

Issue 7

Winter 2008

# NEWSLETTER



## WAKEFIELD & DISTRICT safeguarding children board

### *Welcome.....*

This is the final Safeguarding Children Board Newsletter of 2008. The Wakefield and District Safeguarding Children Board would like to take this opportunity to thank everybody for their hard work over the last year, and for their continued efforts to safeguard and promote the welfare of children and young people in the Wakefield district. Working in the field of safeguarding is a difficult and demanding task, and tragic events in other parts of the country have attracted a great deal of attention in the media, and will undoubtedly have made many of us reflect on the challenges ahead. It is important to remain positive, and to remember the things that we do well. Where we can make improvements, we should be open and honest, and accept constructive criticism from others. Above all, we must remember to keep the child at the centre of our work, and if in doubt, it is always safer to discuss or refer. As Lord Laming said: "never, ever do nothing".

The Wakefield and District Safeguarding Children Board would like to offer all of its partners our very best wishes for 2009.

# Important Safeguarding News

Few can have failed to be aware of recent events in Haringey and latterly, in Sheffield. It is inevitable that in the circumstances, our collective efforts to safeguard children will come under close scrutiny, both internal and external.

In October, prior to the public outcry about Baby P, the DCSF announced a "stock-take" of Safeguarding Children Boards. This stock-take had been planned since the DCSF's 2006 Priority Review *Local Safeguarding Children Boards: A Review of Progress*.

In November, the case of Baby P came into the media spotlight following the trial of the adults involved in his death, and the Executive Summary of Haringey's Serious Case Review was published. This caused an even greater focus of interest on safeguarding of vulnerable children. As a result, the Secretary of State, Ed Balls, announced that Lord Laming, who undertook the independent inquiry into the death of Victoria Climbié, would be asked to undertake a fresh audit of safeguarding nationally. Therefore the proposed stock-take will now be undertaken by Lord Laming.

In addition, the Secretary of State ordered that OFSTED undertake an immediate inspection of safeguarding in Haringey. This was published by OFSTED on 1<sup>st</sup> December, and as a result of this, interim management arrangements are now in place in Haringey.

It is not yet clear exactly how Lord Laming will undertake his work, however it is evident that Safeguarding Children Boards and their constituent partners will face scrutiny of their safeguarding processes and systems. Lord Laming has already written to the Directors of Children's Services nationally, asking them to satisfy themselves of the safeguarding arrangements that are within place, and to report back to him by 5<sup>th</sup> December. He will also be making personal visits to a number of authorities in January (the closest to us is Hull).

As a result of all this activity, agencies of the Safeguarding Children Board in Wakefield are in a process of audit/review. Within WMDC Family Services, a plan is in place to enable the ongoing review of work to safeguard children, and it is likely that similar plans will be put into place by partners. NHS Wakefield District have been required by the Strategic Health Authority to report on their own safeguarding arrangements and processes by late December.

If you have concerns about safeguarding processes within your own, or another, agency, or suggestions as to how safeguarding can improve, now is the time to speak. Let a senior manager in your organisation know, and if you wish, notify the Safeguarding Children Board on 01924 302626 or [wdsbc@wakefield.gov.uk](mailto:wdsbc@wakefield.gov.uk)

Documents related to the case of Baby P, and to the stock-take of safeguarding, can be found on the Every Child Matters website [www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk) or by contacting the Wakefield Safeguarding Children Board.

# Safeguarding Training 2009

The new multi-agency Safeguarding Training Brochure will be published in early January, with courses starting from 1<sup>st</sup> April. In 2009, we will be running the following courses:

- Working Together
- Assessing Risk *NEW*
- Working with Fathers
- Child Sexual Abuse
- Court Skills
- Introduction to CP Law *NEW*
- Domestic Abuse (Introductory and Advanced)
- Parents with Learning Disability *NEW*
- Parental Mental Illness
- Sexual Exploitation
- Practice Issues in Safeguarding Teenagers *NEW*
- Alcohol and Drug Misuse

The training courses in relation to the Child Wellbeing Model will also continue in 2009.

In addition, we also plan to offer a number of safeguarding "master-classes" during the year, aimed specifically at managers and advanced practitioners.

We will be continuing to offer the introductory, basic awareness course online. This course is free of charge, and can be accessed via any internet-enabled PC. Check the current training brochure for details ([www.wakefield.gov.uk](http://www.wakefield.gov.uk) then search for "safeguarding").

