OSCB ANNUAL REPORT 2013-2014

Oxfordshire Safeguarding Children Board






Annual Report Introduction:

I am pleased to present the 2013/14 Annual Report of the Oxfordshire Safeguarding Children Board. It outlines progress made during 2013/14 and summaries the key challenges ahead for all agencies to ensure children across the County are safe from harm, abuse or neglect.

I took up the role of the Independent Chair in May 2014 and have carefully considered the work undertaken by all agencies working with children in Oxfordshire since my arrival. It has been a challenging year for all agencies with public sector reorganisation, increasing throughput of cases within children's services, and a continuing squeeze on resources across agencies. This impacts on staff but also on children and families, facing increased pressure from the economic climate. I have been impressed in my first few weeks by the partnerships across Oxfordshire between Oxfordshire County Council, District Councils, the Clinical Commissioning Group, health providers, schools, Thames Valley Police, the voluntary sector and the many different organisations working with children. There are some good examples of integrated working across Oxfordshire, most visibly in the work of the Kingfisher team, which I visited very recently, ensuring early responses to children at risk of sexual exploitation, going missing or trafficking. Children and young people in Oxfordshire must expect the agencies involved to work even more closely together and to be visionary and creative, particularly when combating organised crime, child abuse and neglect. The designated health staff in Oxfordshire work hard to ensure that primary health providers, hospitals and all health settings prioritise children and that staff can recognise early the signs of abuse. Likewise all schools including independent institutions, academies,

F.E establishments and free schools must continue to improve how they safeguard children. Lessons have clearly been learned from the incidents of child sexual exploitation and OSCB has been proactive in training frontline staff, producing guidance and new tools to help professionals assess children at risk. Similarly, police officers in Oxfordshire are engaged fully in child protection services and have placed a high priority on safeguarding children. This is to be commended. At the end of 2013/14 the local authority and its partners were inspected by Ofsted in relation to the effectiveness of child protection services and were judged 'good'. The OSCB itself was assessed as 'good' and inspectors noted that 'safeguarding is clearly a priority for OSCB. Board members are well motivated and committed, in their desire to secure better outcomes for children, young people and their families…' I am pleased to be appointed as the new Independent Chair following on from this inspection and I have taken note of the hard work put in day by day by all professionals across Oxfordshire to keep children safe and to the engagement shown by political and strategic leaders across the County. This really does make a difference. I know that if we keep the same focus on keeping children safe in the coming year we can expect to provide continually improving services for all children and young people, ensuring too that the most vulnerable children have their voices heard. The OSCB Board Members agreed the priorities for the coming year 2014/15 some months ago and these are captured at the end of this Annual Report. I will review them regularly over this year and report further on the effectiveness of the child protection system across Oxfordshire in 12 months' time.

by **Maggie Blyth**
the Chair of the Board






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CHAPTER 1: LOCAL SAFEGUARDING CONTEXT 2013-2014

Oxfordshire demographics

Oxfordshire is the most rural county in the South East. It has a population of around 635,500, over half of whom lives in towns or villages of less than 10,000. Approximately 138,000 young people under the age of 18 years live in Oxfordshire.

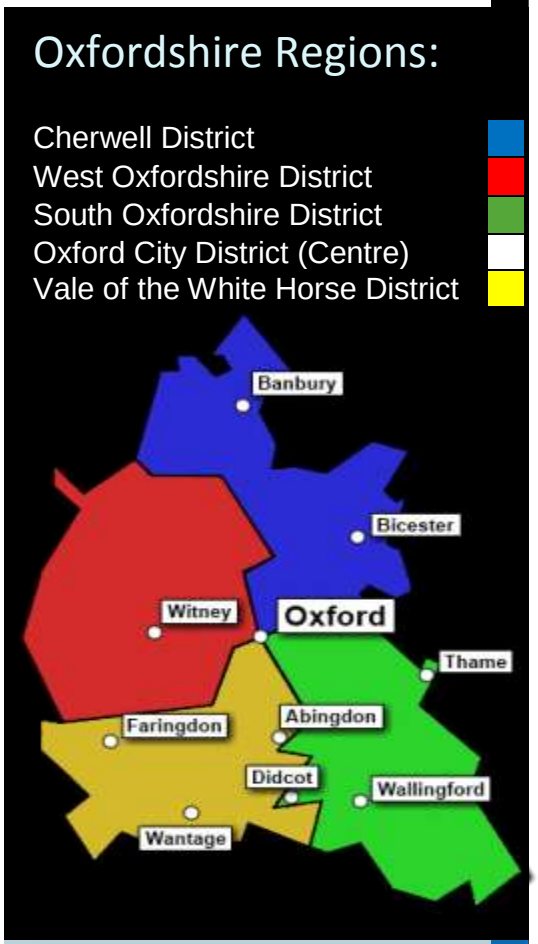
The county has a predominantly white ethnic population, with 86.5% of children and young people of white ethnicity. The largest minority ethnic groups of children and young people in the area are Asian/ Asian British (5.8%) and people from mixed/ multiple ethnic groups (4.9%). Children of non-white ethnicity predominantly live in Oxford City and Banbury.

The county has a mix of affluent and deprived areas. Approximately 12.2% of the local authority's children under 16 are living in poverty compared to the national figure of 22.1%.

The OSCBs approach has been to focus attention on those children who are most vulnerable and at risk of suffering harm.

Vulnerable groups

Children can become vulnerable and at increased risk of harm for a variety of reasons. We know from case reviews that children living in households where there is domestic abuse, substance misuse or their parents are mentally ill are known to be at a greater risk. We also understand the long-term damaging effects of neglectful parenting on children. We know that children who go missing from school or missing from home are also placed in greater danger of harm. Despite this it is not always possible to know the complete picture of the children whose safety is at risk because some abuse or neglect may be hidden. To counter this partners in the OSCB have identified some groups of children that are understood to be at particular risk. This helps ensure that their needs are understood and that they form part of our local picture. Our understanding of these groups is outlined below.



Children with a child protection plan

Children who have a child protection plan are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of two or more of these. The plan details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how we will know when progress is being made.

At the end of March 2014 there were 504 children subject to a plan compared to 430 children the previous year. There were an additional 18 children who were the responsibility of another local authority living within Oxfordshire. This is the highest level for many years. Nationally there was a rise in numbers on a child protection plan between 2008 and 2011, which has since levelled. The increase in Oxfordshire was less pronounced over these 3 years, but is now rising at a quicker rate. OSCB has analysed this increase in general activity and concluded that it reflects greater identification, recognition and response to signs of abuse and neglect as well as sensitivity to risk. Children are staying on plans for longer and also having a new plan when risk is deemed to have increased. OSCB's audit has shown that decision making by front line professionals is appropriate and reflects a good understanding of managing risk.

This increase in plans has created pressures within the safeguarding system for all partners involved in the multi-agency planning of care and for children's social care in particular to maintain close oversight. The OSCB has ensured that partners are clear on their roles, as outlined in the recent **Ofsted report.** The report states that the Board's scrutiny of this work, '*has led to tangible improvements in practice, including better attendance of relevant agencies at child protection conferences and core groups'.*

The OSCB routinely scrutinises child protection activity. There were four audits last year to check the decision making processes for starting and stopping child protection plans. The impact of these audits has been an update to the thresholds of needs matrix, followed by its promotion in all core safeguarding courses and workshops with targeted professionals. *Please click this link to the:* **OSCB_thresholds of needs matrix document** *this can be found at:* **http://www.oscb.org.uk**

Children in Care

Children in care are those looked after by the local authority. Only after exploring every possibility of protecting a child at home will the local authority seek a parent's consent or a court decision to move a child away from his or her family. Such decisions, whilst incredibly difficult, are made when it is in the best interest of the child.

There were 463 children in care at the end of March 2014, compared with 416 at the end of March 2013. There has been a consequential increase in the rate of children in care per 10,000 of the child population which has risen from 30.0 to 33.4. The majority of children (327) were living with foster families.

Last year 14% of children looked after had previously been in care; over half had been on a children protection plan; a third had been subject of a children in need plan and a fifth had received early help. Previously a third of children came straight into the looked after system without any intervention; in 2013/14 this had decreased to just one quarter.

The county council operates 2 children's homes; both were judged to be good or outstanding in their most recent Ofsted inspection.

