Walsall Safeguarding Children Board

Annual Report

2017-18

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1. Introduction

Role and Function

Section 13 Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals who should be represented on LSCB's. LSCB's have a range of roles and statutory functions.

Section 14 Children Act 2004 sets objectives of LSCB's which are to:

A) Coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area, AND

B) Ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 – Local Safeguarding Board Regulations 2006 sets out LSCB functions as:

1. Developing policies and procedures for safeguarding and promoting child's welfare including:
    - Action to be taken when concerns about a child including thresholds for intervention
    - Training of persons who work with children or in services affecting the safety and welfare of children.
    - Recruitment and supervision of persons working with children
    - Investigations of allegations concerning persons who work with children
    - Safety and welfare of children who are privately fostered.
    - Cooperation with neighbouring children's services authorities and their board partners
2. Communicating to persons and bodies in area the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.
3. Monitoring and evaluating effectiveness of what is done by the authority and their Board partners individually, and collectively, to safeguard and promote the welfare of children and advising on ways to improve.
4. Participating in the planning of services for children in the area
5. Undertaking reviews of serious cases and advising the authority and Board partners on lessons to be learned.

LSCBs may engage in other activities that facilitate, or is conducive to, achieving its objectives.

'Working Together to Safeguard Children (2015)' guidance currently sets out how organisations/individuals should be working together to safeguard and promote the welfare of children and governs the scope and requirements of LSCBs.

Walsall Safeguarding Children Board (WSCB) was established as the statutory mechanism for agreeing how the relevant organisations in Walsall cooperate and work together to safeguard and promote the welfare of children and be assured this work is effective.

Our arrangements will be reviewed in line with the publication of Working Together to Safeguard Children (2018).

Working Together (2018) removes the requirement for LSCB's and establish a new duty on three safeguarding partners (LA, Police, CCG) to have 'Safeguarding Arrangements'. These new arrangements must be in place by September 2019. Meetings between the three safeguarding partners took place during 2017-18 to begin scoping the plans to have these arrangements in place before the deadline set by the Department for Education.

WSCB's terms of reference - reviewed annually - details the scope of the Board and expectations of Board members. WSCB Structure and Board attendance is detailed in Appendix 1 and 2. Membership complies with statutory guidance with addition of a lay member.

Board members are of a senior position in their organisation, able to make decisions and access resources to support WSCB's business. Board members chair WSCB sub-groups to support delivery of the WSCB Business Plan.

Attendance is monitored by organisation. Members unable to attend meetings are required to send an appropriate substitute from their organisation. Attendance in 2017-18 was generally good from most organisations. Statutory members whose attendance fell below the expected standard was CAFCASS and NHS England.

WSCB's constitution and members' handbook is a dynamic document continually reviewed by the Board clarifying governance arrangements and setting out partner responsibilities in the discharge of their duties as WSCB members. It also details the legislative framework, the Board's purpose and strategic governance arrangements. The Boards underpinning principles are:

- Keep the safeguarding and welfare needs of children at the centre of everything it does
- Maintain its independence from all agencies and structures (including CYPP, HWB, and Walsall Borough Council) to promote an equal partnership
- Operate a challenge and assurance function to partner members and external organisations
- Involve children, families, carers, frontline practitioners and managers in work
- Develop strong working relationships with strategic partners to promote clear roles, responsibilities and governance arrangements
- To be open and transparent in the work that it undertakes
- To be a learning and development Board that seeks continuous improvement.

During 2017-18 the Board met quarterly and covered a wide range of business including progress reports from sub-groups – regarding work plans and WSCB priorities – and assurance reporting. A Development Day in March 2018 reviewed WSCB's Business Plan and priorities for 2018-19.

WSCB Independent Chair

The LSCB must have an Independent Chair. The LSCB Chair should:

- Work closely with all partners particularly the Director of Children's Services.
- Publish an annual report on the effectiveness of child safeguarding arrangements and promoting welfare of children in the local area regarding the preceding financial year. The report should be submitted to Chief Executive, Leader of the Council, Local Police and Crime Commissioner and Chair of Health and Well Being Board.
- Have access to training and development opportunities including peer network.
- Have an LSCB business manager and other discrete support as necessary for them/ LSCB to perform effectively.

The Independent Chair (Alan Critchley) – for WSCB and Walsall Safeguarding Adults Board (WSAB) started in September 2015 with arrangements in place to meet above requirements.

Mr Critchley ceased his chairing responsibilities on 31st March 2018. A successor has been appointed for 2018-19 (Ms Liz Murphy).

2. Local Context

Walsall's overall population is predicted to increase over the next few years by 5.1% from 270,900 in 2012 to 284,700 in 2022.

Data shows that children and young people under the age of 20 make up 26.0% of the population of Walsall, with 37.0% of school age children from a minority ethnic group.

Walsall has a culturally-mixed population. People of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups in Walsall. The number of Non-UK Born residents in Walsall has increased by 3.7% (or 9,859 people) between the 2001 and 2011 censuses. Walsall now has a small Eastern European population who make up about 1% of the area residents (2,681 people in total). Access and the appropriate provision of services depend upon a well informed understanding of the specific needs of these different communities.

Generally, data indicates that the health of children in Walsall is mixed compared with the rest of England, with 25.0% of the attributes measured being significantly better than England and 40.6% being measured as significantly worse than England. For example, the rates of immunisations for children are higher for both the MMR and the 5-in-1 vaccinations at 97.7% (compared with the England rate of 91.9%) and 98.8% (compared with 95.2%) respectively. However, significantly more children are killed or seriously injured on the roads in Walsall at 28 per 100,000 compared to 17 per 100,000 nationally.

The latest child poverty figures for Walsall (2011) show that there were 16,145 children under 16 living in low income families – representing 29.2% of all children in the borough. This was above both the England average of 20.6% and the regional West Midlands average of 23.8%.

Walsall ranks as the 26th worst performing area for child poverty out of 326 local authorities in England, putting it in the worst 8% nationally. This is poorer than its position in 2006, when it was among the worst 12%.

Locally, infant mortality is consistently higher than regional and national rates, with high levels of deprivation a key contributing factor. England & Wales is at an all-time low and continues to fall, however significant inequalities persist across the country. In Walsall figures remain high but are reducing.

Under 18 conceptions are 50% higher than the national average with 31.5 for every 1,000 pregnancies as opposed to 20.8 for England (2015 data) which is mirrored with the rate of teenage mothers at 1.6% which is double the national rate of 0.8%. (2016/2017 data).

Throughout 2017/18 4,480 children had an episode of need requiring social care intervention, a rate of 702 per 10,000 children and young people aged 0-17. At the 31st March 2018, there were 2,715 children in need receiving a social care intervention, a rate of 404 per 10,000 and an increase of 104 compared with the previous year.

Of the children in need at 31st March, 408 or 61 per 10,000 population aged 0-17 were the subject of a child protection plan and 636 or 95 per 10,000 population aged 0-17 were looked after.

3. Evaluation of the safeguarding system

2017– 2018

Evaluation of performance and effectiveness of local safeguarding services:

What works well?

- Audits and case reviews show some examples of good work.
- A comprehensive programme of multi agency training is available. There has been a positive increase in the numbers of professionals attending from the voluntary and community sector and health settings.
- 'Pockets' of good practice mean some children receive a good or outstanding service.
- There is good partnership attendance at Serious Case Review subgroup and CMET (Children, Missing, Exploited and Trafficked) subgroup.

Difficulties or risks:

- ¼ of all the multi agency case files audited were 'inadequate'.
- The 'pockets' of good practice are not consistently applied across the safeguarding system, therefore the strength of the partnership only works for some children, not all.
- Roles and responsibilities in safeguarding are not understood by all practitioners and therefore they do not always deliver what is required e.g. Core Groups not always effective, failure to identify abuse or neglect.
- There needs to be a better understanding of thresholds across the partnership.
- Responding to neglect continues to be a challenge in Walsall.
- Lack of a clear training needs analysis and training data means it is difficult to understand coverage and impact.
- Partner contribution and engagement in the Board varies. Attendance at subgroups varies. Generally, the Police and Children's Services have not been well represented at Policies and Procedures, Learning and Development Subgroups. Probation attend very few meetings (other than the Board meetings). Partners can be slow to respond (or not respond at all) to meeting requests meaning they have to be postponed or are not quorate.
- The lack of consistent engagement has also led to delays in progressing partnership work programmes, for example agreeing a Neglect Strategy and revising the Threshold guidance and training.
- The majority of multi agency training is attended by LA Children's Services and Education. Numbers from health and the voluntary and community sector remain low although are increasing (see page 28).

What do we know from inspections?

Walsall Healthcare Trust was inspected by the CQC in May and June 2017. The Trust was given an overall rating of 'requires improvement'. The overall ratings for Walsall Manor hospital and urgent and emergency services were also judged as 'requires improvement' with maternity and gynaecology rated as 'inadequate'. However, community health services for children, young people and families and services for children and young people were both rated as 'good'.

An Ofsted Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board judged both to
'Require Improvement'. Adoption services were considered 'Good'.

West Midlands Police underwent a PEEL (Police Effectiveness, Efficiency and Legitimacy) assessment by Her Majesty's Inspectorate, in 2017, which determined 'The extent to which the force is effective at keeping people safe and reducing crime as requires improvement'.

Audits and case reviews show examples of 'Good' work.

A comprehensive programme of multi agency training is available.

4. Ofsted Inspection of WSCB

Between 20th June and 13th July 2017 the Board was inspected by Ofsted as part of the single inspection process for the 'Inspection of services for children in need of help and protection, children looked after and care leavers' and a 'Review of the effectiveness of the Local Safeguarding Children Board'.

The subsequent report was published in September 2017 when the Safeguarding Board was considered to 'Require Improvement'.

The full report can be accessed here: https://reports.ofsted.gov.uk/local-authorities/walsall

The following recommendations were made for WSCB:

- The board should ensure that it undertakes a review of partnership understanding and operation of thresholds for services and reviews the multi-agency threshold for services document as soon as possible.
- The board should ensure that it produces an annual report which analyses progress in safeguarding children and young people in Walsall effectively.
- Proposed developments in the evaluation of training should be put into practice as soon as possible, and learning from feedback should be used to measure impact in improving practice and in informing the commissioning process for further training.
- The board should ensure that a neglect strategy, agreed by partners, is in place quickly and that the board has an overview of the impact of practice in relation to young people at risk of child sexual exploitation and the minimisation of that risk.

What we did:

In response the Board updated its business plan to ensure all recommendations were addressed.

- The Threshold Guidance was consulted on and updated during the remainder of 2017-18 and approved at Board in March 2018. A launch is planned for June 2018 and further roll out to practitioners through single agency and multi-agency training.
- The Neglect Strategy was not 'in place quickly' and took a similar length of time to be developed (6 months) and was also agreed in March 2018. An implementation group will drive forward the business in 2018-19.
- Further multi agency audits of both CSE (Child Sexual Exploitation) and Thresholds have showed both improvements and areas for development.
- The development of a 'Problem Profile' for CSE has further helped the understanding of young people at risk.
- The new programme for the evaluation of multi-agency training has struggled to gain agency engagement, therefore monitoring the impact of training from a manager and practitioner perspective has proved difficult. This will be re-visited in 2018-19 to ensure greater 'buy-in'.

The WSCB annual report for 16-17 was agreed at Board in September 2017.

5. Summary of WSCB activity against its priorities

Priority 1 for 2018

Ensure leadership, management and governance arrangements deliver strong, strategic local leadership that measurably improves outcomes for vulnerable children.

Rationale:

WSCB has identified a range of development activities so that it operates within a clear and well established governance framework, holds partners to account and delivers its statutory functions.

Summary:

Walsall Safeguarding Children Board (WSCB) requires improvement to be good (Ofsted Judgement June 2017).

Position:

The board has established a comprehensive training offer, which is well thought of, by partners. However, more work is required to ensure that the impact of training on subsequent practice is understood and taken into account in the commissioning of further training (Ofsted 2017).

