

West Yorkshire Inter-agency Safeguarding Children Procedures

The first update to the West Yorkshire Safeguarding Children procedures is about to take place. The procedures have been in place since last July and have generally been well received. The format has changed slightly since they were first launched to enable the font size to be changed more easily, bringing them in line with national

Summary of Changes Made to Current Version of Procedures in September 2007

1. Website procedures now in *modified version* to meet website standards, eg being able to increase font size by clicking on a + or -.
2. Several minor amendments, eg Chapter 3.1.6 (Recording that a Child is the Subject of a Child Protection Plan). Amended from *Register Custodian* to "*Designated Manager*", or when clicking on *emergency duty team* it takes you to the contact details.
3. New keywords added: "*Children in hospital*", "*school nurse*", "*paediatric assessment*".
4. Chapter 3.1.3 (Strategy Discussions). In section 3 (When the Strategy Discussion should be a Meeting), additional bullet point "*following the death of a child where there are child protection concerns, and there are surviving siblings, or other identified children who are vulnerable*".
5. Chapter 5.1.6. (Child Abuse and Information Communication Technology). New section 4 on "*Guidance Upon the Discovery of Indecent Images of Children*". This concerns professionals accessing indecent images.
6. Chapter 5.1.12 (Children Living Away from Home). In section 6 (Children in Hospital), additional paragraph (after 4th para.): "*No child known to Children's Social Care Services who is an inpatient in a hospital and about whom there are child protection concerns should be discharged home without a referral ... welfare*". (note – error as this para is repeated).
7. New Part 6 "*Safe Workforce*". 2 chapters moved into this Part: chapter 6.1.1 (previously 2.1.3) (Safe Recruitment, Selection and Supervision of Staff) and chapter 6.1.2 (previously 5.1.4) (Allegations Against Persons Who Work With Children).

8. In Part 7 (Individuals Who Pose a Risk To Children) new chapter 7.1.1 *“Risk Posed By People with Convictions Against Children”* and 7.1.2 *“List of Offences”*. 7.1.1 includes relevant offences, assessing risk, factors to consider, management of convicted sex offenders, concerns about people suspected of offences and exchanging information.
9. New chapter 5.1.23 *“Intimate Care Good Practice Guidelines”*

Proposed Amendments for February 2008 Procedures Update

1. New chapter 5.1.7 *“Children Abused Through Sexual Exploitation”*.
2. Amendments to be made to chapter 3.1.5 (Initial Child Protection Conferences), para 12.2 (Other Agency Reports to Conference). requiring other agencies to share reports in a similar way to social workers, ie 2 working days in advance to parents and 1 working day to conference chair. It follows that chapter 3.1.8 (Child Protection Review Conferences) section 4 (Reports) should also be amended in a similar way, ie report to be provided 3 working days in advance to parents and 3 working days in advance to the conference chair.
3. New Part 9 *“Investigation of Unexpected Deaths of Children”*.

WDSCB Training

The WDSCB is please to welcome Liz Rimmington and Jane McGill to the Safeguarding Children training and development unit.

Hello from Jane and Liz,

We are currently working on the 2008/9 Multi–agency training brochure.

Our main aim is to produce high quality multi agency training in line with national and local drivers, paying special attention to the lessons learnt from serious case reviews.

The board offers high quality multi-agency training within the Wakefield District to all people whose work involves children and young people.

We aim to build an approachable and professional training unit which is friendly and accessible to all. In addition to standard training events’ we hope to offer Master classes, networking and localised workshops in the future.

Details of all WDSCB training courses are available now on the WDSCB website, however the training brochure will be receiving a facelift in the near future.

We hope to regularly contribute to the W.D.S.C.B Newsletter.

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Madressah protocol



The protocol for those working in and with Madressahs (the schools attached to Mosques) was agreed and signed of by the WDSCB in August 2007. These were launched with leaders of the Mosques in November at an event held in Sandal & Agbrigg Community Centre. Shakeel Hafez who has received an award for similar work he has carried out in Kirklees, was the main speaker at the event which was opened by Lyn Burns, Service Director, Safeguarding and Family Support (Family Services).

A copy of these procedures can be found on the WDSCB website. A further phase of training is now underway and future information on these courses will be available on the WDSCB website and on Ipoint.

Safeguarding Unit

As part of the reconfiguration in Family Services we have brought together a number of functions into a new safeguarding unit. The unit includes the current WDSCB Business Manager, the acting Child protection coordinator and the Adult Safeguarding Board Manager. The unit therefore brings together three specialist areas into one generic safeguarding team. This will enable good practice developed in the different fields to be shared across both adults and children's work and builds on the 'Think Family' theme adopted by Family Services.

Rachel Holmes, the child protection coordinator, is supporting Jayne Robinson in her role as Local Authority designated officer for allegation management. If you have concerns about a member of staff the Allegations procedures in the West Yorkshire Safeguarding procedures must be followed. Contact Rachel Holmes on 01924 304290 for any concerns in this area or make a referral through social care direct on 0845 8503503.