During the recent Ofsted inspection of Oxfordshire's Children's Services, Ofsted judged the experiences and progress of children looked after and achieving permanence as good and commented, *'in the large majority of cases, children and young people are settled and thriving in their current placement, with improved outcomes in all or most areas of their lives..'*

All children in care are subject to regular independent reviews of their care to ensure that their circumstances are reviewed, they are kept safe and their needs are met. The local authority and other agencies work together to ensure that children in their care are offered the best possible care and this work is co-ordinated and overseen by the Corporate Parenting Panel. Ofsted commented that, *'Long-term planning to secure stable futures for children is given a high priority. The search for suitable alternative families starts at the earliest possible stage. The contribution made by the adoption service is good. The number of children placed for adoption has increased over the last two years and includes improved adoption rates for older children'.*

Children who are privately fostered

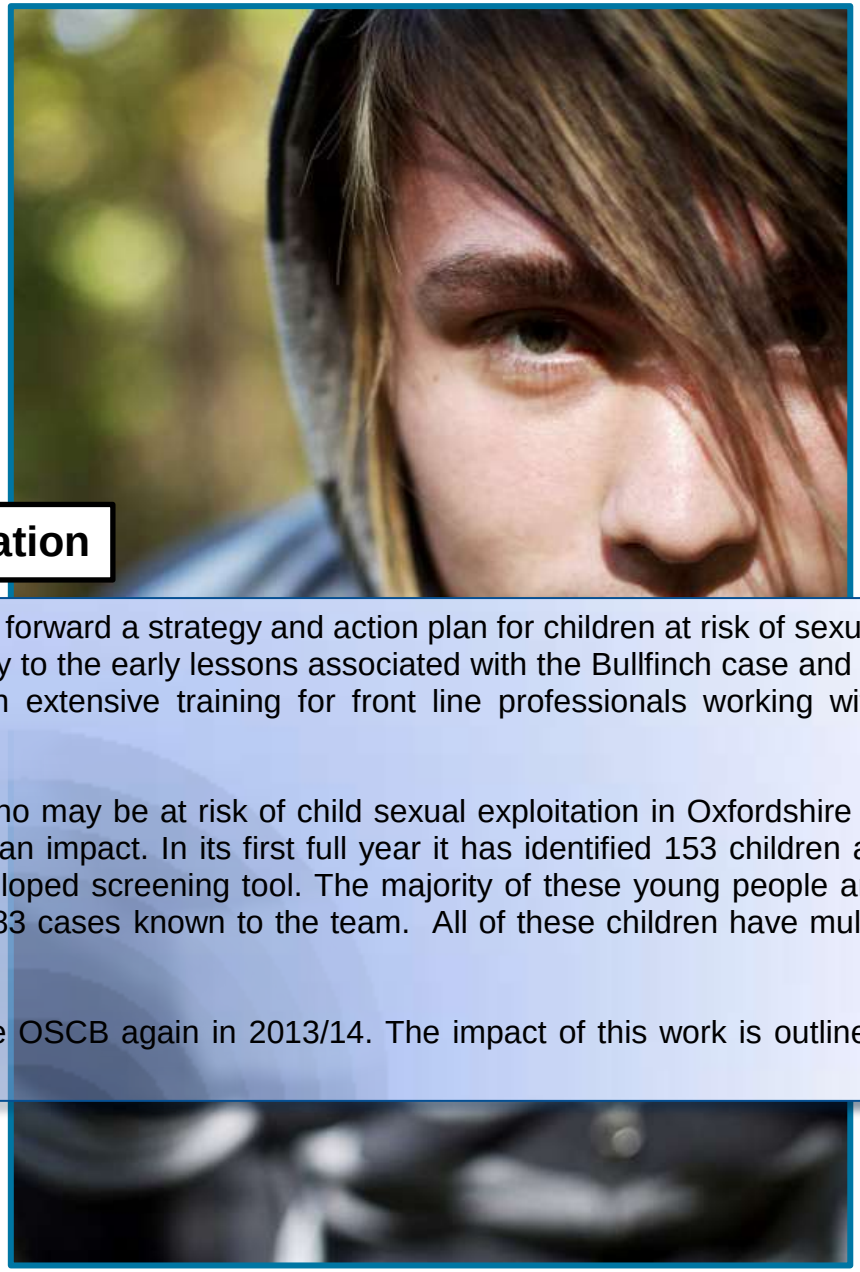
Parents may make their own arrangements for their children to live away from home. These are privately fostered children. The local authority must be notified of these arrangements. At the end of March 2014 the local authority were aware of 34 children living in a privately arranged foster placement which is a decrease from 37 at the end of March 2013. The local authority has a private fostering worker who raises awareness of the need to notify the local authority and ensure the arrangements are visited and checked so that children are safe.

Disabled children

There has been a small rise in the number of disabled children with a child protection plan (CPP). At the end of March 2014 there were 15 disabled children with a CPP. OSCB has established a disabled children sub group which focuses on the needs of this vulnerable group with a particular aim to improve transition arrangements.

Young people who offend or are at risk of offending

The young people who are involved with Oxfordshire Youth Offending Service (YOS) often present with complex needs requiring significant support both in and out of custody. The YOS has continued to see the number of young people they work with decrease from previous years. In 2013/14, 282 young people received a substantive outcome compared with 344 in 2012/13. The proportion of young people receiving a custodial sentence rose slightly from 3.5% in 2012/13 to 4.2% in 2013/14 suggesting that there is a small but significant group of young people that present a high risk of harm to the public and may have additional problems which make them vulnerable. However, the proportion of young people receiving a remand to custody fell from 8.5% in 2012/13 to 4.8% in 2013/14. The decline in numbers of offenders and offences is consistent with a national reduction in the number of young people formally entering the criminal justice system.



Children who are at risk of sexual exploitation

During 2012/13 OSCB established a new sub group to take forward a strategy and action plan for children at risk of sexual exploitation (CSE). Partner agencies have responded swiftly to the early lessons associated with the Bullfinch case and in addition to new policies and procedures, there has been extensive training for front line professionals working with children.

Multi-agency work to identify children and young people who may be at risk of child sexual exploitation in Oxfordshire is coordinated by the Kingfisher Team. The team has made an impact. In its first full year it has identified 153 children as being at risk of exploitation, as defined by the locally developed screening tool. The majority of these young people are female and aged between 15 and 17. Currently there are 83 cases known to the team. All of these children have multi-agency safeguarding plans to reduce the risks.

Child sexual exploitation was identified as a priority for the OSCB again in 2013/14. The impact of this work is outlined extensively later in this report.

Young people with mental health issues

3167 young people and families were receiving a service from the Child and Adolescent Mental Health Services at the end of March 2014. Waiting times for young people to be seen within 4 weeks has fluctuated over the year, ranging from 85% in April 2013 to 59% in October 2013. The complexity of cases has increased with the average number of clinical sessions with each patient increasing from 3 to 6 for PCAMHS, and from 8 to12 for Tier 3 CAMHS; this has limited the capacity of the service to those referred and has increased waiting times. The total number of young people receiving inpatient care increased from 15 in 2012/13 to 34 in 2013/14.

Young people who self-harm

Self-harm presents in a range of forms from cutting, scratching, burning to over-dosing and attempting suicide; OSCB partner agencies are working closely to monitor the prevalence of self-harm amongst high risk groups of young people. Partners are working together with schools to improve identification, information and risk assessment through regular meetings they are monitoring risk and encouraging children to receive preventative support and specialist interventions according to their risks and needs. The OSCB expects commissioners to improve the provision of mental health support to deal with this growing problem alongside the complex cases outlined in the previous paragraph, during 2014-2015.

Children missing from home

The number of children who have gone missing from home has remained similar to last year (636 children compared to 630 last year). The number who went missing three or more times however rose by 20 to 97, meaning the proportion of children who repeatedly went missing from home rose to 12.2% to 15.3%. Regular reports on missing children are provided to the CSE subgroup of the OSCB to ensure that there is multi-agency action. The OSCB is pleased to see the improved vigilance and recording but is concerned by the increase of children who are repeatedly going missing.

CHAPTER 2: GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

What is the OSCB?

The OSCB is the key statutory mechanism for agreeing how the relevant organisations in Oxfordshire will co-operate and work together to safeguard and promote the welfare of children and for ensuring that this work is effective.

OSCB was established in compliance with The Children Act 2004 (Section 13) and The Local Safeguarding Children Board Regulations 2006.

The work of OSCB during 2013/14 was governed by the statutory guidance in Working Together to Safeguard Children 2013, which sets out how organisations and individuals should work together to safeguard and promote the welfare of children, and the Local Safeguarding Children Board Regulations 2006 which sets out the functions of Local Safeguarding Children Boards.

Our remit:

To co-ordinate and ensure the effectiveness of what is done by each agency on the Board for the purposes of safeguarding and promoting the welfare of children in Oxfordshire.

We aim to do this in two ways:

To co-ordinate local work by:

- Developing robust policies and procedures.
- Participating in the planning of services for children in Oxfordshire.
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done.

To ensure the effectiveness of that work:

- Monitoring what is done by partner agencies to safeguard and promote the welfare of children.
- Undertaking Serious Case Reviews and other multi-agency case reviews and sharing learning opportunities.
- Collecting and analysing information about child deaths.
- Publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire.