- Underfunding was resolved in late 2016-17, and has resulted in a new business unit structure in 2017-18 to support the board's required functions. The impact of this was beginning to be visible by the end of quarter 3, for example, the reduction in the outstanding CDOP (Child Death Overview Panel) cases awaiting review.
- The board understands its areas of development, including a need to be able to demonstrate and understand the impact of its work.
- Partners are engaged with the work of the board, including chairing key sub-groups. This supports shared responsibility and accountability for the board's performance however we need to ensure a shared commitment and ownership of the agenda.
- The board was active in helping to deliver the objectives of the Walsall Plan and via the Chair engaged with the Health and Wellbeing Board and with the Strategic Partnership Board.
- Walsall Healthcare Trust was inspected by the CQC in May and June 2017. The trust was given an overall rating of 'requires improvement'. The overall ratings for Walsall Manor hospital and urgent and emergency services were also judged as 'requires improvement' with maternity and gynaecology rated as 'inadequate'. However community health services for children, young people and families and services for children and young people were both rated as 'good'.
- There is an agreed, quarterly, Multi Agency Audit programme, focusing on Board priority areas.

- Section 11 Audit was completed by all partners.
- A challenge log was maintained to monitor issues raised across the partnership.
- A number of 'Assurance Workshops' were held in respect of areas of interest or concern for the Board e.g. Children with Disabilities, FGM.

Example of Impact:

- There is now increased capacity within the Business Unit to enable the coordination of WSCB activity.
- There is a clear set of priorities agreed which will support improved outcomes for children and young people.
- Safeguarding is included in the Walsall Plan, acknowledging it as a key feature of partnership work and importance for the local community.

Scheduled work 2018-19:

- New Safeguarding Board Chair has been appointed for April 2018.
- Operational sub group to coordinate and monitor the work of the Board

Priority 2 for 2017 – 2018

Increase the responsiveness and impact of the help and support provided to children, young people and families, including children with disabilities and mental health issues.

Rationale:

Local intelligence indicates that there is a need to develop (i) a shared understanding and application of thresholds (ii) embed the Early Help offer including role of Lead Professional and (iii) improve the contribution of partner agencies to multi agency safeguarding forums

Summary:

- The board has reviewed it Multi Agency Guidance on Thresholds of Need and Intervention during 2017-18 and a launch of the new document is planned for June 2018.
- A multi-agency 'Assurance Workshop' was held in respect of Safeguarding Disabled Children which showed positive improvements in service delivery and re-design within Social Care and health services, streamlining responses for children and families.
- There has been a positive improvement in CAMHS, particularly in relation to waiting times, which has taken Dudley and Walsall Mental Health Trust from 'Requires Improvement' to 'Good' as per a CQC inspection, with the introduction of a Tier 3.5 service. iCAMHS provide intensive ongoing care and support earlier discharge through safe transition back into the community. This marks a significant increase in access to mental health expertise and is leading to shorter stays in acute paediatrics, ensuring that high risk children and young people receive care and support in the most appropriate setting.
- Partners' understanding of the thresholds of need is not sufficiently established across all agencies. Although referrals from professionals are timely, a high proportion of contacts either do not meet the threshold for statutory intervention or are insufficiently detailed for MASH to make a decision about the next steps.

- ‘The board does not have a comprehensive understanding of agency application of thresholds and the operation of the local authority’s internal thresholds (Ofsted June 2017)’.
- CQC also identified that [midwifery] ‘referrals made to MASH are of variable quality. In records seen there was an inconsistent standard and some referrals did not articulate risk clearly, which is compounded by the absence of an effective, operational quality assurance process. As a result, some referrals may not appear to meet threshold for statutory intervention due to the poor quality of information contained within the referral. This means that some women in vulnerable situations may not receive the appropriate level of support or safeguarding intervention’.

Position:

- 25.5% of referrals to early help were re-requests within 12 months
- Overall during 2017/18, health visitors have been the lead professional in 40 cases (5.1%). This is a significant improvement on 2016/17 when only 5 cases (0.4%) had a health visitor as the lead professional.
- During 2017/18, the LAs 0-19 Family Support services were the lead professional for 481 cases, (61.2%). Schools & Education followed with 260 cases (33.1%). This evidences an Increased professional investment from within the Health Visiting service in Early Help and shared responsibility for supporting families.
- Against an aspirational target of 75% there were positive outcomes for 62.8% of Early Help cases closed during 2017/18. This means the desired outcome was not achieved for 37% of families.
- There has been steady progress in updating the thresholds framework:
- The Multi Agency Referral Form (MARF) was reviewed and re launched in January 2018 and the impact is starting to be felt. There has been targeted work undertaken with schools with a history of inappropriate referrals and this is beginning to have an impact, with a reduction in inappropriate or poor quality referrals. More work is planned with Health.
- The new ‘DV light Triage’ has been in place within MASH from January 2018 and has shown that 48% of DV logs did not meet threshold for social care.

New multi agency Threshold Guidance and referral form launched.

- A briefing took place on the 6 March 2018 between Initial Response Service (IRS) managers and Early Help (EH) managers to reinforce safe step up /down practice. An audit by the MASH management group is planned during May 2018 to monitor impact.
- Two multi-agency audits by the Multi Agency Safeguarding Hub (MASH) management group have taken place to examine application of thresholds and the consensus was that the thresholds were being appropriately applied within the MASH. A further audit of Health referrals was undertaken during March to consider health referrals that came into MASH on the new MARF. This found that in the majority of referrals, the health representative did not indicate threshold for referral. A further health audit is scheduled in April 18 to; explore MARF's that have resulted in No Further Action. The MASH Management Group will also undertake an audit of cases that were referred into MASH during February, which were initially RAG rated as green, as this indicates that the threshold of referral to MASH was not correct.
- Two day Section 47 training course co–delivered by partners was completed for social workers including a focus on application of threshold for Section 47 – with further training scheduled throughout the year.
- A domestic abuse awareness day was facilitated in January 2018 by Early Help and Black Country Women's Aid for all practitioners and lead professionals. The aim of the session was to raise awareness of Domestic Abuse services within Walsall, agencies roles and responsibilities and the pathways and tools (such as the RIM tool) used to aid access to the right service
- 81 professionals from across the partnership, including social care, youth justice, school nursing, health visiting, education and th police attended a WSCB Toxic Trio conference in November 2017.
- At 31st March 2018, 220 children in need had a disability recorded, 8 of these children were subject of a CP plan

Example of Impact – Early Help Case Study:

Reason for involvement:

Rosie came to Walsall to live with her mother and step family after living with her Father in Yorkshire for the past 7 years. Mother self referred to Early Help due to Rosie showing challenging behaviour, she was aggressive within the home and mother felt this was impacting on her own mental health as well. Mother shared she had pre and post natal depression and having not lived with Rosie for some years the bond between them was not strong. During early help's involvement CAMHS diagnosed Rosie with fragmented behaviour and the consultant reported attachment difficulties.

Intervention:

Work was completed with the family encouraging them to spend more positive quality time together. Rosie was supported to explore and access local provision to help raise her confidence and self esteem and a referral to the 18 week Teens and Toddler program was made (life skills). Concerns were also raised around CSE and a screening tool confirmed low risk but mother did attend a PACE workshop. 1:1 parenting and a parenting workshop was attended along with identified work with Rosie.

Impact:

Mother ensured that there was an allocated time set aside each day for Rosie to spend with just her and even when Rosie did not want to, this was accepted, and she was encouraged again the following day. The family also ensured they all had Sunday lunch together and the relationship got stronger over time allowing them to all enjoy a family holiday together. They have been consistent in their approach with Rosie and this has resulted in Rosie becoming much more settled at home, spending more time as a family and reducing the negative behaviour in the home significantly. Rosie said she now feels safe and secure at home and mother no longer feels that she is treading on eggshells waiting for the next argument. Rosie feels that her relationship with her parents has improved and that she can be honest with them. After trying several different provisions Rosie is now engaged in the Duke of Edinburgh program which has helped raise her confidence and self esteem. Having completed the Teens and Toddlers program she has also achieved a NCFE Entry level 3 award in personal and social development. Mother also felt that from her engagement in the PACE she had gained a better understanding on the subject of CSE to help keep Rosie safe.

Scheduled work 2018-19

- New (WSCB) Multi Agency Guidance for Thresholds of Need and Intervention to be launched to partnership (June 2018).
- New training programme to be designed and implemented during summer 2018, to support practitioner use of Threshold Guidance.
- Clarification of the Step up-Step Down Procedure.
- A focus on the effectiveness of Core Groups in early 18-19, across the partnership.
- Board to receive assurance on WHT response to CQC recommendations.

Priority 3 for 2017 – 2018

Coordinate how partners work together to protect children from the harm caused by neglect (including the impact of Domestic Abuse, Parental Substance Misuse and Parental Mental Ill Health).

Rationale:

The most common category of Child Protection Plans in Walsall is neglect.

Exposure to domestic abuse is a significant factor impacting on the safety and wellbeing of children and young people.

Neglect is a feature in fifty per cent of cases referred to Local Authority Children's Social Care

Links to Health and Well Being Board: Walsall Plan priorities – 'Tackle the harm to individuals and communities caused by substance misuse'; 'Reduce the harm to individuals and communities caused by all types of violent behaviour'

Summary:

- In June 2017, Ofsted recommended that a Neglect Strategy be quickly developed and adopted by the Board.
- A Multi Agency Neglect Strategy was agreed by the partnership in March 2018.

- A conference was held for practitioners in November 2017 on theme of 'Toxic Trio' (substance misuse, mental health and domestic abuse).There is a gap in domestic abuse governance across the partnership and no local domestic abuse strategy

Position:

- As per 2016-17, the three main reasons for referral to Early Help were Neglect, Domestic Abuse and Physical Abuse in 2017-18
- The board monitors the effectiveness of some frontline practice through a programme of multi-agency audits. During 2017-18 this included Neglect, Children with Disabilities and Thresholds (in line with identified areas of performance concern). There was also a re-review of previous cases to monitor progress.
- The Board responded to the Ofsted observation in relation to the lack of a Neglect Strategy but was slow to produce and agree a final version.
- The partnership has agreed the implementation of the Graded Care Profile (2) model. Evidence suggests that this tried and tested model enhances practitioners' ability to spot when a child is at risk of neglect and ensure the right help is afforded to families much earlier. Through a range of resources, practitioners will be armed with the prerequisites to better recognise the early signs of neglect, and ultimately we should see reducing issues of neglect through increased timely support to improve the lives of children and young people. The Strategy is underpinned by a delivery plan which outlines the actions required to execute the objectives, and will continue to be embedded during the coming year
- A multi agency audit of 15 cases where neglect was a significant feature was undertaken in Qtr 1; 11 cases 'required improvement' and 2 were 'inadequate'. Good multi agency communication was noted and when children became Looked After this had had a positive impact on their lived experience. However, there were issues recognised in the identification and assessment of neglect, the time taken to intervene in a child's life when progress is not made within the family – sometimes caused by over optimism by professionals or lack of professional challenge.

- The IRIS (Identification and Referral to Improve Safety) project commenced with GP's in Walsall. Core areas of the programme include training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is aimed at women who are experiencing domestic abuse from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

  An advocate educator is linked to general practices and based in the local specialist service – Black Country Women's Aid. The advocate educator works in partnership with a local clinical lead to co-deliver the training to practices.
- The CQC inspection found that midwives do not routinely provide expectant mothers with enough opportunity to explore concerning relationships and worries during their pregnancy. Within midwifery there is no standard procedure to see women alone during pregnancy and in most cases seen, routine enquiry for domestic abuse had not been asked with no evidence of follow up at a later stage. This led to a recommendation for the Trust and development of a team of midwives to support vulnerable women.
- Lessons from Serious Case Reviews have continued to be disseminated through posters and briefings to professionals. Including the need to routinely ask women about domestic abuse.

Example of Impact:

IRIS (domestic abuse) project started August 2017 and has been running just over 7 months and in that time referrals made by GP practices has risen from only 4 in 2016 to 50 in the first 7 months.

Scheduled work 2018-19

- Neglect Strategy to be launched in June 2018.
- Roll out of GCP2 training and implementation of the tool across the partnership
- Refinement and monitoring of the implementation plan to support the strategy.
- Walsall Healthcare Trust will audit 'Routine Enquiry' of Domestic Abuse (by midwives and health visitors).

Priority 4 for 2017 – 2018

Reduce the risk and threat of harm caused by sexual exploitation and missing episodes?