Wakefield and District Safeguarding Children Board now has a full-time Training Officer (Jane McGill). Funding for the enhanced post has been kindly provided by NHS Wakefield District, and it is hoped that the increased capacity will enable the Safeguarding Children Board to continue to develop it's training agenda over the course of 2009.

Finally, please remember that if you apply for a training course, and are offered a place (you will normally find out if you have a place within a week of application) please put the dates in your diary. If you are then unable to attend, please let the training team know as soon as possible, so that your place can be offered to someone on the waiting list. We continue to have a problem with people simply not attending, and from January onwards, your team may be charged an administration fee of £50 to contribute to the trainer's expenses. We would like to avoid this, so please help us out!

## Who is the Safeguarding Children Board?

Are you curious to know who actually makes up the Safeguarding Children Board? Under Working Together to Safeguard Children, certain agencies are required by law to be a part of their local Board, and in Wakefield, agency representation is good. Here are the current board members:

Elaine McHale	WMDC Director of Family Services (Chair)
Dr Gill Pinder	Consultant in Public Health Medicine (Vice Chair)
Max Lanfranchi	Assistant Chief Probation Officer
Superintendent Mark Mulcahy	West Yorkshire Police
Catherine Hall	NHS Wakefield District - Nurse Consultant
Janice Hawkes	Assistant Director - Barnardos (VCS representative)
Tracey McErlain-Burns	Mid Yorkshire Hospitals Trust - Chief Nurse
Noreen Young	SW Yorkshire MH Trust - Director of Nursing
Dr T Myint	NHS Wakefield District - Designated Doctor
Paul Walsh	WMDC Family Services - Service Director
Jayne Robinson	WMDC Family Services - Service Manager
Paul Makin	WMDC Family Services - Service Director
Gareth Sands	Governor HMP New Hall
Stephen Crofts	WMDC Family Services - Service Manager

Richard Fawcett (LSCB Business Manager) and John Crosse (WMDC Community Law Manager) both act as advisors to the Safeguarding Children Board.

In addition, the Safeguarding Children Board also has four sub-committees which all meet on a bi-monthly basis. These are:

**Training sub-committee** - this sub-committee is responsible for the co-ordination of all Safeguarding Children Board training, and also helps to co-ordinate the delivery of "in house" training within agencies. The sub-committee is a useful means of identifying training needs within agencies, and also helps to identify local and national drivers in relation to safeguarding training. The Training sub-committee is chaired by Tracey McErlain-Burns. Tracey is also a member of the Kirklees Safeguarding Children Board and this helps in the sharing of good practice and ideas.

**Performance Management** - this sub-committee takes responsibility for the collating and analysis of multi-agency data relating to safeguarding performance, and is responsible for identifying areas of strength and areas requiring attention. The sub-committee provides a report to the Safeguarding Children Board twice a year, which is also published on the Safeguarding Children Board website. The Performance sub-committee is chaired by Paul Walsh.

**Quality and Review** - chiefly concerned with issues of practice and quality, the Quality and Review Sub-Committee also has a central function in relation to Serious Case Reviews, becoming the Serious Case Review Panel when required. The Quality and Review Sub-Committee is chaired by Jayne Robinson.

**Child Death Overview Panel** - this sub-committee is slightly different to the others in that it is a statutory requirement. The Panel has the responsibility of reviewing ALL child deaths in Wakefield. There is a strong emphasis on health, because of course most deaths occur as a result of health issues, but Family Services, the Police and the Education Welfare Service are all represented on the panel, in order to bring a social and educational dimension where required. The Panel is chaired by Dr Gill Pinder, who is ably assisted by Jan Shakespeare (CDOP Administrator).

The sub-committees are the place where a lot of Safeguarding Children Board work gets done, and each agency is represented on each sub-committee. As a result, there is a strong link between the sub-committees and front-line practice, and in many respects, the sub-committees act as a link between practitioners and the Safeguarding Children Board.

All practitioners are able to contribute to the sub-committees, and therefore also to the Safeguarding Children Board, by raising issues with their agency representative, who can then bring them to the sub-committee.