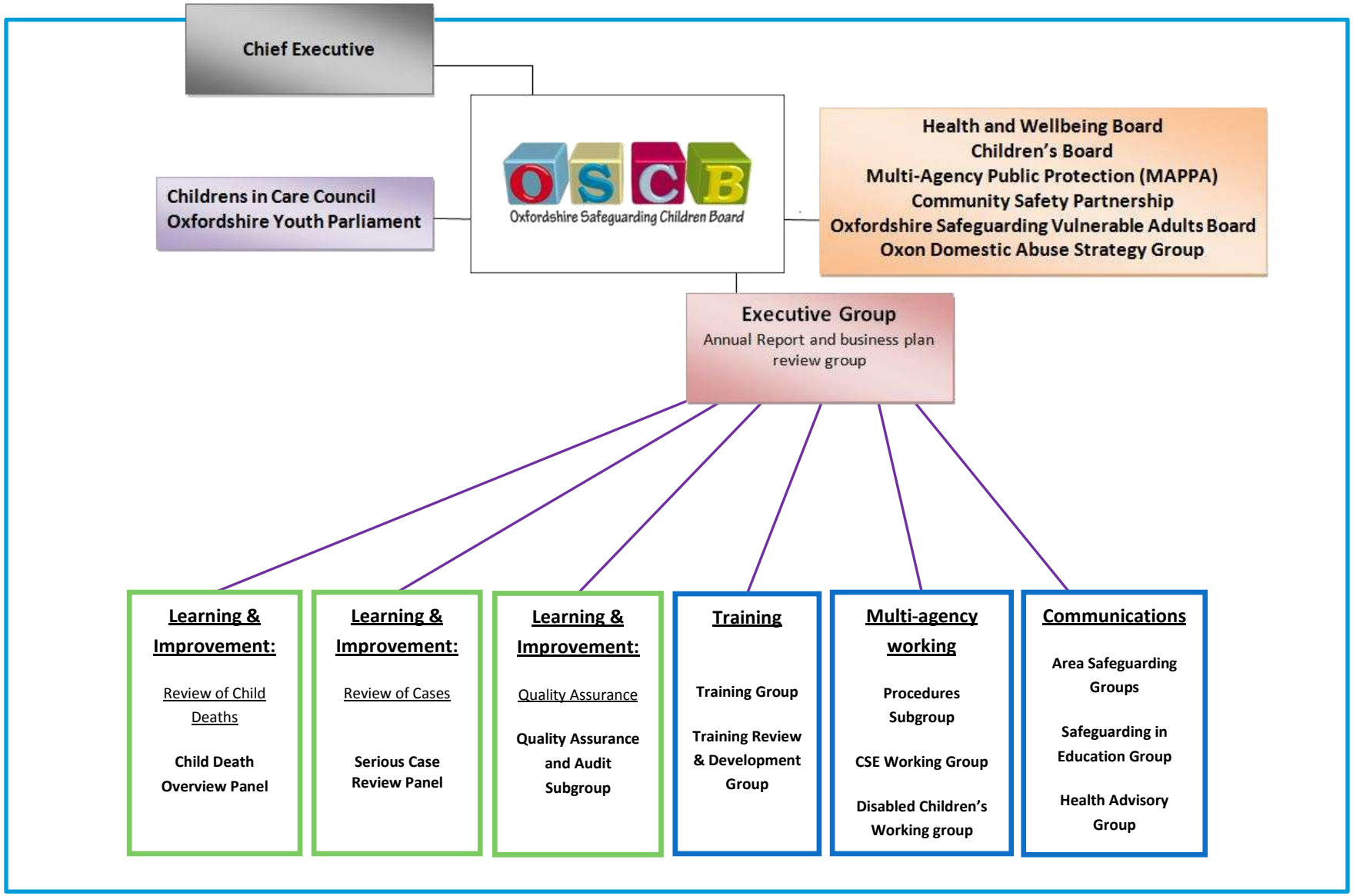
Board Membership:

➢ Independent Chair	➢ West Oxfordshire District Council
➢ Oxfordshire County Council including Children's Services, Adult Services and Public Health	➢ CAFCASS (Children and Family Courts Advisory and Support Service)
➢ Oxford University Hospitals NHS Trust	➢ Thames Valley Police
➢ Oxfordshire Clinical Commissioning Groups	➢ Oxfordshire Fire and Rescue Service
➢ Oxford Health NHS Foundation Trust	➢ Oxfordshire Probation Service
➢ NHS England Area Team	➢ Oxfordshire Youth Offending Service
➢ Cherwell District Council	➢ Representation from Schools and colleges
➢ Oxford City Council	➢ Representation from the voluntary sector
➢ South Oxfordshire and Vale of White Horse District Council	➢ 2 lay members

Attendance at the Board and its subgroups continues to be good.

OSCB Structure

The main Board is supported by a range of sub-groups that enable its functioning.



Key Roles

Independent Chair

The Board is led by an Independent Chair, ensuring a continued independent voice for the Board. During the period of this annual report the permanent Independent Chair, Andrea Hickman resigned and interim independent chair arrangements were provided by Paul Burnett to ensure OSCB maintained its statutory role. In May 2014 Maggie Blyth was appointed as Independent Chair for OSCB. The Independent Chair is directly accountable to the Chief Executive of Oxfordshire County Council but continues to work closely with the Director of Children's Services and key statutory partners to discuss safeguarding challenges.

Local Authority

Oxfordshire County Council is responsible for establishing an LSCB in their area and ensuring that it is run effectively.

The ultimate responsibility for the effectiveness of the OSCB rests with the Leader of the Oxfordshire County Council. The Chief Executive of the Council is accountable to the Leader.

The Lead Member for Children's Services is the Councillor elected locally with responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and young people. The Lead Member contributes to OSCB as a participating observer and is not part of the decision-making process. During this period Councillor Tilley fulfilled this role.

Partner agencies

All partner agencies in Oxfordshire are committed to ensuring the effective operation of OSCB. This is supported by a constitution which sets out the governance and accountability arrangements.

Members of the Board hold a strategic role within an organisation and are able to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account.

Designated professionals

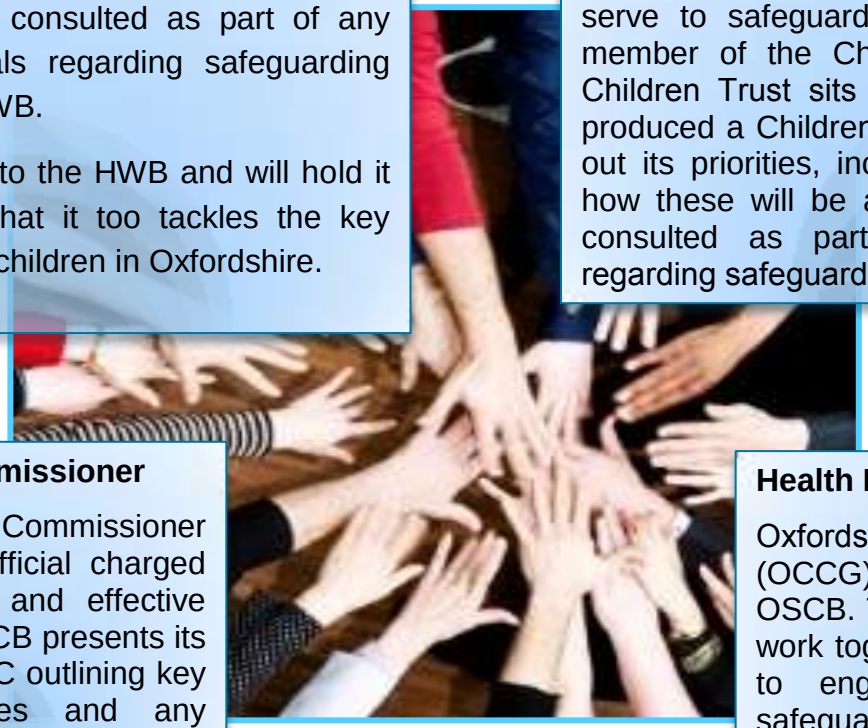
Health commissioners should have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the local area. Designated professionals are a vital source of professional advice on safeguarding children matters to partner agencies and the LSCB. Within Oxfordshire the designated doctor is Clare Robertson and the designated nurse is Alison Chapman.

Key Relationships

The Health and Wellbeing Board

The Health and Wellbeing Board (HWB) was set up in Oxfordshire during 2012/13. It brings together leaders from the County Council, NHS and District Councils to develop a shared understanding of local needs, priorities and service developments. The LSCB and the HWB have established a protocol for the working arrangements between the two boards. OSCB will be formally consulted as part of any commissioning proposals regarding safeguarding children made by the HWB.

OSCB reports annually to the HWB and will hold it to account to ensure that it too tackles the key safeguarding issues for children in Oxfordshire.



Oxfordshire Children's Trust

The OSCB is building its relationship with the Oxfordshire Children's Trust. The Board challenged the effectiveness of this group in 2013/14, which was operating as a 'Children and Young People's Board'. As this annual report was prepared in May 2013, the Board welcomed the development of the Board in to a Children's Trust.

The Children's Trust is responsible for developing and promoting integrated frontline delivery of services which serve to safeguard children. The chair of OSCB is a member of the Children's Trust and the Chair of the Children Trust sits on OSCB. The Children's Trust has produced a Children and Young People's Plan which sets out its priorities, including a focus upon early help, and how these will be achieved. The OSCB will be formally consulted as part of any commissioning proposals regarding safeguarding children made by Children's Trust.

Police and Crime Commissioner

The Police and Crime Commissioner (PCC) is an elected official charged with securing efficient and effective policing in the area. OSCB presents its annual report to the PCC outlining key safeguarding challenges and any action required of policing in the area.

Health Economy

Oxfordshire's Clinical Commissioning Group (OCCG) is an important contributor to the OSCB. The OCCG and local health provider's work together to lead a health advisory group to engage health professionals in the safeguarding work of the board. The local area team (NHS England) supports this.

Financial arrangements

Board partners continue to contribute to the OSCB's budget in addition to providing a variety of resources 'in kind'. Funding for 2013/14 was £372,933. This includes partner contributions and funding for specific training e.g. early years and risky behaviours.