Rationale:

Child sexual exploitation (CSE) and being missing from home/care are key safeguarding risks facing children and young people and WSCB has the statutory responsibility to coordinate the local response to CSE

Summary:

- The Ofsted report following the Inspection of services for children in need of help and protection, children looked after and care leavers noted that 'Managers make sure that everyone has a good understanding about children being at risk of exploitation and why it is important to work together to keep children safe. More needs to be done to make sure that everyone works well together to support children' and recommended that the LA 'Improve the response to all children at risk of child sexual exploitation, making sure that all assessments, safety plans and interventions are of a consistently good quality'.
- There were more crimes recorded using the CSE marker in the 2017 period than in 2016 (24 vs 18) – possibly due to improved recording on police systems.
- The most common offence type recorded was 'Arrange or Facilitate Travel of Another Person With a View to Exploitation' (6 offences).
- CSE offences were recorded in similar locations across Walsall in 2016 and 2017.
- There has been a significant increase in the number of children going missing.
- The most common method of CSE was grooming of young females by older males, frequently involving the use of alcohol. This is comparable with 2016.
- The most common victims were females who identified as white British, between the ages of 14-16. 77% of vicitims and female, 23% are male.

The most common category of Child Protection Plans in Walsall is neglect.

Neglect is a feature in fifty per cent of cases referred to Local Authority Children's Social Care.

Position:

CSE, Missing Children and Trafficking Data:

VICTIMS	Q4 17/18	Q3 17/18	Q2 17/18	Q1 17/18	Q4 16/17
Total number of young people at serious, significant, and standard risk of CSE.	106	138	135	134	151
% young people at Serious risk compared to total at risk	9.4% [10]	1.4% [2]	2.2% [3]	4.5% [6]	2.60%
% young people at Significant risk compared to total at risk	10/3% [11]	5.7% [8]	4% [5]	5.22%[7]	18%
Number of new young people identified at risk in period given	19				
Number of children who had risk reduced (including from “at risk” to “no risk”)	48	12	16	38	18

OFFENCES & REFFERALS	Q4 17/18	Q3 17/18	Q2 17/18	Q1 17/18	Q4 16/17
Number of CSE contacts into MASH	TBC	40	36	59	48
Number of CSE needs identified at referral	TBC	6	15	28	24
CSE needs at end of Assessment	TBC	10	32	22	12
Number of police intelligence logs	75	40	66	154	82
Number of CSE “non-crimes” reported	6	4	5	8	4
Number of CSE “non-crimes” reported	22	23	19	29	20

The three main reasons for referral to Early Help were Neglect, Domestic Abuse and Physical Abuse in 2017-18.

LOCATIONS & PERPETRATORS	Q4 17/18	Q3 17/18	Q2 17/18	Q1 17/18	Q4 16/17
CMOG: Number of potential perpetrators	10	10	13	6	2
CMOG: Number of locations identified	5	6	10	10	8
Number of positive outcomes for CSE investigations	0	0	0	4	2
% positive outcomes (ie charges and cautions) vs overall CSE recorded crime	0%	0%	0%	0%	0%
Number of civil interventions / remedies (including CAWN notices, SRO's etc)	0	3	5	N / A	0

MISSING CHILDREN	Q4 17/18	Q3 17/18	Q2 17/18	Q1 17/18	Q4 16/17
Number of missing episodes	130	81	89	121	85
Number of missing children	70	36	58	63	50
% missing episodes from LA care	19%	28%	54%	55%	52%
% missing episodes from foster care	10%	19%	27%	33%	31%
Number of children with repeat episodes	34	15	14	16	18
Missing Children at risk of CSE	17	10	27	50	19
Average (mean) repeat missing episodes	4.1	3	3	4.6	2
Average days taken to locate missing child	2.5	4.4	4.25	1.4	9.1
RHI's completed within 3 days	49 [38%]	42 [52%]	38 [46%]	45 [31%]	53%
RHI's not completed at all	57 [44%]	16 [20%]	36 [43%]	67 [46%]	32%

TRAFFICKING CHILDREN	Q4 17/18	Q3 17/18	Q2 17/18	Q1 17/18	Q4 16/17
Number of NRM's	5	TBC	1	TBC	4
Trafficking/Modern Slavery crimes recorded involving child victims	5	0	2	0	2

- Safeguarding concerns reported to the police involving a child, which does not meet the criteria of a criminal offence, are recorded by police as a "Non Crime" incident. In the year of 2016-2017 there were 71 Child Abuse non-crimes recorded that had CSE as a factor (or 'marker'). This increased in 2017-2018 where there were 95 Child Abuse non-crimes recorded with a CSE marker.
- Of these records 48 (68%) in 2016-2017 and 77 (81%) were reports from partner agencies raising concerns with the police for potential victims of CSE. This would suggest a positive increase in agencies working with the police to raise awareness of vulnerable children.

Street Teams have continued to be the main provider of specialist CSE services in Walsall.

- Over the past 12 months, Street Teams has provided: practical grass roots support to 268 children/young people affected by abuse/vulnerable to exploitation; there were 439 missing episodes for 165 children of which 35 missing young people were open to Street Teams as CSE service users. There were 56 new referrals into the service with 48 CSE young people worked with over a continued period of time, plus support was also provided to 20 service users in transition, 4 young people affected by gangs, 11 boys displaying inappropriate sexualised behaviour and to 9 families (parents and siblings) affected by CSE.
- The team provided 300 education and prevention programmes to over 28600 school children/pupil referral units to raise awareness of the risks of exploitation and delivered 32 training sessions to 1097 professionals.

The presenting issues of new CSE referrals received included:

27% were regularly going missing

26% were involved / affected directly by CSE

18% were in inappropriate relationships

13% had sexual health concerns

10% had substance misuse related concerns

Impact:

Walsall's Specialist Health Visiting service alongside midwifery supported a pregnant young woman who had been trafficked and coerced into exploitation sex work in the UK. She had been subjected to female genital mutilation (FGM) in her home country and forced to flee the perpetrators, who continued to threaten her and her family members at home. As a victim of trafficking she was supported by the police and Victim Support and placed at a 'safe house' provided by the Home Office, but had to be relocated during her pregnancy creating instability.

Average time taken to locate missing children has reduced.

Decisive action was taken to ensure the unborn baby was monitored under child protection arrangements due to the pressure the expectant mother's family were placing on her to have FGM undertaken in this country. The mother had no family and little support in the UK.

After the baby was born the health visiting service made a referral to Sure Start and also the Breast Feeding Team to ensure that mother and baby had good access to appropriate support. The family stayed on a child protection plan for less than a year before it was deemed that the risks to the baby had reduced and the case no longer required statutory intervention. The mother and baby were able to transition to accessing universal health visiting services as the baby continued to thrive.

The mother was given leave to remain and secured a property locally. Her traffickers were arrested and taken to court. The mother now attends college and attends Stay and Play sessions with her daughter at a local Sure Start Children's Centre.

Through the use of a bespoke CSE 'Outcome Star' tool, during the past 12 months the following outcomes were achieved for CSE service users working with Street Teams:

76% Improved their choices and behaviour

50% Improved their Safety and Security

38% Reduced their drugs and alcohol use

50% Improved their health and well-being (including sexual health)

47% Improved their safety online

42 % Improved their safe relationships

36% Improved their relationships with their family and other adults

45% Improved their education/learning attendance

Quotes

"That's the last thing I needed to hear on a Monday morning, but I respect you, as I did need to hear it" (student after Exposure session)

"I wouldn't go to court if Street Teams wasn't supporting me." (Transition Project)

Scheduled work 2018-19:

- Exploitation will continue to be a priority for the Board. In particular, supporting the local and professional community to recognise and respond to all types of exploitation and missing in a child centred way
- Develop a wider strategy and approach to exploitation.
- Improve transition between services for children and adults, for those young people experiencing sexual exploitation.

Priority 5 for 2017 – 2018

Continue to improve the ability of local and professional communities to safeguard children and young people

Rationale:

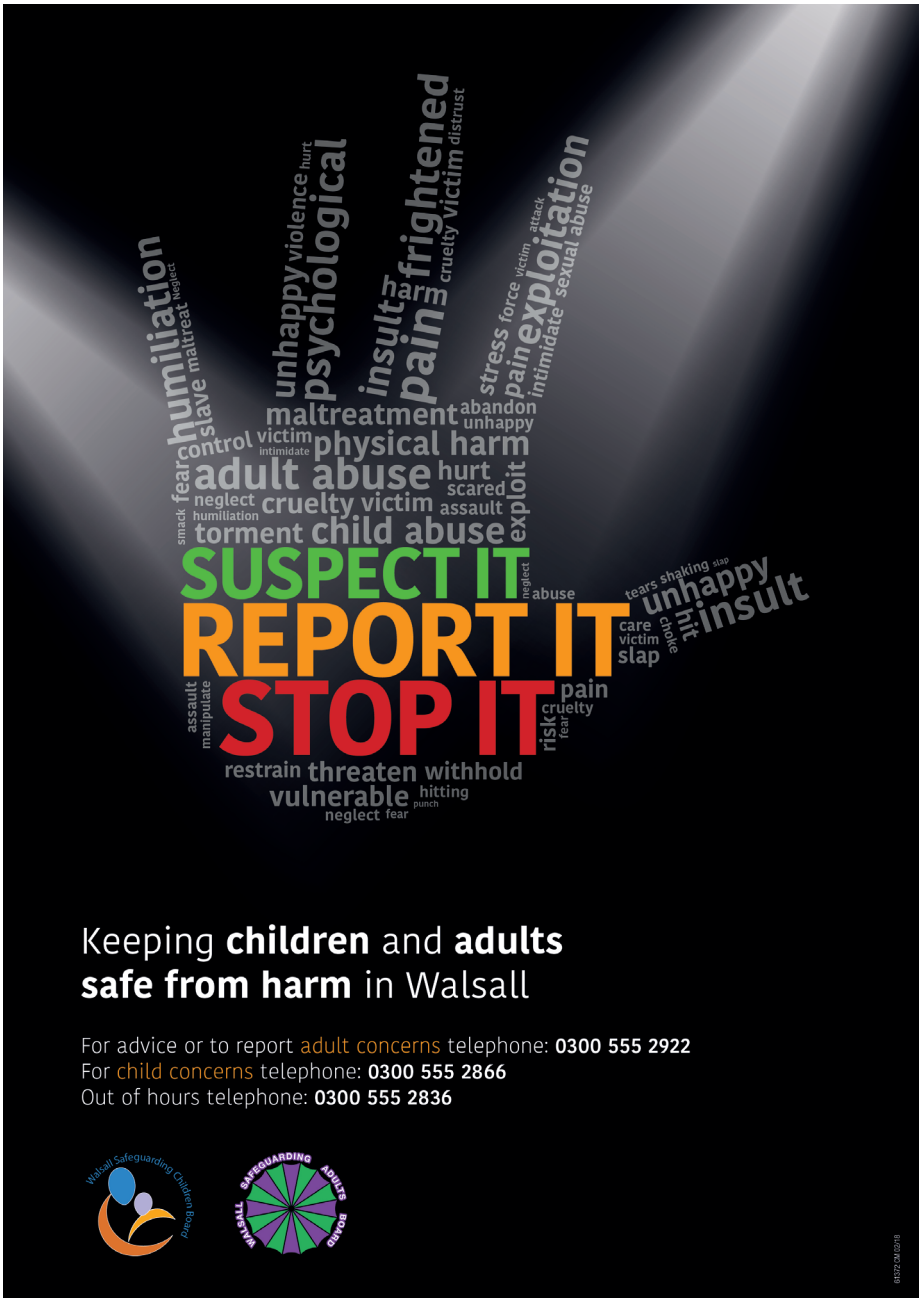
Children and young people will be safer when more people know how to identify and act on safeguarding concerns and WSCB has a statutory responsibility to carry out learning reviews.

Rationale:

Links to the Health and Wellbeing Board, Walsall Plan Priorities – 'Enable children and young people to be better protected and safeguard themselves'; 'Improve emotional health and wellbeing of children and young people'.

Summary:

- The Board has produced awareness raising materials for the general public, including a poster and leaflets.



- The NSPCC PANTS campaign was launched in June 2017. The campaign uses the Underwear Rule to support and encourage parents and professionals to talk to children aged 4-11 about how to keep themselves safe from sexual abuse. https://www.nspcc.org.uk/preventing-abuse/keeping-children-safe/underwear-rule/
- A multi agency Private Fostering task and finish group was established to respond to the low numbers of children being identified as being in a private fostering arrangement.

