East Sussex Local Safeguarding Children Board

Spring 2018 Newsletter

Welcome to the latest edition of East Sussex's Local Safeguarding Children Board (LSCB) Newsletter.

It has been a while since the LSCB last published a newsletter which has provided us with an opportunity to rethink what information is really useful to you. As a result, in future we will 'theme' all editions of our newsletters to make sure communication is targeted and specific to your work. This one is on **'learning'**: through the LSCB's work, what have agencies and services learnt about the quality of safeguarding practice and safeguarding outcomes for children, and how might this apply to your work.

If you have any questions, or would like further information, about any of the items in the newsletter please contact lscb.contact@eastsussex.gov.uk.

Our next newsletter in Summer will focus on **training**

LSCB Neglect Deep Dive Audit

The LSCB's Quality Assurance Subgroup conducted a 'deep dive' audit, involving practitioners engaged with the families, on two complex neglect cases in September 2017.

Both cases had had children's services involvement for around 20 years. They both involved large family groups with long term complex problems including parents out of employment, parents with a mental health diagnosis and siblings differing needs and vulnerabilities.

The audit involved a reflective discussion with practitioners about what had enabled good practice with the family and what challenges they had face at various key points.

There was evidence of very good and creative practice to engage the parents and children, to engender change and strong evidence of good relationship based practice.

The audit noted systemic, environmental and social challenges to good practice and as a result, made the following recommendations:

- Children's Services consider developing a **different strategic model of service delivery for long term chronic neglect**.
- The East Sussex LSCB to raise a request with the Pan Sussex Procedures subgroup to consider whether the procedures could be worded to promote **group supervision to core group professionals in complex cases** and/or direct to local operational instructions (guidance to staff) that promote this

- Children's Services consider having a **legal advisor at Care Planning Forum meetings**. *This is now happening.*
- Social workers to also record the **positive achievements in the chronology so that professionals can see the family's potential** and what is working well.
- Senior managers **recognise that some cases will need low level input on a long term basis**. This long term input could help to prevent a child experiencing an escalation in the family situation from level 2 or 3 to level 4 on the Continuum of Need.

Thank you to all of you who kindly gave your time in preparation and on the day and helping to make this a valuable learning event. There was evidence of much excellent work and areas for learning which need to be taken forward.

The LSCB quality assurance sub group members valued the input and the more detailed understanding of the children and the circumstances of working with these families that front-line workers were able to bring to the discussion. As a result, the QA subgroup plan to conduct two 'deep dive' audits a year to provide richer learning to this area of work.

The East Sussex Neglect Strategy and Toolkit can be found on the LSCB's website.

If you would like to learn more you can watch the Neglect Webinar for Practitioners which introduces the East Sussex Neglect Strategy and Operational Guidance as well as introducing how to use the Neglect Toolkit and the Neglect Matrix.

Serious Case Reviews

When a child dies, including death by suspected suicide, or abuse or neglect is known or suspected to be a factor in the death, the LSCB is required to conduct a Serious Case Review into the involvement of organisations and professionals in the lives of the child and the family.

The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children.

The LSCB have one SCR in progress that is due to be published in early Spring 2018. Once this is published there will be a range of resources and briefing sessions organised to communicate key learning.

The LSCB published two Serious Case Reviews in 2016: Child M and Child K. Briefings on these SCRs can be found on the LSCB's website alongside the final reports of all our SCRs. As a reminder, below are the key features and learning from those two SCRs.

Child P

This serious case review was conducted following the death of a young girl who was killed by her father in September 2014. The SCR Report concluded that this death could not have been prevented, nor could it have been predicted. The Review highlighted learning around:

- Help from services in relation to **domestic abuse and violence**;

- The **challenge to services when a family moves across local authority boundaries**;
- The **disclosure of confidential information** and;
- The **role of the family court**.

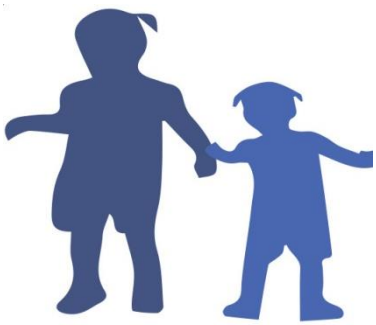
Recommendations from the review, including improvements to the delivery of support relating to domestic violence, have all been taken forward.

Child M

Child M was aged 17 in March 2013 when she died as a result of a drug overdose taken while in the company of at least one adult. Child M was known to CAMHS, psychiatric and community drug services and social services in 6 local authorities. At the time of her death she was a looked after child under a Care Order to East Sussex County Council living in bed and breakfast accommodation in Hampshire.