Planned expenditure was higher than income as the OSCB has a three year plan which includes use of reserves. The budget has been monitored and revised over the course of the year and reported to the Executive. A figure of £83,734 was drawn from the reserves making the total income available to the board £456,667. This income ensured that the overall cost of running the OSCB was met. The biggest pressure on the budget has been Serious Case Reviews which is likely to continue in to 2014/15. The board has agreed to carry forward the underspend from 2013/14 to the 2014/15 budget.

	Original projection	Final year end figure	Variation
Funding streams	£	£	£
Early Years training income	-14,465	-14,465	0
Risky behaviours training income	-31,625	-31,625	0
Income			
Children, Education and Families	-168,843	-168,843	0
Dedicated schools grant	-64,000	-64,000	0
Oxfordshire CCG	-60,000	-60,000	0
Thames Valley Police	-16,000	-16,000	0
Probation	-5,000	-5,000	0
Oxford City Council	-4,000	-4,000	0
Cherwell DC	-2,500	-2,500	0
West Oxford DC	-2,000	-2,000	0
South Oxfordshire DC	-2,000	-2,000	0
Vale of White Horse DC	-2,000	-2,000	0
CAFCASS	-500	-500	0
Public Health	0	0	0
Total Income	**-372,933**	**372,933**	0
Expenditure			
Business Unit	228,890	235,036	6,146
Independent Chair	25,000	28,354	3,354
Independent Chair Serious Case review	0	4,000	4,000
Serious case review	63,600	78,250	14,650
Sub groups	29,400	24,435	-4,965
Communications	10,800	24,022	13,222
Training	70,227	62,570	-7,657
Total Expenditure	**427,917**	**456,667**	**28,750**
Net	**54,984**	**83,734**	**28,750**
CDOP funds transferred from reserves	58,000	58,000	0
Reserves 2013/14			
Opening balance	**363,165**	**363,165**	0
Drawdown during the year	-112,984	-141,734	28,750
Contribution to / pay in during the year	0	0	0
Reserves Balance	**250,181**	**221,431**	-28,750

CHAPTER 3: PROGRESS OVER 2013/14

The Child's Journey

In 2013/14 the OSCB endorsed the revision of the 'threshold of needs matrix' which supports practitioners to make the right referral to the right service. There are a wide range of services providing early help to families in Oxfordshire. This includes the early intervention service's hubs and children's centres, health partners, schools, the voluntary sector, local and district borough councils and social care.

Early help assessments (CAFs) are completed and families are then supported by regular 'team around the child' (TACs) meetings to monitor progress. Support includes help for children where parents or carers misuse substances and help for those families when social care intervention ends. In the academic year 2011/12 there were 584 recorded CAFs and 389 TACs. In 2012/13 there were 677 recorded CAFs and 454 recorded TACs; with schools predominantly taking the lead in this work. The number of under 5's reached in Oxfordshire i.e. seen at least once at an event or activity at any Oxfordshire children's centre was 19105 or 48.2% of the population of under 5s. In the recent inspection of Oxfordshire Children's Services Ofsted commented that there was *'evidence that early help is making a difference and improving outcomes for children'.*

The Thriving Families initiative is working with the most vulnerable families. The initiative has identified 810 families all of which have a named worker from an early intervention service and of which 104 families have intensive family support over the last year. Ofsted reported; '*It is intensive, well organised and cost effective and has led to clear improvement in the lives of particular families*.'

A longer term piece of work is underway to integrate early help and statutory work to support vulnerable children and families. The focus is on services for 'children in need' i.e. for those who meet the statutory thresholds for services but are not deemed to be at the level of significant harm which would warrant a child protection plan. The intention is to develop more robust early help and reduce the numbers of children who are escalated to children's social care.

MASH in Oxfordshire

The OSCB has had oversight of the development of a Multi-Agency Safeguarding Hub (MASH) which will become operational in Autumn 2014 for children's safeguarding and January 2015 for adult's safeguarding. The core partners include Children's Services, Adult Services from the County Council, Thames Valley Police and Health professionals. There will also be links with a number of virtual partners such as Probation services and Housing services.

The MASH will assess all incoming safeguarding referrals to Children's Services and share information to ensure that there is:

- A joint, confidential risk assessment
- Better information sharing and decision making
- Identification of risk
- Early intervention as appropriate
- A coordinated response
- A process to identify victims and emerging harm through research analysis.

The MASH can refer children and families to community or specialist services as well as to Children's Social Care Assessment and Disability Teams.

The OSCB has developed a **'Guide for Good Multi-agency Working'** designed to help practitioners to work better together. This guide incorporates the Local Authority's local protocol for assessment which has been implemented alongside the new single assessment led by children's social care.

During the year there were 5810 referrals to Children's Services which was 9% lower than the previous year. However, referrals have met the criteria for support and have led to an increase in activity levels at all other key points across the child protection process. This increase in general activity reflects the analysis that there is greater identification, recognition and response to signs of abuse and neglect as well as sensitivity to risk. In short, children are staying on plans for longer and also having a new plan when risk is deemed to have increased. Ofsted inspectors agreed that services demonstrated '*improvements in the targeting of intervention, better decision making and more robust management oversight'.* Despite the increase in activity professionals are still completing 'section 47' enquiries to a timeframe which is better than the national average. The system is coping well despite the increasing pressures.

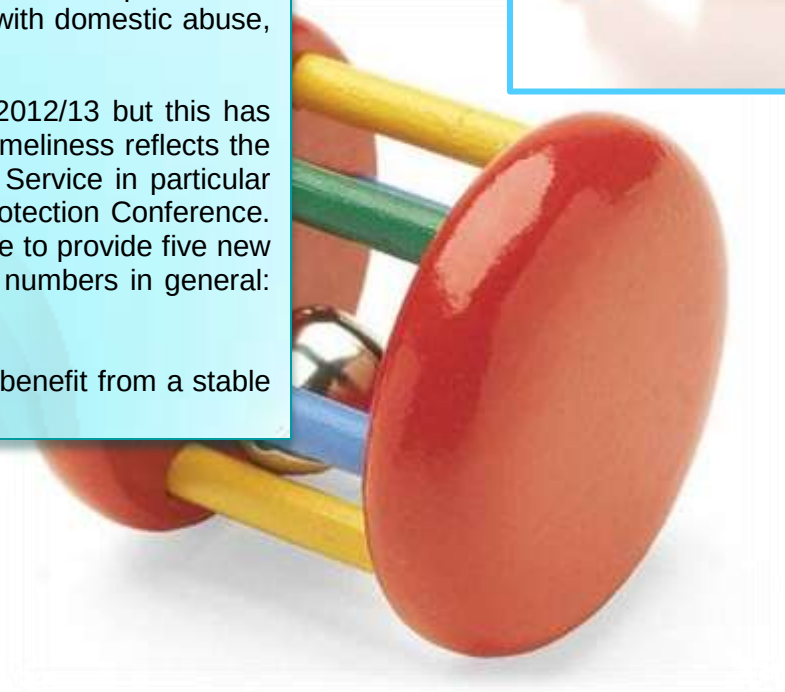
	2012/13		2013/14
	Oxfordshire	**National**	**Oxfordshire**
% of Initial Child Protection Conferences within 15 working days of Section 47 enquiry	86%	70%	84%

The OSCB scrutinised thresholds at four different points in the system to check decision making and would agree with the above analysis as well as the need to further embed multi-agency tools e.g. for identifying need, working together and for identifying and tracking neglect.

During 2013/14 the numbers of children subject to a CPP have steadily increased. At the end of March 2013 the numbers stood at 430 and at the end of March 2014 the numbers stood at 512. The number of children on a child protection plan for the second or subsequent time has increased. At the end of March 2013 the percentage stood at 17.9% and at the end of March 2014 it was 21.2%. This increase is in part due to new episodes of heightened risk, often associated with domestic abuse, which has led to the need for a new plan.

84.9% of plans are reviewed within timescales in 2012/13 but this has decreased in 2013/14 to 82.3%. This decrease in timeliness reflects the increased pressure on the Independent Reviewing Service in particular who have to chair each Initial and Review Child Protection Conference. Additional resource has been allocated to the service to provide five new posts. The County Council has increased its staff numbers in general: 21 new social worker posts were created in 2013.

OSCB has concluded that child protection services benefit from a stable workforce.



Health Visitors and School Health Nurses

Health visitors and school health nurses are part of the Healthy Child Programme (HCP). The HCP is the universal clinical and public health programme for children and families from pregnancy to 19 years of age. The HCP offers every child a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and support for parents tailored to their needs, with additional support when needed and at key times.

The health visiting service is currently commissioned by the local NHS Area Team. Commissioning responsibility will transfer from the NHS to the Local Authority on October 1st 2015. The health visitor service in Oxfordshire has been very successful with recruitment and retention and will reach its staffing trajectory of 122 by April 1st 2015. Within this staffing cohort, there are 8 Family Nurse Partnership Nurses, which is an evidence based programme for young, vulnerable first time mothers.

The school nursing service was re-commissioned by OCC's Public Health Directorate in April 2014. The new service has a public health focus, aiming to improve and maintain health and wellbeing in children and young people. The service is focused on secondary school provision in the first instance, providing 1 school nurse for each secondary school (and the pupil referral unit) in the County. There is also provision for primary schools, which ensures that safeguarding needs are addressed for vulnerable children.