Position:

- Private Fostering awareness raising has led to information being displayed on the screens in the One Stop Shop for members of the public, distribution of promotional materials (x200 posters), training and awareness sessions for professionals (over 400 multi-agency staff) - the aim of this was to increase the numbers of referrals regarding children living in Private Fostering arrangements as they are known to be a vulnerable group. However, to date this has not significantly increased the number of notifications to the LA. There are 5 cases of Private Fostering which the LA is aware of. This is an increase on 1 since last year.
- The NSPCC PANTS campaign has, over the past 12 months, been delivered to over 7000 school children.
- Schools have reported that parents have responded positively to the campaign, it has helped children start to ask questions and set personal boundaries, and the Pantosaurus video has helped them learn the Pants rules and given them strategies to deal with difficult issues (ie. talk to someone).
- The Suspect it, Report it, Stop it! poster and leaflets have been circulated by Board member agencies including police partnership teams, GP's, Dudley and Walsall Mental Health, Manor Hospital, Walsall College, Elected Members to their constituents and those not directly involved in the Board (e.g. community centres and training providers). Over 150 posters and 250 leaflets have been distributed with more being printed. Currently approximately 11% of referrals to children's services are by members of the public, family members or self-referrals. We are monitoring this and aiming for it to increase in 2018-19.
- The poster was uploaded to the Board's joint twitter page and the LSCB website http://wlscb.org.uk/suspect-it-report-it-stop-it/
- In addition to the multi-agency safeguarding training programme coordinated by the Safeguarding Board's, safeguarding awareness training has been delivered to Clean and Green staff working in parks and public spaces, as well as bar staff at the Town Hall. This included safeguarding adult and children awareness training and sexual exploitation information.
- School nurses effectively engage with children and young people through the use of 'Chat Health' text messaging service. The service is monitored by trained nurses who provide advice on a range of health issues such as emotional health, drugs and alcohol, sexual health and weight management. The nurses are also able to signpost young people to other appropriate services or offer face to face contact if necessary. Good uptake of 'Chat Health' is resulting in children and young people accessing support using a medium they are highly familiar with which promotes engagement.
- Street Teams visited 43 schools and delivered CSE and radicalisation awareness sessions to over 13,500 students in the Borough.

- School nurses effectively engage with children and young people through the use of 'Chat Health' text messaging service. The service is monitored by trained nurses who provide advice on a range of health issues such as emotional health, drugs and alcohol, sexual health and weight management. The nurses are also able to signpost young people to other appropriate services or offer face to face contact if necessary. Good uptake of 'Chat Health' is resulting in children and young people accessing support using a medium they are highly familiar with which promotes engagement.

Evidence of Impact:

9 months after attending sessions on CSE and radicalisation, secondary school children were asked about the impact the sessions had had. 95% of the respondents felt that they had a better knowledge of the subject and 98% felt that they were better equipped to be able to spot the signs of grooming. Over half of the young people said that if they had concerns regarding grooming or radicalisation then they would speak to a family member (60%) followed by reporting concerns to CEOP (22%).

Scheduled work 2018-19:

- Work on a comprehensive Comms plan to ensure greater understanding of reach and impact.
- Further work is needed on the Safeguarding Board websites in order to monitor access and activity.
- Work with partners to develop Comms capacity in order to further progress the Walsall plan objectives regarding safeguarding awareness raising and its impact.
- Linking with Comms teams across the partnership to ensure further roll out of key messages.

NSPCC PANTS Campaign was delivered to over 7000 school children.

Street Teams has provided practical grass roots support to 268 children/young people affected by abuse/vulnerable to exploitation.

6. Audit and Performance

Multi Agency Adults and Performance Data 2017 – 2018

Summary:

The Quality Assurance and Performance Subgroup met quarterly to review multi agency data and performance reports.

Quarterly multi agency audits took place, themed around the Board priorities (Neglect, CSE, Children with Disabilities and a review of previous audit cases).

A thematic tracker has been developed to look at recurring patterns and learning.

Performance summary for 2017/18:

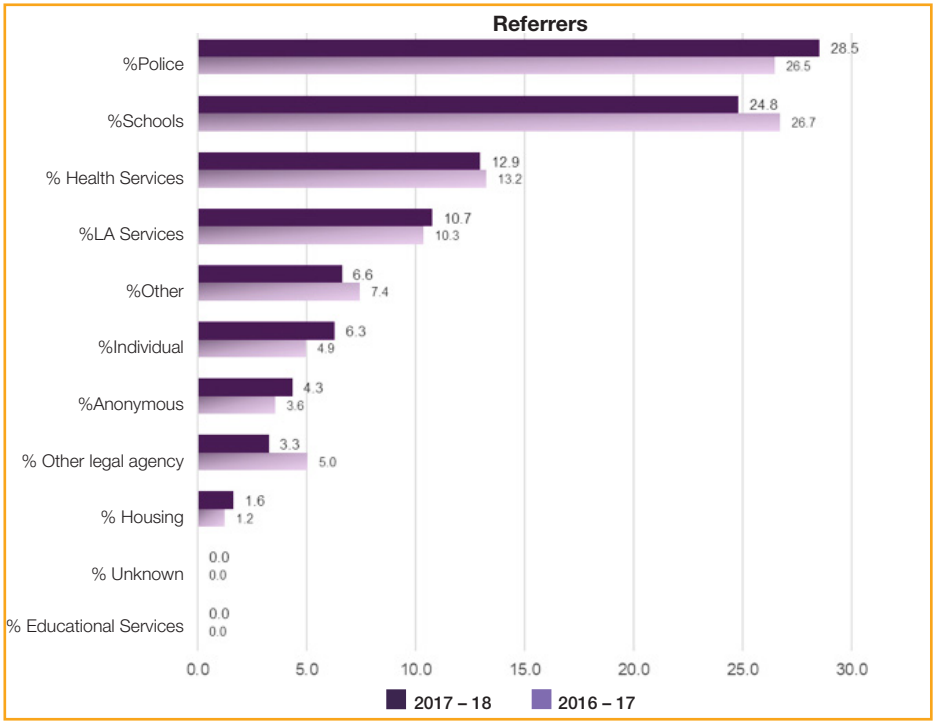
Early Help

- There were 4,295 contacts to Early Help in 2016//17. 583 (13.6%) of these were children who had been stepped down from social care.
- 2,046 (41.7%) Early Help contacts lead to outcome stars, locality panel or reflection group working.
- 421 (8.6%) contacts led to an early help assessment

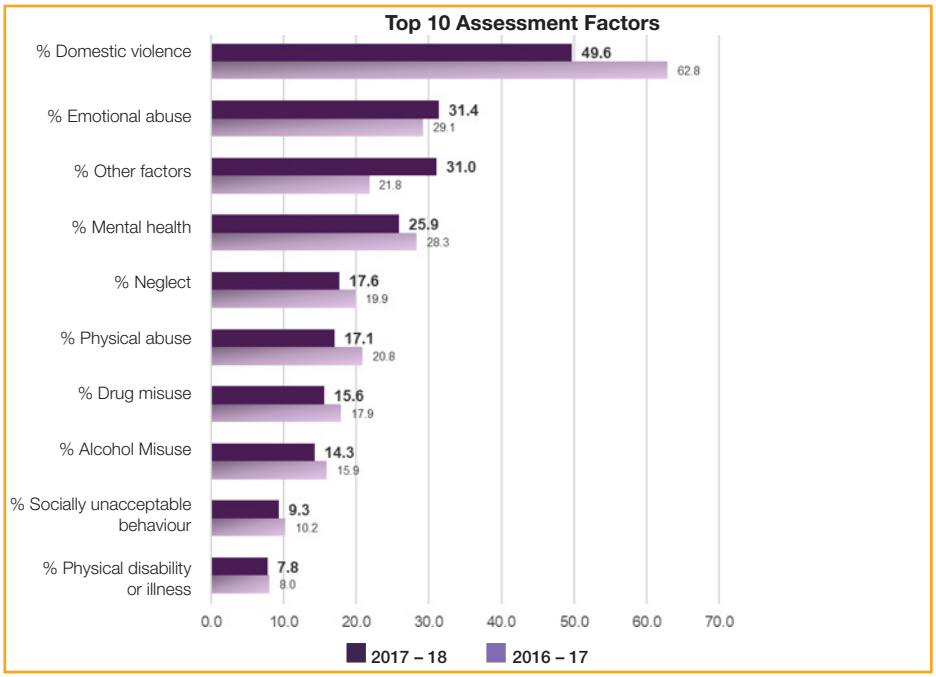
Referrals and assessment

Referrals to social care and the number of child and family assessments being carried out are increasing, however, the proportion of assessments which conclude that the child is in need is decreasing.

- There were 5,228 referrals to social care in 2017/18, a rate of 778 per 10,000 population aged 0-17. This is an increase of 14% on the previous year.
- 5,070 child and family assessments were carried out, a rate of 754 per 10,000 population aged 0-17, an increase of 18% on the previous year.
- The conversion rate of referral to assessment has increased from 93% to 97%
- There was an average of 1.2 referrals per child.
- The percentage of referrals which were received within 12 months of a previous referral increased from 22% to 27%
- 52% of referrals ended in either no further action or an assessment which concluded that the child was not in need compared with 28% the previous year.
- The percentage of referrals by agency were:



- There has been a decrease in the proportion of assessments which identify domestic violence as a factor, however, there has been a slight increase in the proportion of assessments which identify emotional abuse as a factor:



As well as a general increase in the number of referrals, the complexity of assessments and need is increasing leading to more section 47 enquiries and initial children protection conferences:

- There were 1,879 section 47 enquiries in 2017/18, a rate of 280 per 10,000 population aged 0-17 compared with 1,446 in the previous year, an increase of 30%.
- There number of initial child protection conferences (ICPCs) increased by 40% from 565 to 790, a rate of 118 per 10,000 population aged 0-17.
- 11 children had more than one ICPC during the year.
- 42% of section 47 enquiries resulted in an ICPC compared with 39% in the previous year.

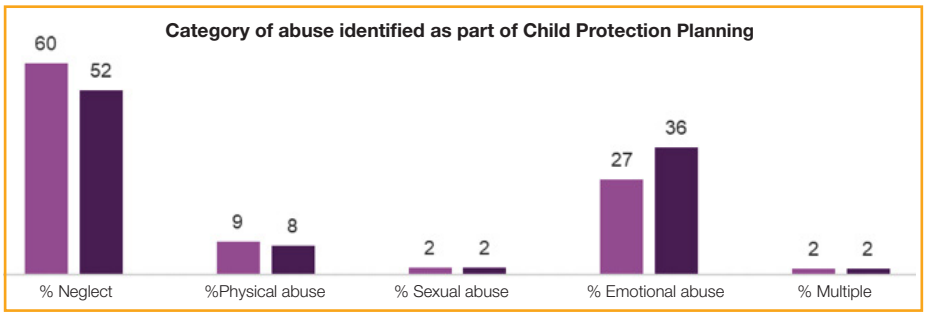
- However, fewer ICPCs led to child protection plans with 87% resulting in the start of a plan compared with 93% in 2016/17.

Although there has been some decline in timeliness performance, it remains good and above that of statistical neighbours, regional neighbours and the national average:

- 90% of assessments were completed with 45 days in 2017/18 compared with 97% in 2016/17
- 88% of ICPCs were completed within 15 days of the strategy discussion being held compared with 93% in the previous year.

Child Protection:

- The number of children who were the subject of a child protection plan at 31st March increased by 22.5% from 333 in 2017 to 408 in 2018, a rate of 61 per 10,000 population aged 0-17.
- The number of child protection plans that started in the year increased by 30% from 528 in 2016/17 to 687 in 2017/18, whereas the number of child protection plans that ended increased by only one from 603 in the previous year to 604.
- The proportion of child protection plans starting that were for children who had previously been subject of a plan increased from 12% to 25%
- The category of abuse identified as part of the child protection planning shows that for children subject of a plan as at the 31st March there has been some movement between the initial categories of abuse identified and the latest category of abuse, with movement from neglect to emotional abuse:



- 96% of children on a child protection plan were reviewed within timescales.
- Attendances by partners at child protection conferences was:
  - Police 38% compared with 44% in 2016/17
  - Health 93% compared with 89% in 2016/17
  - Education 73% compared with 78% in 2016/17
- The voice of the child is taken into account at conferences with evidence of the views of the child or young person being presented in 92% of ICPCs and 93% of review child protection conferences (RCPC)

Looked After Children:

The number of looked after children and performance remained relatively steady between 2017 and 2018, with numbers reducing slightly

- There were 636 Looked After Children as at 31st March 2018 compared with 650 in the previous year. This is a rate of 95 per 10,000 population aged 0-17.

