East Sussex Local Safeguarding Children Board

Annual Report 2016-17: Executive Summary

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The East Sussex Local Safeguarding Children Board (LSCB) is made up of senior representatives from all the organisations in East Sussex involved in protecting or promoting the welfare of children, such as the Police, Health and Community and Voluntary Sector. The aim of the LSCB is to work together to safeguard children in East Sussex and ensure that this work is effective. This requires proactive intervention for children who are abused; targeted work with children at risk of harm; and preventative work within the community, to develop a safe environment for children.

Day to day activities the LSCB are involved with will include coordinating multi-agency safeguarding training; developing robust policies and procedures; raising public and professional awareness of safeguarding issues; participating in the planning of services for children; carrying out serious case reviews where abuse or neglect is known or suspected, and there is concern about the way in which agencies worked together; and ensuring that the wishes and feelings of children and families are considered in the delivery of safeguarding services.

Key child facts about East Sussex:

- In 2016 there were estimated to be 105,873 children and young people between 0 and 17 years old, accounting for 19.5% of the total population of East Sussex.
- East Sussex is becoming increasingly ethnically diverse. Locally the proportion of school age children from BME backgrounds is 12%, but is still significantly lower than the national figure of 30%.
- 3.7% of local children have Special Educational Needs or disabilities which result in an Education, Health and Care plan against an England average of 2.8%, with the biggest proportion within the secondary age group.
- The level of child poverty is better than the England average with 17% of children aged 0 - 15 years living in poverty; this is predominantly centred in and around the Eastbourne and Hastings districts.

As in other parts of the country, some children and young people in East Sussex will be vulnerable and at risk of being abused or neglected.

- During 2016/17 the number of referrals to statutory children's services rose slightly to 3531 compared to the previous year (3,198).
- The rate of children subject to a Child Protection Plan (CPP) in East Sussex (at the end of March 2017) was 45 per 10,000 of the 0-17 year old population. 476 children are currently subject to a CPP in East Sussex, compared 462 in 2015/16.
- There were 564 children looked after by East Sussex County Council as at the end of March 2017; of which 24 were Unaccompanied Asylum Seeking Children (UASC).
- Young people who go missing or run away regularly are vulnerable and are at particular risk of sexual exploitation or of being exploited via other sorts of criminality. During 2016/17 there were 367 reports of incidents of children who were missing, compared to 693 in 2015/16 and 559 in 2014/15.

- The number of children known to East Sussex as being Electively Home Educated (EHE) rose in the last three quarters of 2016/17, ending on a high of 761 in March 2017.
- A total of 128 young people entered the youth justice system for the first time in 2016/17, compared to 146 in the previous year. There were 12 young people sentenced to custody in 2016/17
- In 2016/17 there were 21 young people referred by East Sussex schools to the PREVENT programme, of which only 2 met the threshold for *Channel* intervention

Key awareness raising events in 2016/17:

- ✓ A two day event was held in February 2017 aimed at taxi drivers and local community businesses such as **licenced premises and hoteliers**, in recognition of the important role that they can have in the identification of children who are at risk of becoming victims of exploitation. The event was attended by over 400 taxi drivers and consisted of 4 half-day workshops. Following the success of the event there are plans to run a similar conference for local hoteliers in July 2017.
- ✓ In 2016/17 the LSCB worked with all five district and borough councils to enable more schools across the county to see the production of **Chelsea's Choice**. Chelsea's Choice is a 40 minute production provided by AlterEgo Theatre Company: it is innovative and powerful in highlighting to young people, aged 12 years and over, the serious and emotional issue of child sexual exploitation (CSE).
- ✓ The second **annual safeguarding conference for Schools** was held in January 2017. The event was well attended by Head teachers, Deputy Heads, Designated Safeguarding Leads (DSLs), and LSCB members. The conference focused on: improving safeguarding practice in East Sussex Schools; the voice of young people in relation to safeguarding; a DfE presentation about implementing 'Keeping Children Safe in Education 2016'; and online safety within schools.
- ✓ In February over 170 staff, across a wide variety of partner agencies, attended a conference on **coercive control and domestic abuse** in February 2017. The conference was led by the Safeguarding Adults Board (SAB) in partnership with the LSCB, and East Sussex Safer Communities Partnership. The conference particularly focused on the impact that domestic abuse can have within the family. Workshops included learning lessons from serious case reviews about children; children's lived experience of domestic abuse, and protective behaviours work.
- ✓ In February and April 2017, Sussex Police held two events on **'Youth Produced Sexual Images' (Sexting)**. The LSCB promoted this event to Board members, and to East Sussex Schools. The events, which were pan-Sussex, focused on national guidance on the police response to sexting, and a related training package for Schools and professionals dealing with this type of incident. The events were attended by school staff representing 87 different Schools, 19 other professionals, and 23 police officers from various departments.