Both health visiting and school nurses operate a Universal Plus Model. This entails:

- A Universal (core) offer for all children aged 0-5years
- Universal Plus: Provision and co-ordination of tailored packages of additional care, including safeguarding issues and working with children with additional health needs
- Universal Partnership Plus: Working in partnership with other agencies in the provision of intensive multi-agency targeted packages where there are identified health needs

Key Priorities in 2013/14

The OSCB had 5 priorities last year

To ensure:

- there is effective safeguarding practice from early help to very high need

To improve:

- our quality assurance work
- how we capture the engagement of children and young people & practitioners
- the inter-agency focus on safeguarding-risk groups
- our effectiveness as a Board.

Priority 1: Ensuring effective safeguarding practice from early help to very high need

The OSCB has a role in ensuring effective assessment, shared threshold points and plans which are good quality, responsive and well-coordinated at each stage.

The multi-agency tools for recognising need and managing risk have been implemented and many have been tested through multi agency audit work of over 50 cases. Local practitioners and OSCB trainers have had workshops on their usage, embedding them remains a priority especially with development of the Multi agency safeguarding hub.

- **Threshold of needs matrix**
- **Neglect toolkit: the child care and development checklist**
- **Child sexual exploitation screening tool**
- **The multi-agency risk assessment and management plan**
- **Parental substance misuse toolkit**
- **Guide for Good multi agency working.**

Priority 2: Quality Assurance work

The OSCB has developed a framework which links quality assurance to learning and improvement. It includes extensive multi- and single agency audit work; the section 11 self-assessment and practitioner questionnaires; the schools audit; the LADO service and the OSCB data set.

- **Multi and single agency audit work**

Eight audits were reported last year which reviewed 117 cases from the perspective of all relevant agencies. Their purpose was to check the effectiveness of multi-agency working. The audits were based on concerns from case review and local knowledge. They covered: decision making at four different points in the safeguarding system; working with children in need; managing risk for the most complex young people; supporting young people at risk of child sexual exploitation and substance misuse.

Eight agencies including, for the first time, Thames Valley Police and Probation reported on their internal safeguarding audit work. A review of the audits shows that over 400 cases have been reviewed over the last 12 months. The purpose was to check how effectively they safeguard children. The findings have been reported and have led to the sharing of good practice e.g. Oxford University Hospitals questionnaire for staff adopted for use in other agencies through Section 11 Self-Assessment.

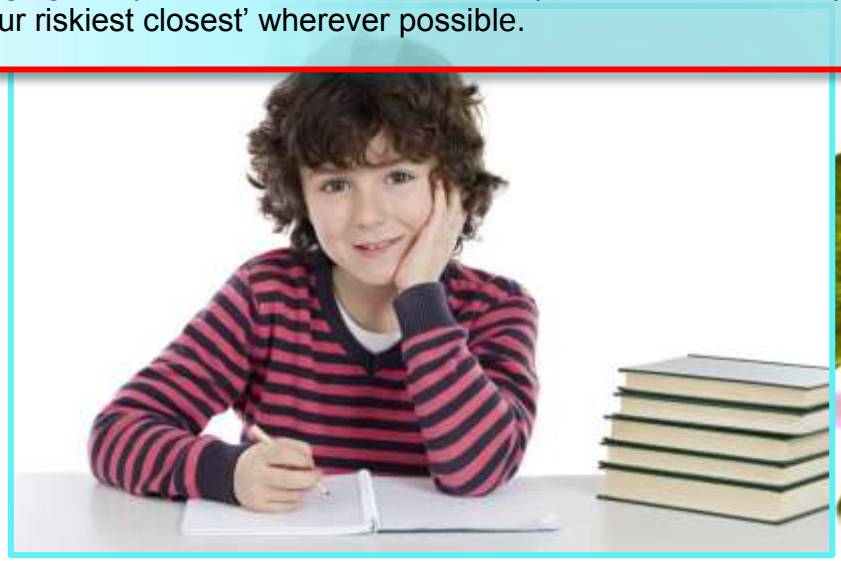
Learning & Improvement: Findings

Audit Findings:

- ✓ Good processes managed in a timely manner
- ✓ Clear single agency plans
- ✓ Evidence of improved multi-agency risk assessment using the new management plan and good examples of the involving children and parents in this process
- ✓ Professionals delivering to the best of their ability despite heavy and stressful workloads
- ✓ Strong relationships and good communication between agencies.

Areas for learning and improvement:

- ➢ Care planning that produces fully integrated plans which effectively manage risk rather than a series of single agency plans
- ➢ More effective child and / or family involvement in plans
- ➢ Corroborating information and using it productively to inform good decision making between professionals
- ➢ Holding partners to account and increasing challenge
- ➢ Undue professional optimism in response to parental behaviour
- ➢ Co-ordinating efforts for more complex cases especially for children who are looked after and have additional vulnerabilities
- ➢ Challenging the placement of our most complex and vulnerable young people out of county and working to 'keep our riskiest closest' wherever possible.



- **School Audits**

The OSCB school audits are sent out to all primary and secondary schools in the county. The DfE statutory guidance 'Keeping Safe in Education' released in 2014, states that 'Under section 14B of the Childrens Act 2004 the LSCB can require a school or college to supply information in order to perform its functions; this must be complied with'.

In 2013 there was a 75% (256 / 343) audit return rate. The returned audits report on the full range of safeguarding requirements in schools e.g. whether the school has had child protection training, adheres to safer recruitment guidance, implements child protection procedures. The audits indicate good levels of compliance with the guidance, the most frequently recommended action for the coming year, is to update safeguarding training for staff. The audit is being improved and developed for 2014/15 and will include all independent school settings as the independent chair has identified this as a gap.

Next year the OSCB will publish details of schools that remain not compliant with this audit.

- **The Local Authority Designated Officer Service (LADO)**

The LADO should be informed of all allegations against adults working with children and provides advice and guidance to ensure individual cases are resolved as quickly as possible. There was been a 26% increase in referrals, a total of 176, to the LADO service during the academic year September 2012 to August 2013 compared to the previous year when there were 135. Most referrals come from schools but in the last year they have increased from non-educational settings. As awareness is being raised the LADO service is playing an increasing role in supporting and challenging a range of non-educational organisations on safeguarding concerns.

Learning & Improvement: scrutinising practice

The section 11 self-assessment and practitioner questionnaires

The OSCB had 100% compliance of returns from statutory members. There were 16 responses from member agencies, and 4 from non-member organisations. Of those returns, 14 out of 20 agencies stated that they were compliant with safeguarding requirements and can 'evidence most of the standards'; the remainder felt that they had more areas for improvement. This year a questionnaire was included for practitioners to complete on their safeguarding knowledge and skill set. Five agencies completed it providing nearly 200 responses from practitioners. The results showed that almost 100% of practitioners felt confident that they would know what to do if they had a safeguarding concern about a child. There is good commitment to safeguarding at a senior level across agencies.

A peer review was held to give Oxfordshire agencies the opportunity to scrutinise and compare the results of the audits. Fifteen agencies attended and the peer review focussed on four standards:

- **Service development takes account of the need to safeguard children and young people** – the review pulled out some good examples but more evidence will be requested next year
- **Staff are trained to an appropriate level in safeguarding** – the review highlighted the need to collate more detail from agencies
- **There is effective interagency working** - the review demonstrated commitment to this and OSCB auditing shows where improvement is needed
- **There is effective information sharing** – the peer review posed the question that this could be better e.g. faster, that follow up feedback makes for better work and electronic based communications are preferred over paper

In its recent inspection report Ofsted commented that, "*learning from these audits has been augmented by a very effective peer challenge event for partners*".

The OSCB dataset: what does it tell us?

An analysis of the quantitative information has highlighted:

1. **Increased activity at all key points across the child protection process; higher than the national average**
2. **Continued growth of children who have a CP plan; whereas the picture is stabilising nationally**
3. **Continued growth of children who have a second or subsequent CP Plan**
4. **Concern about the small number of children who go missing at least three times per year**
5. **Outcomes for vulnerable learners could be better in terms of attainment, attendance and exclusions.**

The OSCB will report against a new dataset next year. The indicators cover:

- **Early help**
- **Assessment of need and child protection services**
- **Children in care**
- **Youth offending services**
- **Working at transition points, including adult services**

Priority 3: How we capture the engagement of children and young people & practitioners

The OSCB has collated the views of practitioners in its annual report on quality assurance. It included views from children's social care practitioner listening events; serious case reviews; audits; child protection conferences and reviews, training and the three area safeguarding groups. Through this means practitioners have told us a range of things, some of which are captured below:

What practitioners told the OSCB:	What the OSCB did:
How the CSE screening tool would work well for them	▪ The CSE screening tool was developed taking on board their suggestions
How the 'threshold of needs' matrix would be easier to use and understand	▪ A revised 'threshold of needs' matrix was developed and published for use in all training
How the neglect tool: the childcare development checklist needs to better reflect the needs of disabled children and be in plain English	▪ A revised 'childcare development checklist' was developed
The type of case studies the OSCB should use in safeguarding training	▪ The training case studies have been developed for use in safeguarding courses
Managing complex cases with vulnerable children becomes more challenging when children are out of county	▪ The Local authority is involving other local agencies in the development of its placement strategy and agreed that 'we should keep our riskiest young people closest to home'
Managing risk for young people is not easy; risk is dynamic, it changes and needs to be reassessed	▪ A new multi-agency risk assessment and management plan has been developed through the local authority and is being promoted by the OSCB
They want to understand the strategic response to female genital mutilation in Oxfordshire	▪ The OSCB has set up a task and finish group to set out prevalence, practice and procedures in Oxfordshire
They want to learn more about learning from case reviews	▪ The OSCB has run practice improvement workshops with the local authority to pass on learning from case reviews on working with parental substance misuse