- Nine of these children (1.4%) were unaccompanied asylum seekers.
- 58 or 9% of children who were looked after were placed with parents
- 71% were subject of Full Care Orders
- The proportion of children placed within 20 miles of home has increased slightly from 83.4% to 85%
- Placement stability is good with just 6% of children who are looked after having more than three placements during the year compared with 7% in 2016/17.
- Long-term stability has reduced slightly but remains in line with statistical and regional neighbours and the national average with 70% of children who have been in care for 2.5 years or more remaining in the same placement for at least two years, compared with 76% on 2016/17.
- Just 9% of children who were looked after had a missing incident during the year. Although this has increased slightly from 6% in 2016/17 it is below the proportion who had a missing incident among statistical neighbours and nationally (11%).
- The emotional well-being and health of looked after children is prioritised:
    - 77% of looked after children received their annual health check on time in 2017/18, down slightly from 85.3% in 2016/17
    - 83.4% of looked after children had up to date immunisations compared with 82.1% in the previous year
    - 85.9% of looked after children had their teeth checked by a dentist compared with 84.7% previously.
    - 15 (3.1%) were identified as having a substance misuse problem, with 12 receiving an intervention and 3 being offered an intervention
    - 82.8% of looked after children had an SDQ score compared with 68.6% in the previous year.

Safeguarding children in particular circumstances

- 132 children aged 0-17 presented at A&E due to accidental or deliberate injuries.
- 9 children were identified as having FGM as an assessment factor
- 17 referrals to social care were made by CAMHS with a further 76 being made by adult mental health services
- 5 children were identified as being privately fostered at 31st March
- 191 children were reported as missing from education at 31st March

Multi Agency Audits

- 4 multi agency audits have taken place throughout the year with good partner engagement.
- On each occasion 15 cases were audited, based on a theme linked to the WSCB priorities (Neglect, CSE, Children with Disabilities and a review of previously audited cases).
- Overall, 32% of cases audited were rated as ‘good’, 45% as ‘requiring improvement’ and 23% as ‘inadequate’. These ratings were based on the multi-agency practice evidenced through the audit process and agreed through discussion within the meetings.

Area's for improvement in practice related to:

- Recording is not being timely, accurate and key decisions not always recorded on the case file.
- Inconsistencies across the partnership regarding what constitutes a 'good enough' home environment for children
- Agencies failing to act quickly enough to respond to the incremental impact of neglect upon children's development
- Agencies failing to communicate with regard to the need to 'step up' a case and the need to escalate when there is a delay or no response
- Cross boundary working creating difficulties in both communication and accessing relevant information
- Lack of robust risk assessments
- The voice of the child and how we evidence the impact of our intervention on the lived experience of the child is not evident
- Lack of supervision and management oversight
- These findings were supported by the CQC, who during their inspection of the midwifery and health visiting service, noted that 'when concerns were identified the referral made to MASH was of poor quality, did not fully articulate risk and there was no evidence of appropriate challenge or escalation to Children's Social Care. The absence of chronologies within maternity and health visiting services meant that each presenting concern was not fully assessed as it was considered in isolation. Supervision was ineffective in improving safeguarding practice as discussions were task orientated with no evidence of follow up to ensure actions were completed.'
- The reports from these MAA audits were shared with QA&P for monitoring and themes shared with L&D to influence the training programme.
- There were no audit specific action plans, this is a gap which will be addressed in 2018-19.

7. Reviews

Serious case Reviews (SCR) and Learning Reviews 2017 – 18

Summary:

There is a requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely: 5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned. (2) For the purposes of paragraph (1)(e) a serious case is one where: (a) abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Position:

- 2017-18 saw an increase SCR activity in Walsall. 3 Serious Case Reviews commenced within the year, compared to 1 the previous year.
- Non were completed 'in year', the reasons for this are outlined below. In addition, the increase in review activity caused capacity issues for partners and the Board business unit.
- There is a recommended timescale of 6 months to complete a SCR. All of the SCR's are anticipated to be outside of this timescale.
    - 1 case (W8) is likely to take 7 months (expected completion Sept. 2018)
    - 1 case (W7) is expected to be complete within 12 months (Sept 2018). This is due to initial delays in identifying an independent overview author and further delays when practitioner meetings where cancelled due to heavy snow preventing people attending the meeting.
    - 1 case (W6) will take approximately 18 months (expected completion December 2018). This is a complex case involving multiple children, over a long timeframe. The Terms of Reference for the review were also amended during the course of the review which created further work for partners in extending their reports.
- Learning has begun to be disseminated and reflected upon despite the reports not being completed.
- 1 review focused on Out of Hours responses. The second related to neglect.
- All reviews have an action plan which is monitored by the SCR sub group. The timeliness of the completion of these varies.
- Learning from these reviews has been incorporated into the multi agency training programme.
- There is 1 report (W5) which remains unpublished from 2016-17. This is due to ongoing criminal proceedings, which are due to be completed in Summer 2018. The report will then be finalised by including the family perspective, prior to publication.
- There have been 2 Learning Reviews (on 4 children) undertaken within the year.
- 1 review focused on Out of Hours responses. The second related to neglect.
- All reviews have an action plan which is monitored by the SCR sub group. The timeliness of the completion of these varies.

- Learning from these reviews has been incorporated into the multi agency training programme.

Themes and Learning:

- Lack of professional curiosity (ask 'why' and don't rely on parents self reports)
- Lack of professional challenge (of each other, particularly within other agencies)
- 'Start again syndrome' as a feature in neglect cases
- Need to ensure fathers are part of assessments and considered in a 'Think Family' approach
- Drift and delay in neglect cases
- Failure to identify child sexual abuse
- Failure to follow child protection procedures

Scheduled work 2018-19:

- Neglect and Child Sexual Abuse (non CSE) will both feature as WSCB priorities in 2018-19, with associated workplans.
- Implementation of GCP2 to address 'start again syndrome' and drift in cases of neglect.
- Audit of progress against Neglect Strategy.
- Training offer
- Timely dissemination of learning

2017 – 18 saw an increase in SCR activity in Walsall.

8. Child Death Overview Panel (CDOP)

CDOP 2017 – 2018

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a CDOP.

The functions of the CDOP include:

- reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law.
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members.
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family.
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths.
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible.
- identifying patterns or trends in local data and reporting these to the LSCB.
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required.
- agreeing local procedures for responding to unexpected deaths of children and cooperating with regional and national initiatives - for example, with the National Clinical Outcome Review Programme - to identify lessons on the prevention of child deaths.

Summary:

A significant number of deaths were reviewed in 2017-18 (41), compared to 2016-17 (15). This was due to a concentrated plan to clear an accumulated backlog of cases.

Position:

2017 / 2018			
Total Deaths in 2017 / 2018	30		
Expected	15	unexpected	15
2014 / 2015 deaths reviewed in 2017 / 2018	1	2015 / 2016 deaths reviewed in 2017 / 2018§	2
2016 / 2017 deaths reviewed in 2017 / 2018	23	2017 / 2018 deaths reviewed in 2017 / 2018	15
Total deaths reviewed in 2017 / 2018	41		
Expected	20	unexpected	21
Modifiable factors	16	No modifiable factors	25
Neonatal deaths	17		
Known to Children's Social Care	21		
Consanguity	3		

*Cause of Death (code):							
Code 1	**0**	**Code 2**	**0**	**Code 3**	**4**	**Code 4**	**2**
Code 5	**8**	**Code 6**	**1**	**Code 7**	**5**	**Code 8**	**13**
Code 9	**1**	**Code 10**	**7**				

** See appendix 4 for full breakdown of categorisation codes.*

Modifiable factors included:

- Co-sleeping
- Smoking (by parents)
- Parental Substance Misuse
- Non-attendance at medical appointments
- Understanding / dissemination of key safety messages e.g. wearing protective helmets, water safety and railway safety.

Evidence of Impact:

Whilst infant mortality in Walsall remains high, a dedicated Public Health campaign on safe sleeping has shown a notable reduction in the numbers of Sudden Unexpected Deaths in Infancy (SUDI).

Scheduled work 2018-19:

- Produce regular newsletters to share key messages with practitioners.
- Implement the new statutory arrangements in relation to CDOP.
- Develop systems to better use CDOP learning to inform prevention activity.
- Non-attendance at medical appointments
- Understanding / dissemination of key safety messages e.g wearing protective helmets, water safety and railway safety.

9. Key Messages LADO / Designated Nurse / Child Safeguarding Coordinator/ PSW

LADO (Local Authority Designated Officer) activity 2017-18:

The role of the LADO is set out in Working Together to Safeguard Children (2015) and is governed by the Authorities duties under section 11 of the Children Act 2004.

The LADO must be contacted within one working day in respect of all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed a child.
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

The LADO is involved from the initial phase of the allegation through to the conclusion of the case. The LADO is available to offer advice and discuss any concerns to assist managers in deciding whether to make a referral and/or take any immediate management action to protect a child.

Summary:

- The Walsall LADO received 288 contacts (consistent with previous years)
- 59 progressed to Position Of Trust meetings – 30% substantiated outcome (a significant increase to previous years)
- 61% were physical allegations and 22% sexual

Position:

A leaflet for workers subject to an allegation has been successfully implemented this year and has received positive feedback. This ensures that all workers receive consistent information about the process and what to expect.

The LADO newsletter has continued to be a mechanism for engaging with wide audience across the children's workforce and sharing some of the learning from LADO contacts. Learning has further informed additional updates to the LADO training and briefings which continue to focus on creating safer organisations where allegations are minimised, children and staff protected and where those who may present a risk of harm are more easily identified and effectively dealt with. Sector specific training has taken place for schools and nurseries and mosque and madrassah staff as well as multi-agency training for other agencies. Bespoke visits and staff briefings have also been undertaken this year has including specific briefings for:

- GPs
- Staff teams in a number of children's residential homes (Walsall Local Authority and independent)
- School staff teams where are there are specific issues or vulnerability to allegations
- Groups of foster carers

The LADO has also attended key team meetings and meetings with managers both internally (LA) and with external agencies, most notably a number of meetings with health colleagues as mentioned above. This has taken place alongside regular visits to settings to support safeguarding practice, which this year has included schools, mosques children's homes and sports settings amongst others.