## List of agency sub-committee members:

### Training

Tracey McErlain-Burns (Chair)	Director of Nursing - Mid Yorks NHS Trust
Angela South	Named Midwife - Mid Yorks NHS Trust
Rachel Holmes	WMDC Family Services - Safeguarding Co-ordinator
Richard Fawcett	LSCB Business Manager
Jane McGill	LSCB Training Officer
Geraldine Allen	Named Nurse - Mid Yorks NHST Trust
Gill Newey	WMDC Family Services - CWB Co-ordinator
Julie Lodge	Named Nurse - SWYMHT
Maureen Kelly	Named Nurse - NHS Wakefield District
Judy Colquhoun	WMDC Family Services - Senior Childcare Quality Controller
Beverley Fearnley	Safe at Home
Sgt Lesley Robinson	WY Police
Dianne Gott	HMP New Hall - Training Manager
John Crosse	WMDC Legal Services
Carol Clark	WY Probation

### Performance Management

Paul Walsh (Chair)	WMDC Family Services - Service Director
Angela South	Named Midwife - MY Hospitals NHS trust
Dr Kiki Vratshovska	Consultant Paediatrician
Gill Marchant	Named Nurse NHS Wakefield District
Jenny Goodchild	WY Probation
Julie Lodge	Named Nurse SWYMHT
Marissa Osborne	WMDC Performance Information Officer
Maxine Hinks	Wakefield YOT
DI Mick Brown	WY Police
Rachel Holmes	WMDC Family Services - Safeguarding Co-ordinator
Richard Fawcett	LSCB Business Manager

### Quality and Review

Jayne Robinson (Chair)	WMDC Family Services - Service Manager (Safeguarding)
Catherine Hall	Nurse Consultant - NHS Wakefield District
Phil Lynch	HMP New Hall
Janice Hawkes	Assistant Director - Barnardos
DI Mick Brown	WY Police
Jennie Rushworth	CAFCASS Manager
Jenny Goodchild	WY Probation
Paul Makin	WMDC Family Services - Service Director
Stephen Crofts	WMDC Family Services - Service Manager (YDSS)
Rachel Holmes	WMDC Family Services - Safeguarding Co-ordinator
Richard Fawcett	LSCB Business Manager

## Child Death Review Processes

Working Together to Safeguard Children gives Safeguarding Children Boards the duty to review ALL child deaths in their area, regardless of the cause of death. The purpose of this review process is to establish the cause of death and ultimately, to establish whether the death could have been prevented.

Working Together to Safeguard Children gives two duties:

- For Safeguarding Children Boards to provide a rapid response to investigate all cases where a child dies suddenly or unexpectedly (SUDIC)
- For Safeguarding Children Board to establish a panel to have an overview of ALL child deaths, regardless of nature or cause.

In cases where a child dies suddenly or unexpectedly, a nominated paediatrician with SUDIC responsibility (in Wakefield this is Dr Kiki Vratchovska) will immediately begin to undertake enquiries. In cases where the cause of the death is immediately apparent, this process may be straightforward. However in some cases, these enquiries may be more complex, and may involve investigative work, and consultation with any other professionals who knew the child. The process is required to support the work of the Coroner by providing a report no later than 28 days after the death. The death is discussed at a multi-agency case discussion that is held once the final Post Mortem results are available (ideally no later than 2-4 months after the death).

Once the SUDIC process is completed, the death will be reviewed by the Child Death Overview Panel (CDOP), which sits on a bi-monthly basis to review ALL child deaths. The SUDIC paediatrician will provide a detailed report for the Panel.

In Wakefield, the CDOP is chaired by Dr Gill Pinder, and administrated by Jan Shakespeare. The Panel consists of representatives from all parts of the Wakefield health "community" as well as representatives of Family Services. As part of the review process, any professional agencies that knew the child will be required to complete a questionnaire that provides the CDOP with background information, to assist in the review process. The questionnaires are designed and produced by the DCSF.

Families are notified of the CDOP process, but do not attend the CDOP meetings, and do not receive specific feedback on the discussions that were held.

All concerned with the SUDIC and CDOP processes are aware that any child death is a tragedy for his or her family, and are aware of the need to treat families with sensitivity, discretion and respect at all times. The CDOP also recognises that the death of a child can also be a tragedy for professionals who knew them, and it is important to recognise this and liaise with people accordingly.

It is important to know that the SUDIC and CDOP processes are not the same as a Serious Case Review. However occasionally, the SUDIC and CDOP processes may run alongside a Serious Case Review. On rare occasions, investigations under the SUDIC or CDOP processes may uncover information that then leads to a Serious Case Review.

If you would like more information about these processes, you can find information in Chapter 7 of Working Together to Safeguard Children, or can contact the Wakefield and District Safeguarding Children Board on [wdsbc@wakefield.gov.uk](mailto:wdsbc@wakefield.gov.uk)

# E-Safety Strategy

The Wakefield Safeguarding Children Board and Wakefield and District Safeguarding Adults Board have joined for the first time, to produce a joint E-Safety Strategy to assist agencies in helping to keep children and vulnerable adults safe from all forms of abuse that are perpetrated by use of technology. This includes sexual abuse and grooming of children using the internet, "cyber" bullying, financial exploitation by internet and email etc.