Rachel provides advice to all agencies regarding child protection issues and chairs strategy meetings where a child is thought to be involved in sexual exploitation as well as other complex cases. Rachel is the link for schools to contact if they have concerns about safeguarding children and also provides all training for schools regarding safeguarding children.

Dennis Appleyard is the Safeguarding Adult Board Manager. Dennis provides support to the Wakefield & District Safeguarding Adult Board and ensures the adult protection procedures are kept up to date and that the adult protection processes are adhered to. He also has responsibility for Serious Case Reviews on adults.

Rosie Faulkner is the Safeguarding Children Board Business Manager. Rosie provides support to the WDSCB. She has responsibility for developing the safeguarding children procedures and works collaboratively across West Yorkshire to ensure the procedures are up to date and in line with government guidance. She also has responsibility for the WDSCB training and serious case reviews.

Hidden Harm

Introduction

The Advisory Council on the Misuse of Drugs produced in 2000 the 'Hidden Harm' Report. This focuses on parental problem drug use, and the actual and potential effects on children.

Headlines of the Report

- There are between 250 000 and 350 000 children of problem drug users in the UK – about one for every problem drug user.
- Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.
- Reducing the harm to children from parental problem drug use should become a main objective of policy and practice.
- Effective treatment of the parent can have major benefits for the child.
- By working together, services can take many practical steps to protect and improve the health and well-being of affected children.
- The number of affected children is only likely to decrease when the number of problem drug users decreases.

The Local Picture

Adult drug treatment is provided by Turning Point, through three community-based teams. There is the District Alcohol Service. This has recently – through a Turning Point Bid to the Big Lottery Fund – gained two 'Alcohol "Parenting" Workers'. These individuals will work with the children of parents experiencing the effects of alcohol misuse. Further detail on these workers is available on request. The Joint Commissioning Support Officer is working to develop a protocol of working between these workers and the Young Carers' Service.

Within district there are the Safeguarding Procedures for Substance Misuse, in relation to child protection.

There are separate Joint Commissioning Groups for adult drug (and alcohol) treatment services, and the substance misuse service for young people.

Action Plan

An action plan has been developed, designed to facilitate closer lines of working between the young people's joint commissioning group and that for adults, with the overall accountability and ownership being at the level of the Wakefield & District Safeguarding Children Board.

The plan will build on the Wakefield Safeguarding Children Substance Misuse procedures, to implement appropriate systems (in relation to child protection) within adult treatment services.

The action plan is available on the WDSCB website under WDSCB Action Plans.

Simon Rowe
Joint Commissioning Support Officer
January 2007



Voluntary Sector

The Voluntary Sector Safeguarding Children training group has received financial support from Children's Fund to enable it to run a training for trainers course aimed at developing safeguarding trainers for the Voluntary and Independent sectors. The course will be run by Pre-school Learning Alliance in conjunction with the WDSCB. The course began at the end of January and successful participants will receive a City & Guilds Training certificate and will be expected to join the Voluntary sector training group to provide training to the sector. This group is supported by the WDSCB who quality assure the courses they provide ensuring that information is as up to date and accurate as possible and assisting the trainers if any difficult issues come up which they don't feel equipped to deal with.

Anyone from the Voluntary, Independent, private Sectors who would like to know more about the training on offer should access the WDSCB website on www.wakefield.gov.uk, search for safeguarding and scroll down to find information for voluntary sector. This website also includes sample child protection policies which can be copied and amended for individual organisations use. These procedures will be updated in the near future.

Sports and recreation procedures

These procedures which are currently available on the WDSCB website are in the process of being updated offering greater clarity to schools a swimming centre staff on roles and responsibilities. More information will be available in the next newsletter.



Serious Case Reviews

A serious case review is a multi-agency review of the practice of all agencies when a child dies or is seriously injured and neglect or abuse are thought to be a factor. The aim of the review is to learn lessons about the way agencies have worked together in order to lesson the possibility of future death or injury. The action plan to the serious case review which took place last year is now almost complete. The main areas covered by the review are:

- Tiers of domestic abuse training to be developed
- All staff to have training in domestic abuse
- Assessments should wherever possible include the fathers views
- Social workers to be more probing in their assessments
- Health services to develop a means of providing better liaison between acute services and community services

A copy of the executive summary of this and other serious case reviews is available on the WDSCB website.

Child Death Reviews

The investigation of all unexpected deaths in childhood from birth to the 18th birthday plus the review of all deaths in childhood are new requirements from the 1st April, 2008 for local Safeguarding Children Boards. Work has taken place locally, regionally and nationally and Wakefield District Safeguarding Children Board is on track to meet these requirements within the timescale. Working Together extends the practice (which has been in place for some years now) of reviewing all unexpected deaths in the first year of life. The requirement now extends this to the 18th birthday and this needs the agreement of formal protocols with, amongst others, the Police and the Coroner.

