the implementation of the action plan from the serious case review, and it was evident that all involved agencies had taken the issues from the serious case review very seriously. The main themes from the serious case review were the assessment of concealed pregnancy, the response to bruising in pre-mobile children, and the planning from children returning home from care.

A communication strategy is in place for the publication of the serious case review, but because of the nature of the evidence in any forthcoming trial, the report will not be published until the criminal process is complete.

A review has been commissioned into the circumstance of physical and possible sexual abuse in a complex family situation. The review will report in the following financial year.

A case of physical abuse was considered for a possible serious case review. However it was concluded that it did not meet the criteria for a serious case review.

A partnership review has been commissioned into the circumstances of a young woman who was detained under the Mental Health (Scotland Act). This report will be concluded in the following financial year.

3.28 Policy and Procedures Sub group

The LSCB Policy and Procedures Sub-Group regularly receive proposals for changes to the procedures and LSCB Members are invited to submit these to the Sub-Group. Changes recommended by the group are then published on the website for consultation and taken to LSCBs for approval. Below are listed changes to procedures;

To summarise, the changes made in the June 2012 update are listed in the table below:

Chapter	Details
Chapter 6, Recognising Vulnerability of Children in Particular Circumstances	Section 9 of this chapter, which relates to Forced Marriage has been updated to add a link to a document produced by **ADASS on Forced Marriage and Adults with Learning Disabilities (Information from the Forced Marriage Unit)** and a further link was added to a document on **Forced Marriage and Learning Disabilities: Multi Agency Practice Guidelines (Forced Marriage Unit 2011**.
Chapter 18, Forced Marriages	This chapter was updated with a link to **ADASS on Forced Marriage and Adults with Learning Disabilities (Information from the Forced Marriage Unit)** and a further link was added to a document on **Forced Marriage and Learning Disabilities: Multi Agency Practice Guidelines (Forced Marriage Unit 2011**.
Chapter 31, Allegations Against Staff, Carers & Volunteers	This chapter has been updated having regard to the DfE statutory guidance **'Dealing with Allegations of Abuse Against Teachers and Other Staff**. This affects Section1 and Section 4.21.
Chapter 36, Serious Case Reviews	This chapter was updated with a link to a **Guide for the Police, CPS and LSCBs to assist with Liaison and Exchange of Information where there are simultaneous Serious Case Reviews and Criminal Proceedings (April 2011)**.
Chapter for Consultation	
Guidance on Management of Concealed Pregnancy	This chapter has been added for consultation.

To summarise, the changes made in the November 2012 update are listed in the table below:

Chapter Name	Details
Appendix 8: Protecting Children and Young People - the Responsibilities of all Doctors (GMC 2012)	This was added.
Guidance on Management of Concealed Pregnancy	This was (following a delay) added.

Updated Chapters	
Chapter Name	**Details**
CHAPTER 4: Information Sharing & Confidentiality	A link was added to 'Protecting Children and Young People – the Responsibilities of all Doctors' (GMC 2012)
CHAPTER 9: Child Protection Conference	This chapter has been updated.
CHAPTER 19: Historical Abuse Allegations	This chapter has been updated.

Chapter for Consultation	
Multi-Agency Risk Assessment Conference (MARAC)	This chapter has been added for consultation

To summarise, the changes made in the March 2013 update are listed in the table below:

New Chapters	
Chapter Name	**Details**
Multi-Agency Risk Assessment Conference (MARAC)	Following a period of consultation this document has now been added to these procedures.

Updated Chapters	
Chapter Name	**Details**
Pre-Birth Procedures	A link to the Berkshire LSCB "Guidance on the Management of Concealed Pregnancy" was added to this chapter a month before this full update (February 2013).
Contact Details for Referrals	Web addresses for each authority have been added to this listing
Recognising Vulnerability of Children in Particular Circumstances	A hyperlink to the MARAC procedures (above) has been added to this chapter.
Throughout the Manual	Throughout the manual the content has been revised and updated to reflect the establishment of the Disclosure and Barring Service in place of the Criminal Record Bureau and Independent Safeguarding Authority. The individual chapters revised in this respect have not been separately listed as updated.