The OSCB has also collated the views of young people, parents and carers through the youth parliament, children in care council, young people forums and sounding boards, serious case reviews, audits, and questionnaires and surveys. Through this means they have told us a range of things, some of which are captured below:

What young people, parents and carers told the OSCB:	What the OSCB did:
Why they take risks, what they think risk taking behaviour is	▪ Showed a film at the annual OSCB conference on working with young people ▪ Ensured that these views were fed in to the OSCB Risky Behaviours training
What their views were on child sexual exploitation; their worries, where they would seek help, who they would talk to.	▪ Ensured that these views were fed in to the OSCB CSE training to inform the push and pull factors behind their behaviour
What they thought about safety on line	▪ Supported the anti-bullying week and ambassadors ▪ Supported the Online Safety day with poster competition in local schools ▪ Ensured that these views were fed in to the OSCB E-safety training
What their experiences were of child sexual exploitation in Oxfordshire	▪ The local authority recorded this information to play to professionals at its conference on CSE to ensure that learning points are put across to professionals effectively. ▪ The OSCB ensured that the author of the CSE serious case review met with all those young people and parents who wanted to meet and give their perspective on services

The OSCB intends to do more work with the Children in Care Council in 2013/14 to support them in their implementation of a pledge with service providers and department leads. It also plans to set up a regular means of consulting with young people on safeguarding matters, by developing a quarterly young people's safeguarding forum. The inclusion of a 'Keeping Safe' section of an app for young people, developed with Oxford City Council, will also ensure key information is fed back to local young people. The OSCB collates a lot of information through the work of the County Council and intends to collate more information from other agencies.

Priority 4: Inter-agency focus on safeguarding-risk groups

The OSCB's approach is to focus on the most vulnerable. Regular scrutiny is undertaken on the effectiveness of multi-agency work to assist the following groups of children.

- **Troubled young people with a complex range of needs**

The OSCB scrutinised the work of the complex case panel which brings together senior managers to support practitioners to move forward on the most complex cases through focused discussions, clear decision making and identification of actions. The OSCB determined that whilst this covered a small cohort, the work was effective in supporting practitioners and managing risk. It endorsed the need to review the routes between different interagency panels to ensure there is clarity on their thresholds and processes. It endorsed the proposal that next year service providers would provide evidence of effective working using a larger cohort of young people.

The OSCB annual conference focused on increasing knowledge of working with children who have a range of needs. It covered self-harm, substance misuse, school attendance, taking risks online, child sexual exploitation and managing complex cases.

- **Children in care placed out of the county**

In 2013/14 125 (26.8% of 467 children) were placed out of county: in foster homes, residential children's homes and residential schools. The OSCB scrutinised the corporate parenting service's report which outlined work to support all children in care. It endorsed the approach to keep the children at most risk, closest to home and supported the local authority's endeavour to develop four new children's homes. The findings from OSCB audit work directly contributed to the strategic discussion on the Placement Strategy about support for our 'highest risk children'. Revised CAMHS pathways have given children in care a much higher priority, including OSCA outreach service having a specific target group for children in care. In addition a revised OSCB Escalation Protocol has been circulated to address the complex issues involved in managing investigations into death/serious injury, including communications and escalation out of hours. This work remains a priority.

- **Vulnerable learners**

The OSCB scrutinised the county council's education strategy with respect to this group of vulnerable young people. The dataset highlights consistently poor outcomes for those children most in need. Safeguarding auditing was undertaken by the Education service for the first time this year. Messages from case reviews this year have highlighted the central role that schools play in terms of safeguarding children. The OSCB endorses the actions taken to date but requires further re-assurance that this safeguarding priority is fully prioritised by schools in Oxfordshire.

- **Children at risk of neglect**

The OSCB scrutinised a range of work undertaken to support children at risk of neglect and welcomed **Ofsted's report** into this matter. Neglect is a frequent factor in case reviews. The OSCB implemented the actions following the audit in 2012/13. This included a revision to the neglect toolkit: the childcare development checklist; a workshop for all trainers in the use of the neglect toolkit; and a new online training course. The OSCB endorses the work that the Health trusts and the local authority is leading on to make sure all frontline practitioners use the toolkit whenever neglect is a concern. The tool is recognised as a good evidence-based framework which shows the real impact of neglect on children's development and helps practitioners to work together with parents in a way that is clear and understandable to everybody. The next stage of the strategy is to improve and accelerate the work undertaken with children who are at serious risk. The OSCB will need evidence that this is in use and making a difference

- **Children at risk of domestic abuse**

Nationally 130,000 children *(Ofsted, October 2013)* live in households where domestic abuse is prevalent. In 2013/14 18% of cases in Oxfordshire assessed identified domestic abuse in the household as a risk factor. 13% of initial child protection conferences in Oxfordshire identified it as a risk factor. This was the most prevalent risk – followed by mental health issues and alcohol abuse. The OSCB has been informed by the work of the Oxfordshire Domestic Abuse strategy group which has continued to prioritise the training and support of DA champions in all schools and children's settings so that information about incidents is shared and professionals work together to focus on the impact on children, as well as adult victims. Training on domestic abuse between children and young people has been undertaken by a small number of DA leads in agencies and raising awareness and improving practice with teenagers will be progressed in the next year. Specialist support to adult victims continues to be provided through the independent domestic violence advisors who maintain high standards of children's safeguarding and good links with children's professionals.

Learning & Improvement: Actions taken to tackle child sexual exploitation pt.1

- **Children at risk of sexual exploitation**

As part of our work dealing with the high-profile Operation Bullfinch investigation and trial, which resulted in the sentencing of seven men for a total of 95 years in May 2013, Oxfordshire Safeguarding Children Board with partners have taken significant and wide-ranging action to address the issue of child sexual exploitation in Oxfordshire and share its learning of dealing with a complex issue at the highest level.

It is important that we all recognise a child as a victim of sexual exploitation as opposed to a young person making poor choices. This is essential if child sexual exploitation is going to be successfully tackled. But it is not easy, as the young people they often do not believe or recognise that they are being exploited.

OSCB has taken a number of important actions to tackle child sexual exploitation, the partnership has: -

- **Established the Kingfisher team** with police, social workers and health staff to spot potential warning signs, identify and support young people who may be victims of child sexual exploitation
- **Provided child protection training** for staff working with children. The training now includes a designated section on spotting the signs of, and responding to, child sexual exploitation. This training has been delivered to more than 3,500 multi-agency staff in Oxfordshire, including all frontline staff working with children.
- Developed a **new child sexual exploitation screening tool** in line with best practice, is used to assess the likelihood and risk level of a young person being subjected to sexual exploitation.

OSCB has commended the local authority for its allocation of **an additional £1.4m** to fund the recruitment of a further **21 dedicated child protection social workers**, plus increasing the budget for children's social care by almost £20m in real terms between 2006/7 and 2013/14.

The OSCB has also been reassured that Oxfordshire County Council has overseen a new placement strategy for children in care seeking to improve the comprehensive package of support available to children to help them settle into their placement. This involves working closely with mental health and youth offending services.

New approach to absconding

The Oxfordshire Safeguarding Children Board Interagency Procedure for Children Missing from Home or Care has been updated to reflect the latest guidance on missing and there is a Missing Persons Panel that tracks and monitors all young people at highest risk within the county, on a monthly basis. OSCB expects schools to report on their safeguarding practice through regular annual audits to OSCB. As part of its work, the Kingfisher team has been holding regular multi-agency forums with schools to raise awareness, develop practice amongst those working directly with children at risk and to gather intelligence on children of concern. OSCB has been informed of the following actions to improve behaviour and attendance to include:

- Notifying carers of looked after children immediately if the child fails to turn up for school.
- Ensuring that looked-after children who are placed in Oxfordshire from outside the county are immediately placed on a school roll at Oxfordshire's Pupil Referral Unit and provided with tutor support.

The OSCB will report on evidence of the impact that this has made in 2014/15.

Mentoring young people: a youth mentoring project for young men focused on preventing sexual offending has been developed.

Work with parents and carers: a specialist parents and carers' worker has been developed, based in the Step Out project (a voluntary organisations), to support individual parents and groups of parents whose children have been exploited or are at high risk of exploitation.

Work with communities

Partners in OSCB are **working closely with community leaders and faith groups** and taking action against child sexual exploitation, for example in focused work with families of potential perpetrators and targeted youth mentoring projects. National youth charity, Street UK, is working with mosques to raise awareness of child sexual exploitation.

OSCB can report that: -

- Oxfordshire **Health and Wellbeing Board**, which looks at the health needs of Oxfordshire, have included tackling child sexual exploitation as a priority in the new Joint Health and Wellbeing Strategy.
- Oxfordshire **Safer Communities Partnership** (OSCP) and the District Council Community Safety Partnership (CSPs) are bringing together key players to share intelligence and take appropriate actions to prevent and tackle child sexual exploitation.
- **Police and Crime Commissioner** funding will be used to raise awareness about how to recognise the signs of potential abuse.
- **Oxfordshire County Council** are already working closely with **city and district councils**, particularly as housing and licensing authorities, and because their frontline staff need to be aware of potential warning signs and know what to do if they have concerns.
- The **health service**s have recognised that they have a role to play in terms of identifying potential victims of this abuse and supporting their health needs, which can often be complex.