Evaluation of Board progress on 2015-18 Priorities

Strengthen the multi-agency response to Child Sexual Exploitation

- ✓ Sussex Police commissioned an independent evaluation of their comprehensive Sussex-wide CSE campaign that focused on raising awareness of CSE. The evaluation summary stated that campaign made a significant impact on the resident population: 76% demonstrated unprompted recall of the campaign and 90% stated the campaign was relevant and thought provoking.
- ✓ Missing People has provided a successful service in the first year of their three year pan-Sussex contract, 1719 missing episodes were reported to them, and they offered a Return home visit to 95% of the children and young people referred to them. Missing People has also provided a 24/7 Runaway Helpline for children and young people.
- ✓ The Multi-agency Child Sexual Exploitation (MACSE) Bronze operational group, which identifies children living in East Sussex who are at risk of being sexually exploited, and ensures risk reduction plans are in place, has considered 126 new referrals of which 30 are still subject to a MACSE plan.
- ✓ In January 2017, a day-long audit was completed on CSE cases. The auditors recognised a significant improvement in practice within agencies and noted the strength of the MACSE Bronze group in providing excellent oversight, co-ordination and expertise in identifying concerns which others may have missed, producing clear plans and mobilising resources. The auditors also found good evidence of a culture change within agencies with regard to CSE demonstrated by lower tolerance of concerning adult behaviour, more professional curiosity, and good police response to vulnerable children with mental health problems.
- ✓ SWIFT (Specialist Family Services) - a therapeutic service for children who have experienced sexual abuse, has supported 164 children through the year. The feedback from children and parents about this service is very positive: *"SWIFT has been an important part in mine and my daughter's recovery. Staff are very knowledgeable, non-judgemental, good facilitators and good listeners. I don't know what I would have done without this service."*

Strengthen Safeguarding in all schools (including Early Years and Further Education providers)

- ✓ 90 schools have undertaken a full Safeguarding Practice Review. The review provides an externally moderated view on the standards of safeguarding in a school; it covers subjects such as record keeping, reporting concerns and safer recruitment. The reviews also include the voice of children in relation to safeguarding by listening to what children have to say about their school.
- ✓ Safeguarding is now a core element in all school improvement work – for example the Primary Leadership Programme. Monthly monitoring meetings of all schools now always consider standards of safeguarding alongside other concerns.
- ✓ The training programme for Designated Safeguarding Leads (DSLs) has been improved and strengthened. There are now formal DSL networks that are aligned to the 9 existing School-to-School support alliances (Education Improvement Partnerships). The networks facilitate

professional development and build capacity for school-to school support in safeguarding practice.

- ✓ Schools took part in a Section 175 Safeguarding Audit. Where the audit information identified weaknesses in schools safeguarding practice, this information was used to target briefings for Head teachers, Governors and DSLs throughout the year, as well as to inform training.
- ✓ The Whole Governor Body Training programme in safeguarding was updated. There has also been training on the 'single central record' for Governors, school business managers and DSLs and this has been well attended and received.

Strengthen the multi-agency response to children affected by domestic abuse

- ✓ The East Sussex protocol for recognition and working with domestic abuse in schools continues to be disseminated in local schools through the DSL networks. To support implementation a Domestic Abuse specialist from within Children's Services is working with the DSL network, the SPOA (Single Point of Advice) and the MASH (Multi-agency Safeguarding Hub) to implement the protocol and ensure that referral pathways to access support are understood.
- ✓ In order to build upon the dissemination of the protocol and improve confidence and skills of staff, the training leads have participated in a multi-agency thematic review of all DVA (domestic violence/ abuse) training, to ensure training better enables local practitioners to recognise the dynamics and complexity for families affected by domestic abuse and be better equipped to intervene.
- ✓ Work is also ongoing to improve and enhance skills to work with perpetrators as well as victims.
- ✓ All agencies have maintained their focus upon the delivery and oversight required to deliver an effective Multi Agency Risk Assessment Conference (MARAC) to high risk families. This year the Office of the Police Crime Commissioner commissioned an independent Pan Sussex 2nd Generation MARAC Review which demonstrated that East Sussex is working well. However, there has been a 29% increase of referrals to MARAC which is a stark indicator of how many lives are affected by domestic abuse in East Sussex.

Coordinate a multi-agency approach to online safety for children, young people and their families

- ✓ Further work to the LSCB website was completed to ensure it remains useful and up to date. The LSCB website provides guidance and signposting to national resources related to online safety, including a resource guide for professionals, and a resource guide for parents/carers.
- ✓ The LSCB also has a thriving Twitter account which is supported by an apprentice in the Equalities and Participation Team within Children's Services. The apprentice is 18 years old and brings valuable experience of using social media, particularly from a young person's perspective. The LSCB uses Twitter to post awareness raising messages about online safety, for example, we tweeted about the national safer internet day, and anti-bullying week.
- ✓ From a poll tweeted by the LSCB in April 2016, we know that around 75% of our followers are professionals, and around a further 15% are parents/carers, so whilst Twitter it is a useful means of communicating safeguarding messages, we know that we do not reach many young people this way.