Chapter for Consultation – (Please forward any comments by the end of May 2013).	
Safeguarding Children and Young People Who May be Affected by Gang Activity	This draft chapter summarises Safeguarding Children and Young People who may be affected by gang activity published by the Department for Children, Schools and Families in 2010.
Supporting Children and Young People Vulnerable to Violent Extremism	This draft chapter summarises the document 'Prevent and Safeguarding Guidance: Supporting Individuals Vulnerable to Violent Extremism', which has been issued by the Association of Chief Police Officers (ACPO)
Cross-Border Child Protection Cases Under the 1996 Hague Convention	This draft chapter sets out the legal provisions and cooperation arrangements in respect of cross-border cases where children's safety or welfare may be an issue (under the 1996 Hague Convention - implemented in the UK on 1 November 2012). A link is also provided to the January 2012 letter from the UK Border Agency to all local authorities regarding the information sharing in respect of children from abroad.

Working Together 2013

A paper was presented to Heads of Children's Services seeking views on whether the cross Berkshire procedures should:

- Be extended to include more commonality / detail (a common approach to an Assessment Protocol and a common approach to thresholds). This approach was favoured by health representatives on the group.
- Be rolled back to allow different LSCBs more scope to take different local approaches, or
- Continue as now with a balance of common standards and local flexibility

Feedback indicated that the third of these options was preferred.

The Sub Group is therefore proceeding on this basis and will add links to local Assessment Protocols (to be provided by Heads of Children's Services) and Thresholds (which need to be approved by LSCBs).
Revised versions of the CP Procedures chapters 7 Referral & Assessment and chapter 8 Section 47 Enquiries have been circulated and will be placed on the procedures website for consultation from July 2013. The Sub Group have agreed with TriX that the rest of the Procedures will also be updated in line with Working Together 2013 at the next update (July 2013).

3.29 LSCB Training Sub group
Summary of activity and achievements

The training sub group from April 2012 to December 2012 functioned as separate training sub groups, one for East Berkshire and one for West Berkshire. A brief summary on achievements is provided for East and West.

East Berkshire

The East training sub group undertook their own training needs analysis and outcome evaluation report both of which were share with all LSCB boards for the east.
A course training programme was published are over 43 multi-agency training courses were provided. The need for targeted Multi-agency courses in the east TNA was high and the training sub group and training officers showed commitment to both providing and promoting courses across the partnership. Over 900 people attended courses on multi agency training in the east which is a fantastic achievement.

The achievements were as follows:

- Course programme published.
- Course evaluation certificate for LSCB courses linked to personal development were designed and issued at all shared responsibility training.
- Multi-agency training shared responsibility was standardised across the east.
- A joint partnership approach to the delivery of shared responsibility was achieved and maintained between health and Slough LA providing some courses with multi-agency trainers which enable a shared learning for delegates regarding local providers.
- Bracknell provided additional course to meet demand following the TNA 2012.
- LSCB conference days.
- Lay person involved with the training sub group.

Berkshire wide Strategic Training sub group pilot 2012- 2013

This commenced in late October 2012 and the first meeting was held in March 2013. Below is a comparison extract from the TNA's undertaken in 2012-2013.

In comparison with the independent TNA undertaken in the West of Berkshire a lower amount of TNA returns were received from the East of the county, 9 received across East Berkshire compared to 14 in West of Berkshire. The total workforce figure reported for the West of Berkshire was approximately 22,723. In comparison to the East reporting 11,563 however estimated workforce data from Slough takes this up to 17,899.

The single agency in both areas has been noted as being the largest group to train and agencies requiring more communication of what to include in this training will remain a challenge to LSCB boards to monitor and scrutinise the single agency provision effectively, particularly in light of working together consultation. More emphasise may be required on self-reporting or audits on quality of training may be required which may impact on resources.

Multi agency training compliance in the West of the County is higher than the East. 1025 staff estimated in the East identified as needing to access training for 2012-2013 compared to 389 staff needing training in the West of the county. This variation may be due to the different expectations placed on various professions within each area. For example Berkshire East are keen to ensure the early year's sector have access to the targeted level.