Initial work at local level has been played into a west Yorkshire-wide protocol recently agreed by all West Yorkshire Safeguarding Children Boards. This is underpinned by hospital-based detailed clinical procedures – in our case currently at an advanced stage of development and led by Drs Karen Stone and Fraser Scott at Mid-Yorkshire Hospitals NHS Trust. This new work requires the designation of a specialist team (termed the SUDIC Team) who will co-ordinate all aspects of the protocol.

The protocol covers what should happen to child and family in the emergency department including the collection of information and liaison with Police, the Coroner and Social Care Direct. It also covers initial questions regarding possible cause of death, further information gathering (including a visit to the place of death if this is appropriate), information to assist the post mortem examination and finally case discussion meeting and reporting to the Coroner and the Child Death Review Panel.

The second requirement from the 1st April, 2008 relates to the review of all deaths from birth to the 18th birthday. Although this aspect of good practice has been in place in Wakefield since 2003, we have been reviewing our processes to ensure that we can comply with what is required. Wakefield's work has been used nationally and regionally – as a National pilot Safeguarding Children Board (1 of 9) in which we have played a full role in the formulation of National guidance. A West Yorkshire-wide protocol and data collection questionnaire has also been led by the work undertaken in Wakefield.

The review process starts with the notification of a baby or child's death which triggers dissemination of a questionnaire to a range of local professionals for completion. Completed questionnaires are collated for discussion at regular child death review panel meetings where membership is drawn from a standing group (independent of the case) of professionals from all local agencies.

Over 2004/2006 inclusive, 52 deaths of children from the ages of 1 month to the 18th birthday have been reviewed in this way. Notification of deaths in babies under 1 month is not fully secured so we have an incomplete analysis of these deaths. We are confident that the 52 records are a relatively complete picture as a result of comparison with national statistics.

Of the 52 deaths, 54% were in the under 5's (28) and 10% were in the 16/17 year-old age range (5). In two thirds of cases (34) the death was defined as unexpected using Working Together definitions.

Of the unexpected deaths, 19 (56%) were as a result of accident and 6 (18%) as a result of infections. Of all deaths accidents account for 37% which reflects the national and regional picture of accidents being the lead cause of death in childhood. Overall, 52% of children dying were known to Children's Social Care. Although a significant proportion were known as a result of them being children with disabilities, nevertheless this proportion appears high and will be examined more closely. Postcode data has been mapped and although the work needs further refinement, there is an indication of childhood deaths where deprivation and disease are highest.

We are refining our local process to be Working Together compliant by the 1st April, 2008 and will add to the gathering knowledge about the causes of death in childhood locally and hence the formulation of preventative strategies.

Dr Gill Pinder
Consultant in Public Health Medicine Wakefield District PCT/ Vice Chair Wakefield
Safeguarding Children Board

UK government supports health professionals working in child protection

High profile cases in child protection has caused some difficulties in recruiting paediatricians into this area of work and many paediatricians have been deterred from giving expert evidence in suspected child abuse cases. A recent study showed some health professional's reluctance to report child abuse cases. These difficulties have resulted in The Chief Medical Officer producing a consultation document '*Bearing Good Witness*'. (Available on DOH website).

On 21 July 2007, a joint statement signed by two ministers was sent to all health professionals working in the field of safeguarding children (child protection) to reassure them about their role and give them the confidence to take forward and share any concerns they might have. This is an official acknowledgement to health professionals working in this difficult and stressful area of protecting children from harm.

Also in July 2005, Professor Sir Alan Craft (president of the Royal College of Paediatrics and Child Health at that time) wrote a personal letter to all the paediatricians reminding them not to work in isolation. His comments are re-iterated in the ministerial letter and the key messages are:

- Our first duty is to the children
- We must act single-mindedly in the interest of the child
- Health professionals undertaking child protection work are part of multi-agency teams and need to be aware of the relevant legislation and guidance
- The European Convention of Human Rights underpins current good practice. The principal purpose of Article 8 (everyone has the right to respect for his or her private life) must be the safety and welfare of the child. By working in partnership with parents and carers, sharing information and concerns with them (unless this would place a child at risk or harm) and involving them to the fullest extent possible, professionals will meet their own professional standards and put themselves in the best position to ensure that their actions meet the requirements of the Human Rights Act.

- In reaching sound judgements professionals should take account of all relevant factors, consider all the options or alternatives, keep an open mind, consult appropriately, recognise the limits of their expertise, and acknowledge where there is lack of information
- Health professionals role when giving evidence in court is as an independent advisor to reach an appropriate decision, not to advocate to a particular party or theory
- Professionals should not feel inhibited in reporting their concerns. They would not be liable for defamation unless it could be proved that they acted maliciously

Despite all these difficulties paediatricians and other health professionals have continued to work in this field to protect children. The ministerial letter is an added bonus for health professionals which is timely and quite reassuring.

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12th November 2007

Any queries raised by this newsletter should be directed to
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If any one has any articles or letters for inclusion in the next newsletter please contact us by WDSCB@wakefield.gov.uk or phone Jean Durham on 01924 302626.