Once the consultation process and draft strategy is completed, and approved by the Safeguarding Boards, the strategy will be published.

We will also be publishing guidance for the public and professionals on both Safeguarding Board websites.

The West Yorkshire Safeguarding Children Procedures include information and guidance on how to respond to abuse perpetrated by the internet.

## **NEWSFLASH.....**

In a letter to OFSTED on 1<sup>st</sup> December 2008, Secretary of State Ed Balls ordered that when a Safeguarding Children Board has undertaken a Serious Case Review that has been evaluated by OFSTED as "inadequate" the Safeguarding Children Board must redo the Serious Case Review with a different independent chair, and must report the findings directly back to Ed Ball's office. This also applies in retrospect to any Serious Case Reviews previously judged inadequate. This is a response to concerns about the way in which Haringey undertook the Serious Case Review in relation to Baby P. Thankfully, this does not affect Wakefield, and hopefully never will!

# Serious Case Reviews

## Learning Lessons Locally and Nationally

Currently, there are three ongoing Serious Case Reviews in Wakefield. All are due for completion in early 2009, and as you would imagine, this has meant a great deal of investigative and analytical work for some agencies. The Safeguarding Children Board wishes to thank the people who have contributed to these Serious Case Reviews, and in particular the Safeguarding Children Board members who have agreed to chair the Overview Panels and write the Overview Reports. They are Jennie Rushworth (CAFCASS Manager), Gareth Sands (Governor HMP New Hall) and Stephen Crofts (WMDC YDSS Service Manager). Their efforts are very much appreciated by the Board. Thanks also to Janice Hawkes (Assistant Director - Barnardos) whose efforts in producing our last Serious Case Review Overview Report were very positively evaluated by OFSTED.

Once completed, the new Serious Case Review Executive Summaries will be published on the Safeguarding Children Board website. Agencies will receive feedback on the Serious Case Review outcomes internally, and some staff who were particularly involved will receive de-briefings where required. Please remember that although a Serious Case Review is not a blaming exercise, and even when good practice is identified, being involved in a case that is subject to a Serious Case Review is often very hard for professionals. Please support your colleagues.

### *OFSTED - Learning Lessons 2008*

OFSTED has recently published their "Learning Lessons 2008" report, which provides national information on how Safeguarding Children Boards have undertaken Serious Case Reviews (it also includes their gradings) as well as themes arising from the investigations within these reviews. It can be found on the Every Child Matters website. This report highlights issues such as a perceived lack of independence, and a lack of self-analysis and self-criticism as factors that undermine many Serious Case Reviews nationally.

### *Analysing Child Deaths and Serious Injury Through Abuse and Neglect: Biennial Analysis of Serious Case Reviews*

Every two years, the DCSF commission an analysis of Serious Case Reviews nationally, to try to detect common themes etc.

The last published analysis covers 2003 to 2005 (a new one is expected shortly), and some key points that arise in this are:

- Approximately half of Serious Case Reviews involve children of less than 1 year old
- Slightly over half are male
- Three quarters of children subject to Serious Case Review are white/British
- Two thirds of Serious Case Reviews involve death of the child. The remainder involve serious injury
- Physical assault is by far the most common factor, being the primary cause in a third of Serious Case Reviews. Neglect is the second most common factor.
- Serious Case Reviews are spread evenly throughout the country, and there are no significant geographical variations.
- Only 12% of Serious Case Reviews involved a child subject to a CP Plan at the time of the incident.
- However 22% involved children who had been subject to a CP Plan at some stage in their life.
- In 20% of cases, parents had been known to children's social care as a child.
- Domestic violence was present in two thirds of households
- Substance misuse by adults was a factor in over half of Serious Case Reviews
- Mental health problems in adults were a factor in over half of Serious Case Reviews.

- In almost 50% of Serious Case Reviews that were analysed, the case was being managed at Level 1 or 2 of the CAF/CWB Model (i.e. the level *before* intervention by children's social care).
- In only 12% of cases, the child was subject to a Child Protection Plan.
- In many of these cases, there had previously been "threshold wrangles" about whether the case met the threshold for intervention by children's social care.
- In over two thirds of cases, parents had been perceived by agencies as "not co-operating" (to varying degrees) with professionals.

Information like this can be used by agencies such as Family Services Safeguarding and Family Support Directorate, and by the Safeguarding Children Board, to help strengthen safeguarding services, by knowing where the most risky areas are.