Remaining Challenges

Representation from police, probation and housing, remains a challenge and has been identified to all boards as a continued issue, the chair and members continue to encourage membership. The Police data was attained in 2012 across Berkshire and identified that refresher training in the force was a significant gap from front line staff. Attendance at multi-agency LSCB course remains very low and dependant on local area links. The Child sexual exploitation (CSE) training for the police will need to be explored by the sub group and compared with local CSE groups to ensure a more co-ordinated approach that provides assurance that training is consistent across areas.

Collaborative work with section 11 panels is essential in 2013 -2014 with clear direction from the training sub group for partner agencies to provide organisational training strategies to enable effective scrutiny. It has been a challenge to obtain data from the majority of the PVI sectors, it has been inconsistent and difficult to co-ordinate any meaningful response to provide assurance across Berkshire. Thus the training sub group may need to seek more assurance reports from the section 11 process and LA who were tasked with addressing self- audit compliance for the PVI, schools and early year's sector. Safeguarding children training in local prison will need to be reviewed by the sub group in 2013-2014.

In response to the new working together 2013 and focus on early help it is clear that the LSCB role has expanded. Enabling scrutiny and ensuring effectiveness of safeguarding training for both single and multi -agency training will be a challenge for the group, The Berkshire wide group is in agreement that the previous working together guidance will remain as a standard guidance for training for staff groups.

It will remain a challenge to assure consistency across Berkshire about the threshold for early help and single assessment training. The learning and improvement framework and threshold documents are key to supporting the role of training sub group.

Priorities for 2013-2014

A Berkshire wide training sub group with joint TOR is being piloted across the area and has established strategic priorities and work plan. The operational training sub group meet east and west and feed into the strategic Berkshire wide group. The Berkshire wide group will

- Produce a report on follow on evaluation outcomes from training across Berkshire; it will focus on staff confidence and learning from Serious Case Reviews.
- Continued implementation of the Berkshire wide quality assurance documents and guidance for training across Berkshire.
- Work collaboratively with the section 11 panel in relation to assurance from agencies about their training strategies.

- Continued joint work with the adult safeguarding partnership boards and the production of a mapping document for boards to compare training provision and mandatory status from key agencies across Berkshire for safeguarding children and adult training.
- Designated named professional training to be explored Berkshire wide.

3.30 Berkshire Child Death Overview Panel

From 1st April 2008 each Local Safeguarding Children Board (LSCB) has had a responsibility to operate a Child Death Overview Panel (CDOP) as outlined in Chapter 7 of the Government guidance Working Together to Safeguard Children (DfE, 2006, 2010, 2013).

This is the fifth year since all six local authorities joined together to form a Child Death Overview Panel in Berkshire (CDOP). Every LSCB is required by law to establish a CDOP, in order that the causes of all child deaths can be analysed and recommendations made to reduce deaths in future. The Panel gathers and reviews data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident within Berkshire. This enables themes to be extracted from a greater number of deaths and trends established in the circumstances leading to the deaths.

There are two inter-related processes for reviewing child deaths. Either process can trigger a serious case review. The processes are:

1. **An overview of all child deaths** in the Berkshire LSCB areas, undertaken by a panel drawn from key organizations represented on the LSCBs. Deaths are reviewed from birth up to 18th birthday, excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law.
2. **Rapid Response** by a team of key professionals who come together for the purpose of enquiring into and evaluating cases of unexpected child death or cases where children are seriously unwell and not expected to survive). This process not only identifies areas of serious concern through their information gathering and discussion, but also sources ongoing support (e.g. care needs for children who do ultimately have a good outcome and survive).