Evidence of Impact:

Below is some feedback to indicate the impact of some of the above activities:

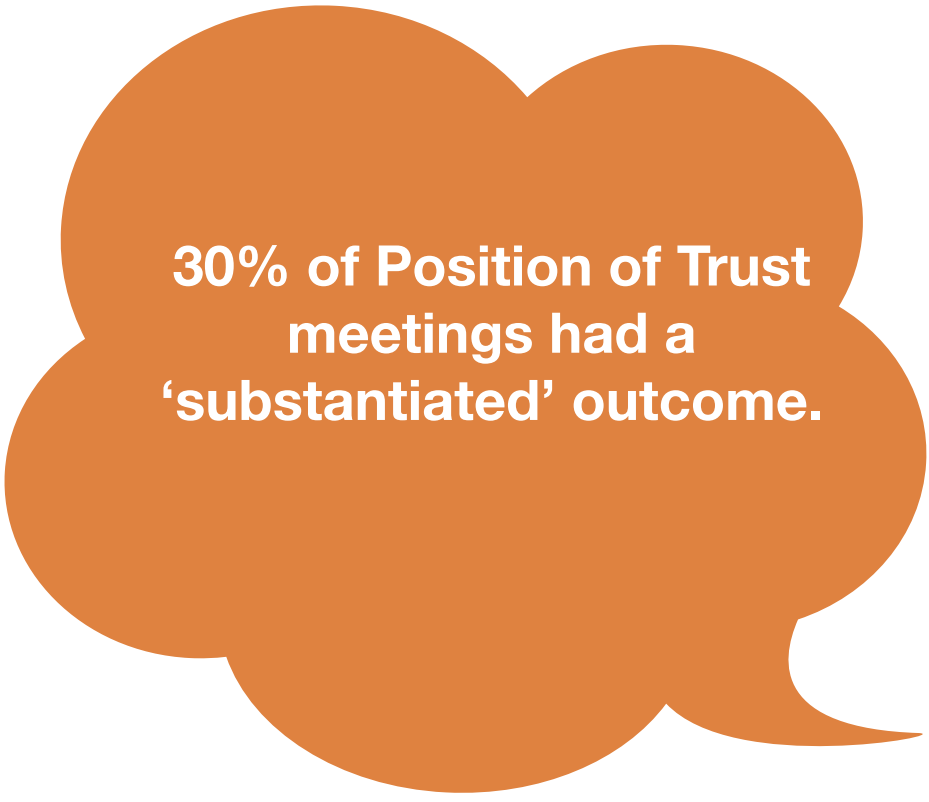
Following visits to settings:

My colleagues and I really found the information you provided, very informative. We received all the information we needed in case a safeguarding issue arises. We were extremely pleased that you found the time to come out and visit us to answer any of our questions. Thank you

I would like to say a huge thank you for your support in relation to the recent safeguarding issue that came to light… From the advice and guidance you have offered… we will continue to carry out regular training focusing on safe reporting and whistleblowing.

Newsletter feedback:

Residential managers discussed your newsletters during our latest meeting all the managers were in agreement that we find the newsletters very useful and informative, thank you so much.



Feedback about LADO contacts:

Thank you for your email and your oversight and advice with this process. I would just like to highlight the responsiveness and quality of advice in relation to this case, enabling us to progress to the internal review of this incident in a timely way so much easier. As a general observation, I was able to find you name and number on the website with no problems, when I needed to speak to you I was offered your mobile number as well as your direct line and we were able to discuss and agree a way forward very quickly. This is, I have to say, in marked contrast to the experience we have with other local authorities in relation to similar issues.

…when I have called you to share information or discuss safeguarding matters with you. You have always been open and transparent in your discussions which I find really helpful. I work with a number of Designated Officers in all authorities across the West Midlands and find your style of discussing allegations particularly helpful.

Following an event with foster carers:

The delivery really connected with the carers who I feel have a greater understanding of the fuller remit of the LADO. The session also helped to highlight a number of practice development issues the service will take on board to support our carers' in minimising the risk of allegations and supporting safe care practices.

Designated Nurse (CCG), activity 2017-18:

The Designated Nurse for Safeguarding Children Team provides safeguarding, child protection expertise and leadership throughout health and multiagency partnerships. The role is pivotal to complex case management, improved partnership working, strategic planning, quality assurance and performance monitoring. It is essential when advising on the development and provision of services. (Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework 2015)

Position:

The Designated Nurse for Safeguarding Children and Children Looked After team advise Walsall Safeguarding Children's Board from a health perspective. They sit on sub committees' of the board and Corporate Parenting Board. They have contributed to the work around Private Fostering, Neglect strategy and Thresholds. Also contributing to Child Death Overview Panel where the Designated Nurse is the vice-chair.

They act on behalf of Primary Care with regard to the completing IMR's to contribute to SCR's. Safeguarding level 3 children training events for primary care staff have been held throughout the year with excellent attendance by Primary Care staff. These have included topics such as:

- Role of the LADO
- Private Fostering
- Role of CAMH's and Primary Care
- SEND
- IRIS
- Child sexual abuse
- MASH
- Early Help

Delegates are invited to supply details of any subject areas relating to Safeguarding Children that they would like to see included in a future programmes.

The Designated Nurse for Safeguarding Children and Children Looked After team provides regular communications for the health economy via various methods such as emails/articles in GP bulletins and telephone conversations to improve practice such as feedback from inadequate MASH referrals.

The Deputy Designated Nurse has held Lead GP Network Forums where sharing of good practice takes place also providing a forum where Lead GP's can voice any safeguarding concerns.

WCCG engaged in a s11 Peer Challenge exercise November 2017 as organised by WSCB.

Safeguarding assurance visits have been undertaken highlighting good practice with regard to the Safeguarding agenda. Areas identified as needing improvement shared with Safeguarding leads action plans put in place. The Designated Nurse for Safeguarding Children and Children Looked After team provide information for CCG staff for example a presentation on Private Fostering.

A self-assessment exercise was instigated by WCCG across Primary Care sites to gain insight into local GP Practice Safeguarding Children arrangements were positive overall with thematic areas for improvement highlighted for action during 2017. Details informed the existing work programme and the business of the Safeguarding Children GP Leads Network Forum. Full coverage of nominated Safeguarding Children GP Leads for local Practices was in place.

The Designated Nurse for Safeguarding Children and Children Looked After team have contributed to the OFSTED inspection carried out in Walsall 2017. There was also a CQC inspection in Walsall CCG for children Looked After and Safeguarding which was co-ordinated by the CCG and an action plan was submitted and is being progressed by health and local authority partners led by the Designated Nurse for Safeguarding Children and Children Looked After team.

Evidence of impact:

Improved working relationships within the health economy.

Assurance visits commenced for safeguarding Areas identified as needing improvement shared with Safeguarding leads action plans put in place.

Feedback from learning events:

- CSA presentation Really Good and Relevant
- Very Useful tips on making good MARF referrals
- Fantastic CSA presentation very relevant case scenarios
- Really useful to hear about LADO
- Early Help – Good to understand the services
- Fantastic CSA presentation very relevant case scenarios
- MASH speaker very informative and interesting
- Good Clinical Cases of CSA

Child Safeguarding Coordinator, Education and Early Years, activity 2017-18:

Summary:

This is the second academic year that the service is traded with approximately 70% of all schools having a service level agreement (SLA).

During the last year in excess of 300 school staff have received training to support their role of designated safeguarding lead and safer recruitment; satisfying requirements within Keeping Children Safe in Education guidance.

Position:

- There is a proportionate spread of maintained, academies and independents who buy into the traded offer.
- Schools and academies who opt not to trade still receive a core offer which includes a model child protection policy and information relating to new government guidance.
- If an issue is identified within a school that does not trade this does not deter the service from investigating issues and responding to LA senior leaders.
- Three workshops have been well attended where the focus is sharing good practice for safeguarding covering issues such as private fostering responsibilities, early help engagement, preventing exclusions and managing behaviour, GDPR and school records, NSPCC/Pants campaign, completing a good quality MARF and understanding thresholds.
- The service also organised an anti-social behaviour, knife carrying and gang risk event attended by secondary schools and alternative providers. A separate report indicated real value and a better understanding of agencies available to support children and families.

Evidence of Impact:

Ofsted reports from schools inspected in the LA report that safeguarding is effective in all but 3 in the last 18 months. One of the schools has since signed an SLA and after intense

An anti-social behaviour, knife carrying and gang risk event took place and was attended by secondary schools and alternative providers.

During the last year in excess of 300 school staff have received training to support their role of designated safeguarding lead and safer recruitment.

support by the service their safeguarding is now deemed to be effective. The other 2 schools had SLA's and the service has evidence of support/challenge for safeguarding procedures before they were inspected by Ofsted. Evaluations reflect that the work of the service contributes to the safeguarding of children and young people in our schools and academies as systems are more robust.

Principal Social Worker (PSW) activity 2017-18:

The key focus of the role is to ensure that the correct conditions are in place to ensure that effective Social Work practice can exist.

As the lead for the Academy of Social Work and Early Intervention, the PSW is responsible for the recruitment and retention of Social Work practitioners and the delivery of a comprehensive Training and Development Programme which has included Restorative Practice, Graded Care Profile 2 Training, NSPCC Reunification Framework, Barnados Domestic Violence RIM and RAM Programmes.

Our aim is to ensure that our practitioners have assessment and intervention models that are evidence based and supported by research, through our ongoing subscription to Research in Practice.

The PSW facilitates a monthly meeting called Practice Improvement Forum (PIF). The purpose of this meeting is to enable practice leads (Group Managers, Team Managers, Assistant Team Managers and Senior Practitioners) from across Children's Services and Early Help to collaborate, network, share best practice, reflect upon performance and ensure greater consistency of services for children, young people and their families, providing the opportunity to identify areas of service need and development. This forum will also be utilised to develop and launch new policies, procedures and practice development.

Recent PIF meetings have been themed to focus upon key areas of practice and social need. The sessions on Criminal Exploitation, which was facilitated by Catch 22, and Neglect, which centred upon the Neglect Strategy and implementation of GCP2 have been well received. The focus of discussion and the session has been:

"What is it like to be experiencing exploitation/neglect in Walsall?"

This has ensured that there is a key focus upon local issues in the context of national intelligence and research. Attendees will then disseminate the content of these sessions to their staff in unit meetings to ensure that this knowledge is shared and practice improves as a result.

Weddell:

In March 2018, the Academy of Social Work and Early Intervention launched the Weddell Partner and Family Programmes Training Programme. Historically, Walsall Children's Services used the McEwan programme to offer group work to parents previously in a relationship with a perpetrator (alleged or convicted) or the parent of a child that had been sexually abused, to assess their vulnerability and increase their understanding of risks. The McEwan programme did not have a recognised evidence-base and therefore we sought to identify a tool for assessing risk alongside an intervention programme to reduce potential further harm.

A Team Manager and Senior Practitioner for Sexually Harmful Behaviour were asked to explore the development of a workbook which could be delivered by Social Workers in the absence of the McEwan programme. Hampshire & Thames Valley Circles (HTVC); a charity that works with offenders of sexual abuse with the aim of reducing the harm caused by sexual abuse within the community, were approached for assistance in developing a workbook, due to their experience working with non-abusing partners.

It was agreed that the Workbook would follow three principles of developing greater and long-term protection:

- 'Awareness' i.e. increasing parent attentiveness and ability to recognise the signs and symptoms of abuse in children.
- 'Information' i.e. teaching parents about how sexual abusers operate; their motivations, justifications and grooming techniques, and/or about children displaying sexually harmful behaviour, and
- 'Support' i.e. helping partner/parent to develop their own appropriate social support network outside the family and reducing social isolation.

Walsall Children's Services have consulted with Hampshire & Thames Valley Circles (HTVC) to develop the 'Weddell' workbook. The Weddell Partner and Family programmes have been named after 'Weddell' Seals.

Weddell seals are one of the toughest mammals on the planet, and Weddell mothers must take on the mammoth task of raising babies and equipping them with essential life skills single-handedly, in the Antarctica where conditions are amongst the most extreme on earth.

Non-abusing partners and parents of children displaying sexually harmful behaviour have to protect their children in a potential risky situation of contact with a known perpetrator. They have the overriding responsibility of identifying risks, protecting their children, and giving their children the right skills to recognise and respond to future risks themselves.

Practitioners have been implementing the Weddell Programme with positive outcomes; raising the knowledge of parents, equipping them to make safer decisions in relation to their children. It has also been used to evidence where sufficient safety cannot be achieved for children and young people and court intervention has been necessary. It this situation, the Judge provided positive feedback on the development and use of such a tool, indicating that it provided clear evidence of structured assessment and intervention.

Weddell Impact – Case study:

Child A was a young female (9 yrs) who reported, to teachers, having been sexually abused by her brother (13 yrs) in the family home. It transpired that at the time of the event she had reported this abuse to her mother who had minimised this, and told her not to tell her father or anyone else. Despite knowing about the abuse the children were then subsequently left in the family home each morning and each afternoon, before and after school as parents worked, resulting in there being no safeguards in place to ensure the safety of child A and she was fearful of the abuse continuing.

At the commencement of the Weddell programme with the family, parents minimised the incidents. They were evidently torn between both of their children and they were also trying to justify their actions. Father was initially seen as having some unassessed protective capacity as he had been concerned by the fact his wife had not told him. Mother lacked any insight into the concerns held by the LA and as such the stance that was taken initially was that she allowed her daughter to remain at risk, she failed to safeguard the children and she lacked the capacity to help support her daughters repair and recovery.

Throughout the completion of this programme parents engaged and reported enjoying learning more about how they could support both of the children. It transpired that mother had experienced familial sexual abuse herself and this had in some way acted as a barrier to her ability to act in accordance with protecting her children.