Twenty-eight agencies from several local authority areas and regional agencies that contributed to the SCR have between them made 70 recommendations. These deal largely with important local aspects of practice and procedure within individual agencies and are focused on:

- Better **sharing of information at the point of referral and case transfer**;
- **Improved risk assessment**, including the recording of risk assessments;
- Policy and practice in relation to **young people who repeatedly go missing**;
- **Information sharing about vulnerable students** in schools and colleges;
- The **response of acute hospitals** in contact with young people who overdose;
- **Health provision for looked after children**;
- Improving responses to the **needs of children who are being treated in Tier 4** psychiatric inpatient units



There has also been significant practice development and understanding of child sexual exploitation since the date of Child M's death. It is of significance that many agencies referred to Mr C as a 'boyfriend' when this was an exploitative relationship and posed a risk to child M.

Working Together 2018 – Proposed changes to Serious Case Reviews

At the end of October the DfE published a consultation on significant revisions to Working Together to Safeguard Children 2015, the statutory guidance setting out what is expected to safeguard and promote the welfare of children. (See Annexe B in the consultation document **Changes to statutory guidance: Working Together to Safeguard Children; and new regulations: Government consultation**

These revisions reflect legislative changes introduced by the Children and Social Work Act 2017 including the **replacement of Local Safeguarding Children Boards** and **Serious Case Reviews** (SCRs), and **new arrangements for child death reviews.**

Local child safeguarding practice reviews

It is proposed that SCRs are replaced with Safeguarding Practice Reviews. The consultation:

- confirms that the purpose of local child safeguarding practice reviews is to identify improvements that should be made locally to safeguard and promote the welfare of children
- proposes safeguarding partners will be responsible for identifying serious child safeguarding cases which raise issues of importance for their area
- suggests safeguarding partners will be responsible for commissioning reviews of

those cases where they consider it appropriate to do so including the appointment of reviewers.

- Provides details of the establishment of a national Child Safeguarding Practice Review Panel with responsibility for identifying and commissioning national child safeguarding practice reviews
    - the national Panel is to receive notification of all child safeguarding cases where a child has died or is seriously harmed
    - copies of all local reviews are to be sent to the Panel to enable the identification of improvements to be made locally or nationally

It is anticipated that the final Working Together 2018 will be published in spring. There is local consensus that current LSCB partnership arrangements in East Sussex work well and deliver improved safeguarding outcomes for children and young people. Transition plans to new arrangements will take place over time and in consultation with lead safeguarding partners.

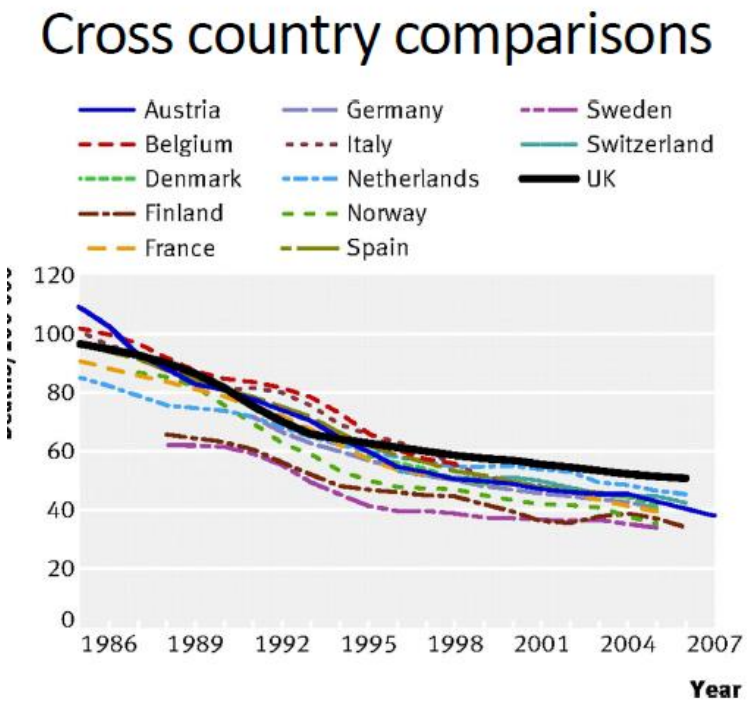
Child Death Overview Panel – South-East Learning Event

Members of the East Sussex Child Death Overview Panel (CDOP) attended a Sharing Good Practice Event, hosted by Surrey CDOP on the 1 November 2017. The event was well attended by Surrey, West Sussex, East Sussex, Brighton & Hove, Kent, Medway and Sutton CDOPs.