The Biennial Analysis includes lots more detailed information, which can be of assistance to workers in assessing risk in ongoing cases, and for strategic managers in planning and evaluating service delivery. The full document, which is extremely interesting, can be downloaded from the Every Child Matters website at:

<http://www.everychildmatters.gov.uk/socialcare/safeguarding/seriouscasereviews>

## Wakefield Serious Case Review - Executive Summary Published

The Serious Case Review into the death of a child in Wakefield was completed in April 2008, and has now been evaluated by OFSTED. We were awarded an "adequate" rating, although the Overview Report (authored by Janice Hawkes at Barnardos) was described as "excellent" and several of the constituent management reviews were rated as "good".

The Executive Summary can be downloaded from the WDSCB website ([www.wakefield.gov.uk](http://www.wakefield.gov.uk) and search under S for Safeguarding).

Agency Action Plans have been in place for some time, and are being monitored by the Safeguarding Children Board.

# Referring to Children's Social Care

If any person has a concern that a child may be suffering or at risk of, significant harm, they have a duty to refer this to their local children's social care department. In Wakefield, this is within Wakefield Council's Family Services directorate.

All referrals should be made to Social Care Direct, which is a team of professionals that deal with all initial referrals about a child or an adult.

## Making a Referral

When making a referral to Social Care Direct, it is useful to remember the following:

- Do you have all the relevant details? It is helpful to know full names of all family members (including parents or carers) and dates of birth, addresses etc. This will help Social Care Direct to cross-reference in order to check whether any parties are already known.
- Do you have parental consent to make the referral? If you are expressing child protection concerns, you do not need parental consent, however it is good practice, if you are a professional, to have informed the family that you intend to refer them (unless doing so may place a child at increased risk). If you are requesting support for a family, but the child is not at risk of harm, you *will* need their consent.
- If you are seeking support for a family, what has already been done to help them? If they feel that at this stage, the need for social care involvement is not clear, Social Care Direct may advise that you, or another professional, implement the Child Well-being Model instead.
- It is also useful if you consult with any other professionals who know the family, if you are aware of them. This will mean that you can give a clearer, fuller picture of the level of need when you speak to Social Care Direct. It will also give Social Care Direct a guide as to which professionals are involved already, so that they can make an informed decision as to how to respond to the referral you are making.
- Making a referral is more effective if you know why you are making it. Therefore it is worth thinking about your reasons for making the referral, and discussing with a colleague or your manager. You should also be clear about how you expect social care to respond to the referral.
- Referrals to Social Care Direct by professionals can be made by telephone, but must be followed up in writing by the referrer. You should do this by using the Social Care Direct referral form which can be found on the WMDC website:  
<http://www.wakefield.gov.uk/HealthAndSocialCare/SocialCareDirect/default.htm>
- Although members of the public can ask to remain anonymous, professionals who are making the referral in their professional capacity can not.
- If you are unsure whether or not to make a referral, ring Social Care Direct on 0845 850 3503 and seek their advice.

## Resolving Disagreements

If you are not happy with the outcome of your referral, you can discuss this with Social Care Direct, and can, if you wish, speak to a Social Care Direct manager. It may be helpful to inform your own manager, so that they can speak to Social Care Direct themselves. If it is not possible to resolve the difference of opinion in this way, you, or your agency, must put the matter in writing at a more senior level.

The Safeguarding Children Board advise you to ensure that you keep clear records of all discussions, in case these records are required in the future.

# Safeguarding Adults

Dennis Appleyard (WMDC Family Services – Adult Protection Manager) has provided the following information from the world of adult safeguarding.

In relation to safeguarding vulnerable adults, the biggest issue nationally concerns the ongoing consultation regarding the future of the 'No Secrets' guidance. This was launched in 2000 and is equivalent to 'Working Together' but without Working Together's statutory backing. The consultation document considers in a high level of detail most of the issues, including leadership, the roles of the Police, NHS and Housing, as well as the need for legislation and definitions. Anyone with an interest in the safety of vulnerable adults should take this opportunity to contribute. The link is:

[http://www.dh.gov.uk/en/consultations/liveconsultations/DH\\_089098](http://www.dh.gov.uk/en/consultations/liveconsultations/DH_089098)

Locally of course, the big news is that Wakefield is the only council in Yorkshire and Humber to receive the three-star, double excellent rating for Adults' services – the highest accolade possible from the Government's Commission for Social Care Inspection. Well done to everybody concerned!

If you are a professional who works mainly with children, you may still encounter situations in which you think that a vulnerable adult may be at risk. If this happens, you need to speak to Social Care Direct on 0845 850 3503.