Summary of CDOP Activity and Achievements over the year:

- **A reduction in perinatal/neonatal mortality:**
    - In Berkshire as a whole there was a 16.2% reduction in *reviewed* deaths from 68 in 2011/12, to 57 in 2012/13. There was a 55% reduction in *actual* numbers of deaths, from 75 in 2011/12 to 34 in 2012/13*
    - A key contributing factor to this was the Berkshire-wide 35% reduction in reviewed perinatal/neonatal deaths from 26 in 2011/12, to 17 in 2012/13
    - This exceptional reduction took place following the April 2012 change in status of our local district general hospitals to Local Neonatal Units (LNUs), resulting in the transfer of high-risk (e.g. very premature, very unwell, etc.) neonates to nearby specialist tertiary centres, allowing the most unwell neonates to receive specialist care. Feedback from Oxford (the most common target of transfers) has suggested that this has not led to a corresponding rise in neonatal deaths there, suggesting that this protocol has a genuinely positive impact in reducing mortality[+] However, it is important to

note that transfer of unwell patients carries its own risks, and that centralisation of higher level specialist care can result in deskilling of professionals at the local centres; unexpected high-risk births will still take place locally as parents cannot always plan to travel to a specialist centre in time, so it is important that we retain local expertise for when it is required

- 2012/13 saw the completion of the Wokingham neonatal deaths review (in response to the noted rise in neonatal deaths in this area), which identified no clear modifiable factors among any of the reviewed deaths with the exception of low birth weight. Wokingham has since seen the largest reduction in 2012/13
- A focus for 2013/14 should be on continuing to halt and reverse this trend by picking up unwell neonates early, including identifying those pregnancies that are high risk at an early stage so that appropriate specialist care can be planned in advance
- We need to remain cognizant of the fact that the positive reduction in mortality seen in 2012/13 may be a 'one-off' data point, and it will be the numbers in 2013/14 and beyond that confirm whether this reduction reflects a true trend.

- **Positive findings and challenges identified in the audit of Rapid Responses:**
  - 12 Rapid Responses were undertaken in 2012-13 year, fewer than the 21 Rapid Response cases held in 2011-12
  - 9 Rapid Responses were undertaken by the Berkshire West teams, and 4 by Berkshire East teams (case breakdown: 1 Bracknell, 2 Royal Borough of Windsor & Maidenhead, 1 Reading, 2 Slough, 3 West Berkshire, 1 Wokingham, 2 out-of-area)
  - Audit of the 2012/13 cases determined the generally good response of frontline and Emergency Departments, with close multi-agency team working. Geographical borders (out-of-area deaths) made information gathering and sharing a challenge, but CDOP panels made good efforts to gather information from teams in other areas, despite complex cross-border communication challenges
  - Healthcare professionals should be reminded that Rapid Response serves as a valuable tool in all cases where children are either seriously unwell and not expected to survive, or in unexpected deaths, as the process can identify sources of support for parents, staff and children who have good outcomes and do survive their illness.

- **A successful move for the Berkshire CDOP function into the Local Authority:**
  - Public Health has been through a major transition from April 2013, moving from the NHS into Public Authorities where the teams are now better placed to address key issues together with our social care partners.
  - There has been a safe and successful transfer of our CDOP resource to Slough and their subsequent integration into the Slough Public Health team. In addition, there has been embedding of the coordinator function at the Royal Berkshire Hospital, as planned.

- We have safely upgraded and transferred our CDOP database to the Slough Local Authority IT system, with further updates planned to take into account suggestions from the CDOP reviews with our social care partners.

- **Implementation of consistent red book advice:**
  - We have continued with a more consistent approach to educating new parents, through standardising 'red books' across all six areas, and with all staff (i.e. midwives, health visitors, early years teams) equally trained in providing consistent advice, such as the 'Back to Sleep' campaign for safe sleeping.
  - This is likely to have had a positive impact, with no reviewed deaths in 2012/13 classified as SIDS or SUDI.

- **Circulation of new CDOP newsletter:**
  - The new-style newsletter has been in production in 2012/13 and will continue to be distributed via email so that we can continue to share learning widely to all staff involved in the CDOP processes.
  - The newsletter was re-designed to make it more readable to ensure that relevant staff receive the information they need.
  - At present, it is circulated to the CDOP panel members and around 200 GPs in the Berkshire area. In 2013/14 it is hoped that this distribution list will widen to include a greater proportion of Berkshire's GPs and more secondary care clinicians in relevant specialities (e.g. Paediatrics, Obstetrics) in order to share important learning and to help further reduce child deaths.