Oxfordshire Safeguarding Children Board and Oxfordshire County Council **support the introduction of specialist child sexual abuse courts** and further protection and support for victims, including offering video-recorded cross examination, and limiting repeated cross-examination by multiple defence barristers when witnesses give evidence.

Awareness raising – spotting signs and symptoms

We think professionals, families and the broader public need to be much more aware of the danger signs of child sexual exploitation and we have been **proactively sharing information with parents and carers** as well as with the young people via our work with schools and other parties. See the next page to find out work to date.

Learning & Improvement: Actions taken to tackle child sexual exploitation pt. 2

Raising Awareness of sexual exploitation

The recent Ofsted report commented that there is, '*excellent awareness raising activity'* Oxfordshire. The impact of this activity is as follows:

- **'Values versus violence'** has been introduced in to over 12 primary schools in Oxford City reaching over 1100 pupils. This programme, funded by the County Council and Thames Valley Police, aims to build the resilience of young people, encourage them to make the right choices and understood who they should talk to.
- **'Chelsea's Choice'** has run for a second consecutive year in local secondary schools for year 8 and 9 through the support of the Kingfisher Team. It raises awareness of CSE. This short play, funded by the County Council, has been seen in 40 venues by thousands of pupils who have watched the show and taken part in the Q&A afterwards.
- **''Somebody's Sister, Somebody's Daughter'** has been developed as an interactive drama workshop with children 16+yrs and has been commissioned to run in secondary schools and further education colleges to keep the focus on CSE. This will happen over the 2014-15 academic year.
- **The Kingfisher Team** has undertaken a concerted effort to run workshops and raise awareness of this issue and is estimated to have reached over 1800 colleagues in the last year alone.
- '**See Something, Say Something'** training for door staff at licensed venues has been undertaken in the County, as well as awareness raising and safeguarding requirements for taxi drivers.
- **'Street UK'** was commissioned to undertake a scoping study on the awareness of CSE in the BME communities. This project engaged children, young people, parents, carers, faith leaders, community groups and local business people: mostly from South Asian communities in Oxford and Banbury. The study has produced a wide range of important messages for agencies to work on, with a view to supporting the communities in their efforts to be aware, prevent and protect children and young people from the harmful effects of both victimisation and offending.
- **OSCB Training – Risky Behaviours - CSE** developed in partnership with colleagues from Oxford City Council has been implemented reaching thousands of colleagues in multi-agency settings through bespoke training as well as through the generalist training which also covers this issue.

Priority 5: OSCB's effectiveness as a Board

Learning & Improvement: Communicating and raising awareness

The OSCB:-

- delivered another **successful annual conference** for over **200 delegates** with **6 workshops** on key subjects such as; **self-harm**, **behaviour and attendance**, **child sexual exploitation**, **social media and the internet**, **drugs & alcohol** and **working together on high risk cases**.
  Evaluation exert: ***"Excellent Conference: Relevant, Reflective and informative."***
- ran workshops on the multi-agency tools for practitioner trainers on subjects such as **child sexual exploitation, the childcare and development checklist (neglect toolkit)**, **CAF & TAC**, **social care referrals forms** and the **Thresholds of Needs Matrix**
- and **updated the website** for better access and content
- delivered **termly newsletters** to over **4000 members** of the workforce
- set up a **virtual education network** with a **bi-monthly e- bulletin**
- met with the **children in care council** to tell them about its work ; went to **sounding boards** to explain its purpose and role in safeguarding
- developed a **new communications group** and strategy linking key partners

Responding to revised statutory guidance

OSCB together with partner agencies progressed a number of work streams to ensure compliance with Working Together to Safeguard Children 2013.

- ✓ **Thresholds of needs matrix endorsed**
- ✓ **The neglect tool kit: the childcare development checklist was updated**
- ✓ **Update of on line procedures completed**
- ✓ **A new single assessment implemented county wide**
- ✓ **A local learning and improvement framework published**

In 2013/14 the OSCB undertook an independent review of its working and set out a series of improvements to improve its strategic relationships with other groups in Oxfordshire and its effectiveness in delivery. This work is on-going in 2014/15…

Safeguarding procedures

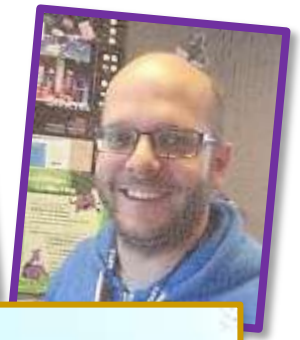
The OSCB conducted a gap analysis of local procedures against the pan-London procedures. The gaps were prioritised and all top priority changes were implemented within the year. This led to them being rated by Inspectors as "*comprehensive and up to date*". The group is currently reviewing the Information Sharing Protocol with partners to ensure it is compatible with changes being introduced via the creation of MASH. Emerging national and local issues, such as Female Genital Mutilation, have been addressed and procedures have been put in place in a timely fashion.

Female genital mutilation

In 2013/14 OSCB undertook a review to estimate the prevalence of FGM in Oxfordshire, based on World Health Organisation data and local population figures. In 2014/15 a strategic group consisting of OSCB members from OUH, OCCG, TVP and CSC has been formed to review FGM protocols and care provision in the county. New referral pathways are being set up, together with an operational group of specialists from each agency to deal with cases.





Learning & Improvement: OSCB safeguarding training

OSCB training is delivered by over **70 local practitioners** including police officers, teachers, social workers and clinical leads from across health. OSCB trainers work with children, childcare professionals and safeguarding issues on a regular basis. Many are specialists in their own setting.

They are first trained by the OSCB, observe and then co-train before they are fully fledged. They are then kept up-to-date on the learning from case reviews and local tools endorsed by the OSCB through **3 development days per year**. They help develop courses and last year produced new case studies based on their local knowledge.

In 2013/14 over 93% of all delegates said that their safeguarding course was either excellent or good at enabling them to understand their role in multi-agency working.
Delegates have told us OSCB courses are, *"Interesting, informative and relevant".*

Working Together 2013 requires that LSCBs monitor and evaluate the effectiveness of training, including multi-agency training, for all professionals in the area. The OSCB is undertaking a review to assess the impact of training on frontline practice.






Feedback from responses to the question "**How are you going to use what you learnt in the training**?" featured on the OSCB training evaluation form:

- **I will feed back to my team**
- **I will feed back to colleagues and share learning through team meetings and supervision**
- **I will be more aware of the signs and symptoms to look out for**
- **It enabled me to develop my skills**
- **I will create a protocol for my organisation**
- **It highlighted the need to take responsibility for safeguarding**

Last year the range of courses increased. There were **19 different types of face to face courses and 8 new online** courses. The options for learning also improved. Bite-size workshops were introduced e.g. harmful sexual behaviours. Themed courses were introduced in response to Oxfordshire's learning from case reviews and audits e.g. working with men and boys, disabled children.

OSCB CSE training developed by OSCB partners was delivered through the Kingfisher Team to schools, colleges, foster carers, children's homes and children's centres amongst others. This has made a big impression. They are estimated to have reached over 1800 colleagues. OSCB training output improved again in 2013/14. In total 2170 members of the children's workforce attended over one hundred different training sessions. 2007 completed online learning. The total of over **6000** trained delegates is a year-on-year improvement since 2008. Thank you to all OSCB trainers!

Working Together 2013 requires that LSCBs monitor and evaluate the effectiveness of training, including multi-agency training, for all professionals in the area. The OSCB is undertaking a review to assess the impact of training on frontline practice.

Ofsted's review of the LSCB

The OSCB was judged as **"GOOD"** by Ofsted in its 2014 review of the effectiveness on the LSCB. This provided assurances to the OSCB, partners and the public that local partnership work is effective in safeguarding the welfare of children. Ofsted proposed areas for improvement for the OSCB which will be addressed via the OSCB business plan for 2014/15:

- Increase the influence of the Board by clarifying relationships with key strategic groups in Oxfordshire
- Ensure that this annual report has a closer focus on the child's experiences of safeguarding services
- Ensure that the views of children, young people and their families inform planning and training and that this contribution is then fed back to families
- Evaluate the learning and impact of training delivered across the partnership particularly its longer term impact on the quality of practice in partners agencies
- Accelerate the implementation of a strategy in relation to female genital mutilation.






CHAPTER 4: WHAT HAPPENS WHEN A CHILD DIES OR IS SERIOUSLY HARMED IN OXFORDSHIRE?

Child death review

The Child Death Overview Panel (CDOP)

CDOP is a sub-group of the OSCB. It enables the LSCBs to carry out their statutory functions relating to child deaths. It carries out a systematic review of all child deaths to help understand why children have died. Child deaths are very distressing for parents, carers, siblings and clinical staff. By focusing on the unexpected deaths in children, the panel can recommend interventions to help improve child safety and welfare to prevent future deaths. The findings are used to inform local strategic planning on how best to safeguard and promote the welfare of the children.

In 2013-14 there 41 child deaths Oxfordshire of which 17 were unexpected and 24 expected. The Department of Education data for the year ending 31st March 2013 estimated a child death rate of 35 per 100,000 children in the population. CDOP calculates that the expected average for Oxfordshire would therefore be 49 deaths per annum. At present confirmed figures of child deaths in Oxfordshire fall below this expected average.