- ✓ This highlights the challenge for the LSCB to reach children and young people directly to ensure they have the knowledge and confidence to keep safe online. However, the LSCB does have a significant role in ensuring professionals who work with children and young people, have the knowledge they need about online safety to support children, young people and parents to keep safe online. To achieve this, the LSCB has:
    - Continued to run training courses for professionals on safeguarding in a digital world
    - Contributed to the new Online Safety Guidance and Model Policy for Schools which was produced by SLES and launched in January 2017
    - Ensured online safety is covered within the section 11 safeguarding audit which concluded in 2016/17
    - Attended a national event on the latest on child online safety in the UK, technology, education and policy priorities.

Learning from Board Activity

The Case Review, Quality Assurance, and Child Death Overview Panel subgroups are the LSCB's key mechanisms for evaluating the effectiveness of safeguarding activity and ensure that the Board really makes a difference to local practice and children's outcomes.

The themes and learning from board activity are disseminated in several ways by the LSCB: presentation to the two Local Safeguarding Children Liaison Groups (LSCLG); incorporating themes and learning across all LSCB training; providing learning briefing sessions as part of the LSCB training offer; highlighting SCR learning on the LSCB website; and sharing SCRs with the NSPCC library repository;.

The QA Subgroup regularly scrutinises multi-agency performance data and inspection reports, and conducts an annual programme of thematic and regular case file audits. During 2016/2017 the QA Subgroup carried out thematic audits on neglect, domestic abuse, CSE, children missing from education, and one case file audit of a random selection of cases subject to a child protection investigation. Of the eighteen cases that were audited during this year, 72% were graded as *Good*, which represents a significant improvement compared to 36% graded 'Good' looking back to 2014/2015.

In relation to the audits completed in 2016/17, the auditors found that in the majority of cases:

- ➢ Agencies worked well together and with children and families
- ➢ Social work assessments were analytical, considering the history, siblings and wider factors
- ➢ 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
- ➢ There was 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

During 2016/17, auditor made a number of recommendations to improve outcomes for children; these include:

- The need to consider any risks posed by a parent's current choice of partner in cases where there has been domestic abuse in a previous relationship
- The need for social workers to be aware that health services are provided by a range of different organisations which do not have shared access to records
- Health Visitors and the School Health Service should ensure they share records they receive from key professionals

The LSCB Case Review Subgroup considered cases referred in by group members, professionals from partner agencies, or are identified by the Child Death Overview Panel or via the audits undertaken by the Quality Assurance Subgroup.

In 2016/17 the East Sussex LSCB published one SCR – Child M. The SCR concerned the death of a 17 year old girl who died as the result of a drug overdose in 2013 in the company of at least one adult. This was the final of a series of overdoses which had resulted in hospital admissions and serious health concerns from the age of 15. The themes of this SCR include: exploitative relationships; working with children who abuse drugs and alcohol and are resistant to attempts by family and professionals to support them to change their behaviour; working arrangements in cases where services are being provided for adults and children; work with children who move either in a planned way or go missing across local authority boundaries; and work with 16/17 year olds, including issues of consent and ability to make important decisions in this age group.

The learning and recommendations from this SCR include:

- 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
- The response of acute hospitals to 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
- Use of language by professional when a relation is an exploitative one (i.e. Mr C was referred to as Child M's boyfriend by agencies – this had an impact on perception of risk).

The Case Review group also considered a number of other cases which did not meet the threshold for a Serious Case Review but required multi-agency consideration to identify relevant learning. One cases considered involved a large family with issues of long term neglect in the context of parental learning difficulties and variable engagement with the support offered. As a result of the oversight of the Case

Review group a multiagency learning event was held in December 2016 which brought together front line professionals and their managers working with this family.

The Child Death Overview Panel (CDOP) is a statutory function of the East Sussex LSCB. If, during the process of reviewing a child death, the CDOP identifies: an issue that could require a serious case review (SCR); a matter of concern affecting the safety and welfare of children in the area; or any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area, a specific recommendation is made to the relevant LSCB.

During 2016/17 there were no recommendations made to the LSCBs regarding the need for a serious case review. The following recommendations were made regarding matters of concern about the safety and welfare of children, and wider public health concerns:

- The LSCB should ask all member agencies to review the information they provide to parents about feeding young children to ensure that it includes reference to the need for supervision of young children whilst eating and highlights the risk of choking from certain foods.
- The CDOP is concerned regarding a problem with the coronial process namely that the parents had not been informed of the date of the post mortem and that almost a year after the death the GP had still not received a copy of the post mortem or the cause of death. The CDOP recommends that the chair of the LSCB raise these concerns with the coroner in Southwark.

Of the 22 deaths of East Sussex children reviewed during 2016/17, four were identified as having potentially modifiable factors where action could be taken to reduce the risk of future deaths. In summary, the relevant preventable factors related to foetal anomaly scanning arrangements and practice in the East Sussex Hospital Trust, service provision for adolescents who abuse drugs, service provision within the East Sussex Hospital Trust for a boy suffering from a viral illness and the need for supervision of children whilst eating to avoid choking incidents.

One of these deaths occurred three years ago and was the subject of a serious case review. The two deaths in ESHT were investigated as serious incidents. There are action plans in place to respond to the service limitations in all four deaths.