**Note that actual numbers of deaths in individual categories (e.g. perinatal/neonatal) cannot yet be compared as some 2012/13 deaths still await classification as they were not reviewed in the 2012/13 financial year (data is presented are as per financial year - i.e. the 2012-13 year runs from start April 2012 to end March 2013).*

[+] *CDOP are awaiting confirmation of the precise numbers of perinatal/neonatal deaths from Oxford to formally verify this.*

Key issues emerging from the work of the Board

The Board has developed its understanding of the additional vulnerabilities of children placed out of Borough and the complexity of arranging educational and health services to support the child in placement. The Board will seek updates on numbers placed out of Borough to consider if the vulnerabilities associated with out of Borough placements are being addressed.

There has been regular reporting by agencies of the capacity to meet the high level of demand that has been evident throughout the year. The Board will continue to oversee the management of capacity issues by all agencies of the Board to ensure that strategies are in place to manage the circumstances within individual agencies as well as to have an overview of the collective impact on services for children and families.

The Board has been overseeing the attendance at and reporting to child protection conferences. There has been improvement, but there is a need to achieve full contributions to child protection processes from all agencies. A process of challenge by the chair to agencies who have not attended is in place and the Board will continue to oversee conference attendance and reporting.

The focus by the Board on sexual exploitation has enabled the Board to develop a clearer picture of the incidence of sexual exploitation in the Borough and the preparedness of agencies to address the issues. From a previous low level of recognition, agencies are now demonstrating they are better attuned to recognise sexual exploitation and the operation and strategic response has been strengthened. This will be an ongoing piece of work.

4. LSCB Income and Expenditure for 2012-2013

Income

Agency	**Contribution 2012-13**
RBWM	£85,090
Berkshire PCT	£20,869
Thames Valley Police	£2,132
National Probation Service	£955
CAFCASS	£500
Other Income	£2,608
TOTAL INCOME	**£112,154**
Under spend from previous year	£18,919
TOTAL BUDGET AVAILABILITY	***£131,073***

Expenditure

Area of expenditure	**Actual Spend 2012-13**
LSCB Independent Chair	£11,000
LSCB Business Manager	£19,740 (vacant post for 9 months)
LSCB Secretary	£23,525
Transport Costs/Mileage	£768
Lay Members Allowance	£400
External Consultants	£8,200
CDOP	£5,125
SCR & Partnership Reviews	£13,867
Promotional/Admin Costs	£7,775
TOTAL EXPENDITURE	**£90,400**

5. Priorities for 2013-2016

The key priorities for the LSCB in 2013-16 are to;

- Integrate the requirements of Working Together 2013 into the work of the Board and its partner agencies
- Embed the practice of early help and intervention across all agencies
- Develop a Learning and Improvement Framework
- Publish a threshold document for early help referrals across all agencies
- Ensure that all services providing support and intervention to adults also consider whether there are associated children who may need help or protection from harm
- Ensure that voluntary, private and faith organisations have appropriate arrangements in place to safeguard and promote the welfare of children
- Ensure a strategic multi agency approach to identification and awareness of CSE
- Clarify the ability of the Board to assist transition to adult services for post 18 year olds
- Address the disparity between agencies in relation to the varying upper age threshold of a child
- Ensure greater LSCB representation from schools
- Consider early help intervention for children under 10 approaching the age of criminal responsibility
- Assess the current protocols and policies between agencies around information sharing
- Create a directory of services to include early help agencies across statutory, voluntary and faith organisations in the area
- Increase analysis work and understanding of safeguarding from the service users and front line practitioners' viewpoint
- Introduce a cue-card for identification of and referral to early help services
- Ensure agencies look behind the child to the wider family for risk assessment and information
- Explore the wider efficiencies and strengths of combining with neighbouring LSCBs in Berkshire
- Scope the synergies between Children and Adults Safeguarding Boards
- Analyse reasons for out of borough placements for children and explore options for more local placements
- Promote awareness of, and ways to effectively deal with adolescent suicide and self-harm
- Promote awareness of, and ways to effectively deal with domestic abuse and its effects on children

Further Information

For further information about the work of the LSCB, or to find out general advice and information about safeguarding children please visit our website at; www.wamlscb.org