Most unexpected deaths were considered medically explained following post-mortem. However CDOP did consider that modifiable factors were present in some cases such as: consanguinity; smoking in the antenatal period; alcohol consumption and smoking in pregnancy; co-sleeping; consumption of alcohol while under the required legal age and water safety. Many of these messages are nationally known and campaigns are on-going, however specific recommendations were made by the CDOP in relation to:

- Teenagers drinking alcohol while under the legal age. Specifically with regard to sports clubs. Being mindful of their safeguarding responsibilities.
- Water safety particularly around children having unsupervised access to pools and ponds.
- Minimising the trauma to children who are required to attend a police witness interview in the aftermath of a child death.

The Rapid Response Service

When a child dies unexpectedly a process is set in motion to review the circumstances of the child's death called the 'rapid response' process. Colleagues work together to gather information in a timely, systematic yet sensitive manner to inform understanding of why the child has died.

In Oxfordshire, the rapid response service is well established. It is provided by the Chaplaincy and Bereavement Team at the John Radcliffe Hospital. In collaboration with the Designated Doctor for Child Deaths the rapid response service provides support to families, professionals and the wider community in the event of a sudden and unexpected child death.

The service has continued to work collaboratively with other organisations including the Coroner's office, Schools, Youth Projects, Social Care, South Central Ambulance Service, Thames Valley Police, Oxford University Hospitals Trust, Oxford Health, Helen and Douglas House Hospice and the child bereavement charity SEE SAW, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families.

Home visits take place in consultation with Designated Doctor for Child Deaths and other responding agencies including the Coroner's Officer. Home visits inform the rapid response multi-agency meeting and assist in developing a programme of support based on the family's particular needs as well as providing extended support and information to other agencies involved with the family.

Update on recommendations from 2012/13

Recommendation: To develop and distribute information in relation to the dangers of air-rifles and BB Guns for the attention of children and young people. The Home Office Communications Directorate has been contacted to request that retailers selling air-rifles and BB guns are required to provide safety information including associated risks of use. Within Oxfordshire a local gun club have agreed to assist in the production of a leaflet that will be distributed to local retailers in 2014/15.

Recommendation: Review of the work across Oxfordshire in relation to "risky behaviours" in children with a particular focus on Suicide. Public Health Oxford has developed a suicide risk reduction plan with local partners. CDOP learning is incorporated into this. Two risk summits have taken place with multi-agency partners to review on-going work to reduce morbidity and mortality due to suicide.

Reviews of serious cases

Serious cases

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.

Serious case reviews

LSCBs must always undertake a review of these serious cases. These reviews are called Serious Case Reviews (SCRs). The purpose of a SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. OSCB has also been committed to undertaking smaller scale partnership reviews for instances where the case does not meet the criteria for a serious case review but it is considered that there are lessons for multi-agency working to be learnt.

During 2013/14 one serious case review known as Child Y and one partnership review was completed and learning shared. Nine new cases where brought to the attention of the OSCB for consideration. Of these three serious case reviews were commissioned during the year, one was subject to a single agency review with partners and the remainder led to no further action by the OSCB.

The OSCB is generating a lot of learning for local agencies about how we can work better together. It takes seriously its responsibilities to ensure that lessons learned from case reviews are disseminated and embedded into frontline practice and used to support improvements across agencies. The OSCB is setting up a series of practitioner workshops to share key learning from both national and local cases in 2014/15.

Story of Child Y

The serious case review examined the services provided to the family of a toddler, who died following a serious head injury. Not all agencies were aware of the mother's vulnerabilities and as a result the impact on her capacity to parent young children, in conjunction with the father, was not fully understood. There were two child protection referrals which would have provided the necessary triggers. Unfortunately neither led to the robust inter-agency risk assessment and planning that might have levered in additional support and oversight of the children's safety.

Responding to the findings:

- All health safeguarding training now includes the significance of bruising in babies less than 1 year and guidance on response
- The County Council has undertaken quality assurance checks to ensure that assessments of families are thorough and fully consider the involvement of fathers / male care givers
- All paediatric referrals for a child protection assessment, or for referrals whereby Safeguarding emerges as a feature of the assessment, are discussed with at least one other experienced paediatrician

CHAPTER 5: CHALLENGES AHEAD AND FUTURE PRIORITIES

National Drivers

- Tackling child sexual exploitation.
- Improving the effectiveness of 'early help' services.
- Implementing new statutory safeguarding guidance.
- The focus on safeguarding across inspection regimes.
- Ensuring that the potential risks to safeguarding practice and arrangements are kept under review in response to increasing demand for services and on-going reshaping of public services.

For the Board

- Embedding robust and rigorous quality assurance activity.
- Maintaining the quality assurance, learning and improvement framework.
- Capturing the views of children, young people and practitioners.

For local multi-agency work

- Ensuring there is sufficient provision of 'early help' and improving the effectiveness of 'early help' services.
- Progressing actions to tackle child sexual exploitation.
- Safeguarding those Oxfordshire children who are living outside of Oxfordshire within residential, educational and secure settings.
- Ensuring there are effective arrangements in place to safeguard vulnerable learners.

Key priority areas

Reviewing the challenges ahead the Board remains committed to responding to the following key priority areas:

- Evaluating the effectiveness of early help.
- Missing, exploited and trafficked children.
- Maintaining a quality assurance, learning and improvement framework.

CHAPTER 6: WHAT NEXT FOR CHILD PROTECTION IN OXFORDSHIRE

Key messages to:

Messages for local politicians

- You can be the eyes and ears of vulnerable children and families in your ward making sure their voices are heard by OSCB. Councillor Melinda Tilley is the lead member for children and families. The lead member provides the route for individual councillors to make sure the voices of children and young people are heard by the OSCB and for councillors to be aware of local safeguarding children priorities.
- When you scrutinise any plans for Oxfordshire, keep the protection of children at the front of your mind. Ask questions about how any plans will affect children and young people.

Messages for Clinical Commissioning Groups

- CCGs in the health service have a key role in scrutinising the governance and planning across a range of organisations.
- You are required to discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children.

Messages for the Police and Crime Commissioner

- Ensure that the voices of all child victims are taken notice of within the criminal justice system, particularly in relation to listening to evidence where children disclose abuse.
- Monitor what police and probation staff do to share information regarding high risk MAPPA and MARAC cases and the risks that some adult present to children.

Messages for Chief Executives and Directors

- Ensure your workforce is able to contribute to the provision of OSCB safeguarding training and to attend training courses and learning events.
- Your agency's contribution to the work of OSCB must be categorised as of the highest priority. Every agency must ensure that it takes into account the priorities within the OSCB Business Plan and the agency's own contribution to the shared delivery of the OSCB's work. This includes meeting the duties of section 11 of the Children Act 2004 and ensuring that agencies are able to contribute to the OSCB's work programme with appropriate resources and personnel
- The OSCB needs to understand the impact of any organisational restructures on your capacity to safeguard children and young people in Oxfordshire.

Messages for Head and Governors of Schools

- Ensure that their schools are compliant with 'keeping children safe in education' (DfE, 2014) which outlines the processes which all schools, in the maintained, non-maintained or independent sector, must follow to safeguard their pupils.

Messages for the Children's Workforce

- Ensure you are booked onto, and attend, all safeguarding courses and learning events required for your role
- Be familiar with, and use when necessary the multi-agency tools designed for you: Threshold of needs matrix, the Guide to Good Multi-Agency working, the neglect toolkit: the graded childcare development checklist; the CSE screening tool, and the online Safeguarding procedures
- Use your representative on the OSCB to make sure the voices of children and young people and front line practitioners are heard
- Be connected to your area safeguarding group as appropriate.

Messages for the community

- You are in the best place to look out for children and young people and to raise the alarm if something is going wrong for them
- We all share responsibility for protecting children. **If you are worried about a child, call Oxfordshire Children's Services please see last page.**

Messages for the local media

- Communicating the message that safeguarding is everyone's responsibility is crucial to the OSCB and you are ideally positioned to help do this
- The work of OSCB will be of great interest to your readers and listeners.

Messages for children and young people

- Children and young people are at the heart of the child protection system. Your voices are the most important of all. OSCB plans to develop better ways of hearing children and young people's voices.

Reporting Concerns

Oxford City (including Cowley, Headington, the Leys and Wolvercote)	**01865 323048**
North Oxfordshire (including Banbury, Witney, Bicester, Carterton and Woodstock)	**01865 816670**
South Oxfordshire (including Faringdon, Wantage, Thame, Didcot, Wheatley and Henley)	**01865 897983**
The Emergency Duty Team (the "Out of Hours Team" not accessible during the day, only when the offices above close: 5PM Monday-Friday and 4PM Friday)	**0800 833 408**
John Radcliffe Hospital Assessment Team (for antenatal safeguarding concerns and issues concerning children in the hospital)	**01865 221236**
Child Sexual Exploitation If a child or young person has made a disclosure regarding sexual exploitation or if you think a child may be at risk of being sexually exploited, please contact the Kingfisher Team on: *Out of hours calls to this number will be diverted to the Thames Valley Police Referral Centre*	**01865 335276**

OSCB
Oxfordshire Safeguarding Children Board