The key note presentation was by Dr Peter Sidebotham, Associate Professor of Child Health at Warwick University. Dr Sidebotham's presentation very interestingly highlighted that while child deaths have dramatically decreased over the past 30 years, compared to other European countries the UK has higher rates of child deaths (see chart below). If the UK had a **similar rate of child deaths to the best in Europe this would equate to 1500 less child deaths a year** – a very sobering figure.

The Learning Event also looked at the proposed changes for reviewing child deaths as set out in the Working Together to Safeguarding Children consultation. The consultation proposes that responsibility for reviewing child deaths will transfer from the LSCB to 'child death review partners' (the local authority and clinical commissioning groups) and at a national level ownership of government policy for child deaths will transfer from the Department for Education to the Department of Health.

A presentation was also given by Susan Koffler, Local Specialist for the



- 1500 'excess deaths'
- Ethnic diversity
- 'Health spend'
- Social policy
- Income inequality

Provide hypotheses about optimum configurations but not precise predictions on health outcomes

South East, National Child and Maternal Health Intelligence Network during which she introduced the group to **Fingertips** https://fingertips.phe.org.uk/profile/child-health-overview/data an online Public Health data source that provides area/regional and UK data on a wide range of measures and which shows where areas are performing well against the UK average or performing below average (with a positive or negative trend data).

The post course materials can be found online at the following link:
http://www.surreyscb.org.uk/child-death-overview-panel-professional-development-day/
Please note you will need the following **password** to access the materials: **CDOPDEVELOPMENT2017**

Quality Assurance Annual Audit Report 2017

The LSCB QA sub-group is responsible for monitoring and evaluating the effectiveness of the work carried out by LSCB partners to safeguard and promote the welfare of children. It does this through an annual programme of case file audits and scrutiny of multi-agency performance data and inspection reports.

During 2016/2017 the QA sub-group held three thematic audits on neglect, domestic abuse, and children missing from education, and one regular case file audit.

Of the eighteen cases that were audited 13 were graded Good, three were graded as Requires Improvement (RI) and two as Inadequate. The percentage of cases audited as 'good' has continued to improve from 36% in 2014/15 to 72% in 2016/17. Concerns that led auditors to grading cases as RI or inadequate this year included:

- Lack of a Social Care Child's Plan.
- Professionals failing to escalate a case when the situation had not improved.
- Lack of a strategy discussion where one was needed, in one case.

In the majority of cases auditors found:

- Agencies were **good at sharing information and working well together** and with the children and families.
- Children's **views and wishes were recorded and used to inform planned work**
- There were **improved outcomes** for children as a result of intervention from professionals.
- Professionals had a **clear understanding** of the longer term nature and risks of neglect.
- Improved representation of the School Health Service at strategy discussions.
- **Step Down to Early Help Services** helps to ensure that professionals have a higher level of long term engagement after the end of a child protection plan, (CP plan).

Following on from audits (on neglect, child sexual abuse, female genital mutilation and unaccompanied minors) held in the previous year:

- A multi-agency learning event on neglect was held in December 2016. This strengthened focus on the needs for each **individual child in large sibling groups in cases of neglect.**
- Sussex Police Officers have been trained in enhanced interview skills to **improve children's engagement in Achieving Best Evidence interviews.**
- Information on the use of direct therapeutic intervention while a criminal investigation is ongoing was disseminated to staff. This will help ensure that **child victims of sexual abuse do not experience unnecessary delays in accessing support**.
- The Sussex Paediatric Sexual Abuse Referral Centre (SARC) produced an information leaflet to explain forensic medicals and health assessment. This is to **reduce anxiety**

and misunderstanding and to increase the number of children who benefit from these holistic medical assessments.

- Sussex Police and Border Force met to share details and ideas on safeguarding practice on unaccompanied minors entering the country. This has helped professionals to **respond in a more coordinated and effective way** when children enter the country.

Domestic Homicide Review – Adult E (Henrietta)

Domestic Homicide Reviews (DHRs) are conducted when someone has died as the result from violence and abuse. A DHR was recently published following a review of the murder of 'Henrietta', a woman in her early 20s, who had two young children. The perpetrator 'Peter' was charged and later convicted with her murder. Peter was Henrietta's ex-partner and the homicide happened three weeks after they separated.

Full details of the Review and Learning Briefings can be found on Safe in East Sussex: Domestic Homicide Reviews

The review identified issues in relation to contact with the police, the role of housing providers and health services, as well as how professionals identify perpetrator behaviour. Other findings included: ensuring there are simplified referral pathways to specialist services; access to specialist services in health settings; as well as **learning for Children's Social Care (relating to administrative process and systems, follow up and early help services)**.