Prior to the completion of the programme it appeared that these events may result in both of the children being cared for outside of their birth family and the LA sought legal advice to enable this to happen. However at the end of the programme, the LA were able to assess and evidence that parents were able to safeguard the children, they both reported that they had learnt from Weddell, a safety plan was completed and the pre proceedings was concluded, in addition the family were able to step down from Child Protection to Child In Need.

Weddell: Partner and Family Training Programmes launched.

10. Voice of children and Young People

Voice of children and Young People 2017-18:

Summary:

- There is a nominated Young People's Representative who is an ongoing member of the WSCB.
- There was a young people's 'Take Over' event in November 2017.
- The Youth Of Walsall have produced a knife crime campaign.
- The Board has struggled to maintain active engagement with Children and Young People and ensure their voice is represented within its business

Position:

By Zara Khan, Young People's Representative, Board Member

'Real Knives, Real Lives' Knife Awareness Campaign

YOW have undertaken this knife awareness campaign as a result of a survey that we sent out in April 2017 on the back of the United Kingdom Youth Parliament (UKYP) Elections. We sent the survey out to various secondary schools and asked young people what they felt the issues were for them in Walsall. Knife crime and gangs came out as number one with 918 votes out of 5241 votes across 6 secondary schools. The name of the campaign is 'Real Knives, Real Lives' and the aim is to educate young people about the dangers and consequences of carrying a knife. We will be supported by a Youth Desistance Practitioner to run 10 workshops in the Autumn for young people who are at a high risk of knife crime. We will also create a short film which will portray the effect that knife crime has on friends and family and Public Sector services such as: the Police, A&E, the prison service, youth justice etc. We have been successful in securing funding for this project from the Active Citizens fund through the Police and Crime Commissioner's (PCC) Office.

Takeover Q&A Session

The former Chair, Alan Critchley, and the Board Manager, Sarah Barker, encouraged the Youth of Walsall (YOW) to put together an event for Takeover Day on the 24 November. This is a national, annual initiative which encourages professionals to allow young people to take over their job role for the day. We had a great deal of support from the board's Project Manager at the time, Yvonne Byrne, to put this event together. We decided to organise a Q&A session where young people could ask professionals any burning questions that they had about their lives in Walsall. We had a few professionals on board to do the panel, including Debbie Carter, Children's Services; Alan Critchley, Chair of the LSCB; Councillor Aftab Nawaz, Portfolio Holder for Children's Services; Rebecca Johnson, Clinical Commissioning Group (CCG) and Jo Clews, Borough Commander for the Police. The event went well despite their being a low number of young people in attendance. If given the chance to organise another Takeover session, I think as a group (YOW) with the board, we would have to brainstorm better ways to engage schools and young people. [10 young people attended the event]

A&E Inspection

Alan and Sarah suggested to YOW that it might be a good idea for them to do an inspection of specific public services. YOW chose to inspect A&E as it is an issue that affects one of our members. The aim of the inspection was to gain an insider's perspective as to how A&E is actually run over 3 different days and times during August 2017. The plan was to create and conduct a survey to ask patients/staff what their experience of A&E is. It would include: food/drink facilities, presentation of A&E, any obstructions, i.e. any difficulties getting into A&E and the way that patients are treated. Unfortunately, there were a number of barriers that did not allow us to conduct this inspection, including the need for DBS checks. In hindsight, I think this inspection was rushed into and although I appreciate the encouragement from the board and the opportunity to conduct an inspection, I don't think that the relevant systems are in place for young people to go into A&E to conduct an inspection. If given the chance to do something similar, we would definitely have to rethink the logistics of the process and how best to approach an inspection of A&E or other similar services.

This is an area of development for the Board and will continue to be a priority in 2018 – 19.

Scheduled work 2018-19:

- Further develop the engagement of young people and mechanisms for the voice of the child to be reflected in Board business.
- Understand how partner agencies gather the views and experiences of young people who use their services.

WSCB will further develop the engagement of young people in 2018 – 19.

'Real Knives, Real Lives' Knife Awareness Campaign launched.

11. Learning and Development

Multi-Agency Training 2017-18:

From 1st April 2017 to 31st March 2018, 22 courses were delivered attended by 1,077 delegates, see table below. This is an additional 10 courses and an increase of 45% in attendance compared to the previous year.

All courses are delivered by experienced professionals from across the partner organisations, commissioned service providers and specialist external consultants.

The full programme includes:

- Child Sexual Abuse
- Child Sexual Exploitation Advanced
- Child Sexual Exploitation Awareness
- Children Who Display Sexually Harmful Behaviour
- Core Working Together (Advanced)
- Disguised Compliance
- Domestic Abuse Advanced
- Domestic Abuse Awareness
- Drugs and Alcohol awareness and Parental Substance Use
- E-Safety Awareness
- Forced Marriage and Honour Based Violence
- Introduction to Parental Mental Illness
- Managing Allegations against People in a Position of Trust
- Multi Agency Thresholds Workshop
- Recognising and Understanding the Sexual Exploitation of Boys and Young Men
- Safeguarding and Child Protection for Disabled Children
- Safeguarding Children and Young People (Awareness)
- Safer Recruitment
- Supporting Parents with Learning Disabilities
- Understanding Neglect
- When Children and Young People go Missing – Advanced
- When Children and Young People Go Missing – Awareness
- Working with Fathers

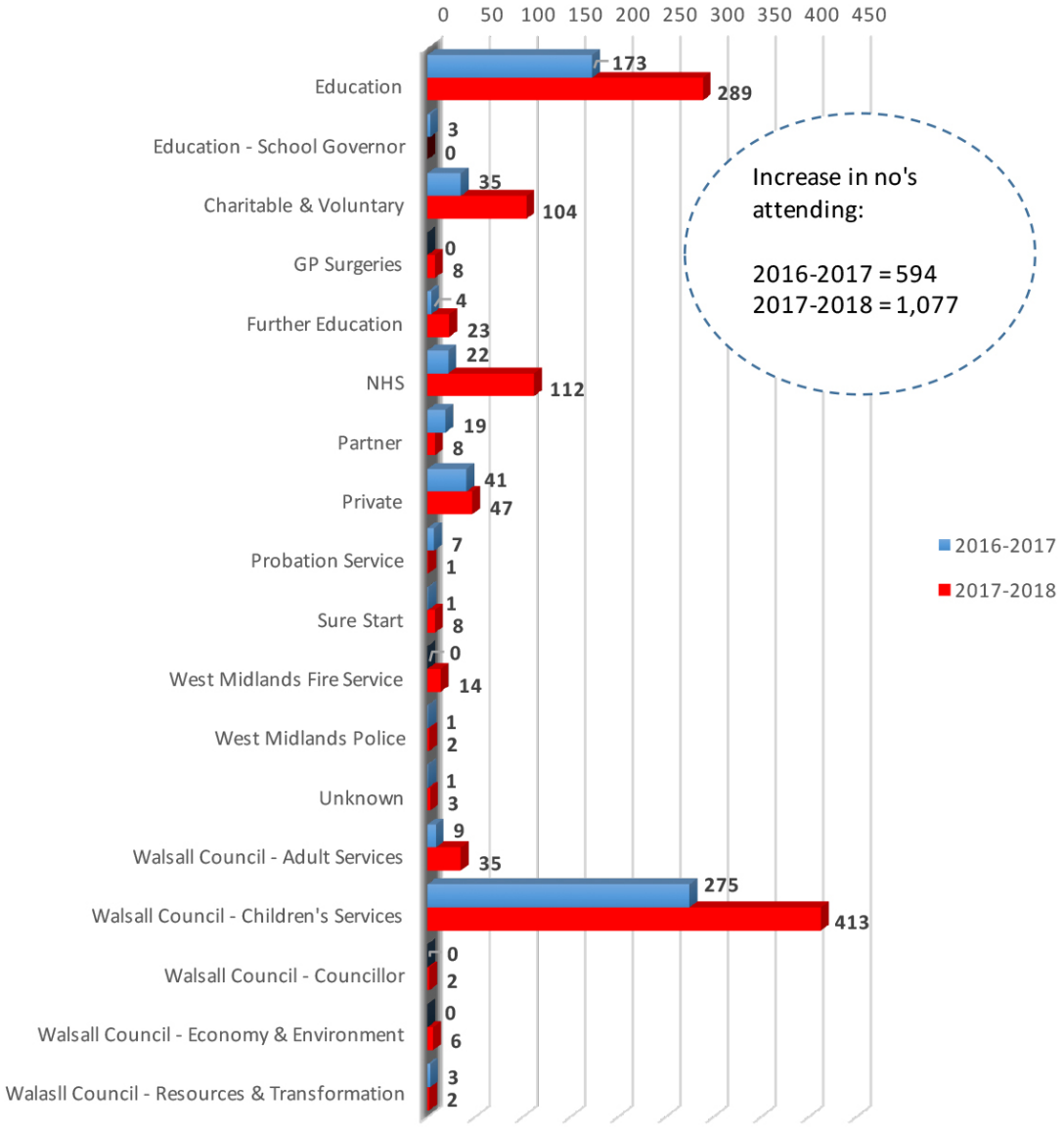
This year's programme has included five new courses being delivered in response to the learning from serious case reviews/significant incidents; outcomes of audits; feedback from practitioners and review of the regional training offer:

- Understanding Neglect
- Forced Married and Honour Based Violence
- Safeguarding and Child Protection for Disabled Children
- Child Sexual Abuse
- Working with Fathers

From 1st April 2017 Schools were encouraged to access Safeguarding Children & Young people level 1, 2/3 and Safer Recruitment training as part of a 'traded offer' delivered by the Child Safeguarding co-ordinator – Education and Early Years.

The overall programme continues to be well attended by multi-agency staff from across the public, voluntary and private sector. However, difficulty in obtaining a detailed training needs analysis means it is unclear how much of the workforce has been reached by this training.

Comparison of attendance over the last 2 years (2016 – 2017 and 2017 – 2018) by Agency:



The majority of the attendees in both years are from Walsall Council, followed by Education and NHS.

In 2017-2018:

- Walsall Council – Children's Services 38.3%
- Education 27%
- NHS 10.3%

In comparison to the previous year, there has been an increase in attendance from:

- West Midlands Fire Service = 14 (100%)
- NHS = 90 (80%)
- Adult Services = 26 (74%)
- External voluntary and charitable organizations = 69 (66.3%)
- Education = 116 (40%)

A number of courses are in higher demand and so have a waiting list these include: Core working together level 2/3; Safeguarding Children & Young People level 1; Parental Mental Illness; Disguised Compliance; Domestic Abuse (Advanced) and Child Sexual Abuse (new course).

Child Sexual Abuse Awareness is a new course introduced this year in response to learning from reviews. The course has generated a high level of interest and now has a waiting list for places, therefore additional sessions will be offered in 2018-19. Despite the introduction of training in 17-18 Child Sexual Abuse continues to be a feature of reviews and will be a Board priority in 18-19.

6, half day, Disguised Compliance workshops were held in response to learning from reviews.

Evaluation of training:

Working together 2015 requires LSCBs to monitor and evaluate the effectiveness of both single agency and multi-agency training; in particular the impact the training has on outcomes for children and families. Both qualitative and quantitative evaluation data is sought that takes into account the participants' reflection on their training experience; the extent of their increased knowledge and skills to ensure that training is of a high standard and is transferred into practice.

It is important that evaluation takes place at all levels of safeguarding training and whilst responsibilities for this will be shared among agencies, WSCB will lead and support the evaluation process which will include:

- Attendees complete an evaluation sheet on the day they attend training;
- At six weeks an online survey is sent out to 100% of delegates who attended a course;
- At three months an impact evaluation questionnaire is sent to a 20-25% dip sample across the multi-agency practitioners who attended the training session and their Managers. Those completing the impact evaluation will receive a follow up in-depth telephone interview to establish the difference the training has made to the welfare of children and young people in Walsall and whether participants were enabled to put their learning into practice.

The outcome of the evaluations is used to provide evidence on an annual basis to WSCB Learning and Development Sub Group of the effectiveness and impact of local safeguarding training and to support the development and improve future training.

The impact evaluation tool and process adopted by WSCB is based on a Black Country model and it's implementation was an Ofsted recommendation. As this was a new process it was decided during 2017-2018 to focus on 4 specific themes relevant to Board priorities and learning from reviews:

- April – September = Thresholds & CSE Awareness
- October – March = Neglect & Sexual Abuse/ Disguised Compliance

As a newly implemented process the response to the online survey and telephone interviews has been low (approximately 10%). This has impacted on the ability to undertake a more detailed analysis of impact.

Examples of how some of the training will be used in practice:

Following the Child Sexual Abuse (CSA) Course participants were asked how they hoped to change their practice, responses included:

- Being more aware and vigilant
- Recognising the signs/symptoms of CSA
- Working together more – share knowledge with other agencies
- Referring to Crisis Point when necessary

Following the Disguised Compliance workshop participants were asked how they hoped to change their practice, responses included:

- Ask the 5 'whys'
- Discuss at unit meetings
- Rethink methods of questioning
- Continue to listen to the child
- Be more professionally challenging
- Develop tighter chronology in records
- Develop certain skills e.g. questioning skills, general approach with 'clients' – more observant e.g. disguised behaviour and repeat statements back to 'client'
- Change the way I write conference reports; change the way I 'do' active listening.

The numbers of professionals attending multi agency training has doubled.

Despite positive responses to the training, the SCR's and audits undertaken by the Board continue to show identification of Child Sexual Abuse, effectiveness of Core Groups and professional challenge to be areas of practice which require improvement.

As the L&D subgroup have been unable to obtain figures on how many people require some of these courses across the partnership, it is difficult to say whether the Board has reached a sufficient audience to influence practice.

A copy of the full Multi Agency Learning and Development Annual Report is available on the WSCB website.

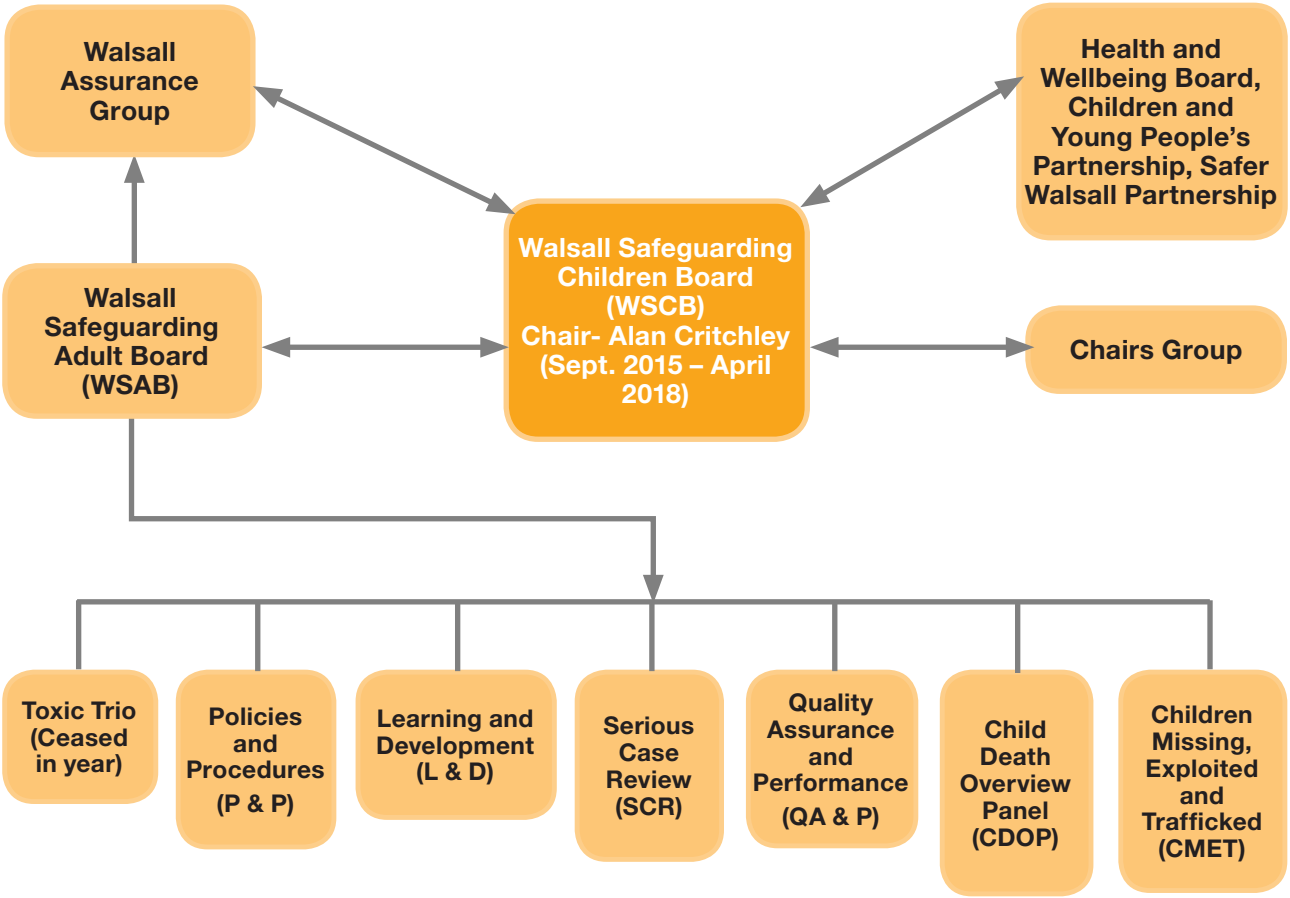
WSCB Conference: 'Does one thing lead to another?'

Walsall Safeguarding Children Board held its Annual Conference on Thursday 30th November 2017 in Walsall. The theme for the conference was the Toxic Trio: 'Does one thing lead to another?'; chosen to ensure the three significant areas of vulnerability i.e. Domestic Abuse; Drugs/Alcohol and Mental Health were explored as they continue to impact on the lives of children and families supported by multi agency professionals within Walsall. The event was very well attended by 81 professionals from across the partnership. Geese Theatre provided powerful interactive drama sessions to explore the themes with delegates. 90% of delegates 'agreed' or 'strongly agreed' that the event would have an impact on their day to day practice.

Scheduled work for 2018-19:

- Further develop the multi agency offer and agree a training strategy across the Borough.
- Seek opportunities to liaise with the Safeguarding Adult Board in Learning and Development opportunities that promote a 'Think Family' approach.

Appendix 1: Board Structure



Sub Group Chairs:

- **Toxic Trio** – (when subgroup in operation)
  David Haley, Director of Children's Services
- **Policies and Procedures**
  Diane Rhoden, Corporate Senior Nurse, Quality and Safeguarding, Walsall Healthcare Hospital Trust
- **Learning and Development**
  Jayne Holt, Assistant Principal, Walsall College
- **Serious Case Review**
  Debbie Carter, Assistant Director, Children's Services Social Care / Alan Critchley, Independent Chair
- **Quality Assurance and Performance**
  Sally Roberts, Chief Nurse, CCG
- **Child Death Overview Panel**
  Amanda Viggers Designated Nurse, Walsall CCG / Independent Consultant (until Dec 2017), then interim arrangement with Vice Chair, Jackie Haden, New Designated Nurse, Walsall CCG.
- **Children Missing, Exploited and Trafficked**
  DCI Derek Lambert, West Midlands Police

Appendix 2: Walsall Safeguarding Children Board

Meeting Attendance April 2017 – March 2018

ORGANISATION	Apr 2017	June 2017	Sept 2017	Dec 2017	March 2018	Total (%)
Independant Chair	✓	✓	✓	✓	✓	100%
Lay Member	✓	✓	✓	✗	✓	80%
Walsall Council Children's Services	✓	✓	✓	✓	✓	100%
WSCB Business Unit	✓	✓	✓	✓	✓	100%
Clinical Commissioning Group	✓	✓	✓	✓	✓	100%
Walsall Healthcare NHS Trust	✓	✓	✓	✓	✓	100%
Walsall College	✗	✓	✓	✓	✓	80%
CAFCASS / Family Justice Board	✗	✗	✗	✗	✗	0%
West Midlands Police	✓	✓	✓	✓	✓	100%
National Probation Service	✓	✓	✓	✓	✗	80%
Community Rehabilitation Company (CRC)	✗	✗	✗	✗	✗	0%
West Midlands Fire Service	✓	✗	✓	✓	✗	60%
Lead Member/Councillor	✗	✗	✓	✓	✓	60%
Youth Justice Services	✓	✓	✓	✓	✗	80%
Walsall Council Public Health	✗	✗	✓	✓	✓	60%
Dudley & Walsall Mental Health Partnership Trust	✓	✓	✓	✗	✗	60%
Housing – whg	✓	✗	✓	✓	✓	80%
NHS England	✗	✗	✗	✗	✗	0%
Schools:						
Nursery	✗	✗	✓	✓	✗	40%
Primary school	✗		✓	✗	✓	40%
Secondary school	✗	✗	✗	✗	✗	0%
Special	✓	✗	✗	✗	✗	20%
College	✓	✓	✓	✓	✓	100%

Appendix 3: Finance

Budget 2017 – 2018			
Funding 17/18	**Children's £**	**Adult's £**	**Total £**
Walsall Council Contribution	79,457	15,000	94,457
Walsall Council Additional Investment	200,000	0	200,000
NHS Walsall	5,000	5,000	10,000
Probation Services (NPS & CRC)	3,000	1,500	4,500
West Midlands Police	15, 322	15,272	30,594
CAFCASS	550	0	550
CCG	25,000	15,000	40,000
CCG Additional (One off)	30,000	0	30,000
Other	319	0	319
Total	**358, 648**	**51,772**	**410,420**

Costs	**£**	**£**	**£**
Salary Costs	101,150	5,569	106,718
Chair Costs	24,470	24,269	48,939
Agency	67,170		67,170
Consultants Costs	119,950	32,500	152,450
Workforce Development SLA	15,003		15,003
Section 11/157/175 Tool	0		0
Chronolator Tool	790	790	1,580
SCR / SAR	2,275	6,000	8,275
Development Day / Conference	3,968		3,968
Online Child Protection Procedures	7,141		7,141
Other Costs - Catering, IT, Room Hire, Membership Fees etc.	4,139	1,000	5,139
Shortfall in contributions	0	0	0
Additional income	-7,461	0	-7,461
Total	**346,056**	**70,328**	**408,923**

Forecast Out-turn Over / (Under)	**-1,497**

- The Safeguarding Board Business Unit services the Children and Adult Safeguarding Boards, therefore the financial resources are managed across both.
- Additional contributions from the LA and CCG enabled the Board to employ consultants to drive forward development work and clear backlogs of cases in the Child Death Overview process 2017-18.
- The Section 11 Audit tool was paid for in the 16/17 budget and does not therefore appear on this table (above).
- Work has taken place to employ permanent staff to the Board Business Unit. All roles are now recruited too except the QA Officer and Vulnerabilities / CSE Coordinator.
    - Following advertising on WM Jobs for the QA Officer post, which elicited 22 applications and no one who was short-listable, the role was advertised as a secondment and opened up to all board partner agencies. Unfortunately this also proved unsuccessful. Therefore, the Board Manager is going to explore the possibility of utilising agency staff / consultant whilst another round of advertising take place.
    - The roles which were proposed in the original draft of the business unit structure were graded higher than expected when they were accessed by the LA Pay and Grading team. This has meant there will not be enough resource within the budget to recruit to the vulnerabilities / CSE coordinator role.
- The Workforce Development SLA outlines the costs of multi agency training (in addition to the Training Officer salary costs). This will increase in 2018-19 due to the merger of the Children and Adults programme.
- 2018-19 will see a significant reduction in the costs for the Online Child Protection Procedures due to a new regional contract.
- Increased funding has been set aside in 18-19 for the high costs expected with the increased number of SCR's already being undertaken.
- 'Additional income' is generated through non-attendance charges for training.
- Additional resources have been allocated in 2018-19 for both Boards for a Conference, Development Day and further development activities to progress Board effectiveness.
- Overall, across both Boards, at the year end, there was an underspend of just under £1500.

Appendix 4: CDOP

Cause of death categorisation codes

Cause Code	Name & description of category
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (Category 1).
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week).
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).


Walsall Safeguarding Children Board