A range of lessons were learnt in this case, including the take up of opportunities to have conversations with a victim of domestic abuse, in order to understand their relationship with a former or current partner or any concerns they might have. Other lessons include: the use of Domestic Abuse Stalking and Harassment Risk Identification Checklist (DASH RIC) and professional curiosity, in particular in relation to the role of housing providers and health professionals.

A specific action for the LSCB was agreed to engage housing providers in future section 11 audits (which monitor the effectiveness of safeguarding arrangements). The LSCB has been invited to contribute to a learning event for the Housing Sector in January 2018 on Domestic Abuse and Violence.

The next multi-agency LSCB Training on 'Adopting a Whole Family Approach to Domestic Abuse and Promoting Safety' is on 13 and 20 March 2018. You can book your place via the East Sussex Learning Portal.

Joint Targeted Area Inspections – learning on Domestic Violence & Abuse

The programme of joint targeted area inspections (JTAIs) began in January 2016. The programme brings together the inspectorates Ofsted, Care Quality Commission (CQC), HMI Constabulary and

Fire & Rescue Services (HMICFRS), and HMI Probation (HMIP) to 'examine how well agencies are working together in a local area to help and protect children'. Each set of JTAIs focus in depth on a particular issue.

The last and current focus of JTAI's is '**the multi-agency response to children living with domestic abuse'**. In November 2017, the inspectorates published a report considering the extent to which, in the areas inspected, multi-agency professionals were effective in safeguarding children who live with domestic abuse. The report calls for a national public service initiative to raise awareness of domestic abuse and violence. It also calls for a greater focus on perpetrators and better strategies for the prevention of domestic abuse.

Key findings include:

- domestic abuse is a widespread **public health issue that needs a long-term strategy to reduce its prevalence**.
- While much good work is being done to protect children and victims, **far too little is being done to prevent domestic abuse and repair the damage** that it does.
- There also needs to be a focused effort across agencies to **develop and test interventions with perpetrators** of domestic violence and abuse.
- More thought needs to be given to how local areas can collectively supply the **emotional, psychological and practical support that is needed to help children and victims** – or families that have stayed together – get safe, stay safe and move on to reach their full potential.
- Work with families is often in reaction to individual crises. However, keeping children safe over time needs long-term solutions.
- The focus on the immediate crisis leads agencies to consider only those people and children at immediate, visible risk. As a result, agencies are not always looking at the right things, and in particular, not focusing enough on the perpetrator of the abuse.

In other news…..

Safer Internet Day – 6 February

East Sussex Local Safeguarding Children Board is proud to be supporting Safer Internet Day 2018. The day will be celebrated globally on Tuesday 6th February with the slogan 'Create, Connect and Share Respect: a better internet starts with you.' More details can be found on our website: Safer Internet Day 2018 | East Sussex Safeguarding Children Board

Professionals can help to create a better internet by equipping the children and young people they support to talk about what they do and share online and by developing their critical thinking skills. They can empower them to make positive choices online and can set a personal example of online behaviour. A range of resources can be found on our website:
http://www.eastsussexlscb.org.uk/our-priorities/online-safety/

Stop Child Exploitation Day – 18 March

The National Child Sexual Exploitation Awareness Day on 18 March aims to highlight the issues surrounding CSE; encouraging everyone to **think, spot and speak out against abuse** and adopt a zero tolerance to adults developing inappropriate relationships with children or children developing inappropriate relationships with other children.

The LSCB will be asking professionals in East Sussex what they can to do think, spot and speak out against abuse. Our Child Exploitation page has details of local resources and support.

Pan Sussex Safeguarding and Child Protection Procedures

Wen was the last time you used the Pan Sussex Child Protection and Procedures Manual? Why don't you refresh yourself! If you want to sign up for alerts when the procedures are updated please add your details on the website.

http://sussexchildprotection.procedures.org.uk

LSCB Multi-agency Training Programme 2018-19

We have an exciting programme of multi-agency training planned for 2018/19, which continues to provide a wide range of courses to keep up-to-date with current local and national safeguarding concerns.

www.eastsussexlearningportal.org.uk

Contact us

Telephone: **01273 481544**

Email: **lscbcontact@eastsussex.gov.uk**

Website: **www.eastsussexlscb.org.uk**

If you think a child is being harmed or may be at risk of harm, please contact:

SPoA Mon-Friday 8.30am-5pm
Phone: 01323 464222
Email: 0-19.SPOA@eastsussex.gov.uk or 0-19.SPOA@eastsussex.gcsx.gov.uk

If you urgently need help outside of office hours you can contact the **Emergency Duty Service** for East Sussex and Brighton and Hove. Phone **01273 335905** or **01273 335906.**