Peterborough Safeguarding Children Board Newsletter

Message from the Editor:

We have said goodbye for the second and last time to Kay (Mayor) who has been our Administrator for many years. In spite of the fact she retired in June she came back to help us out for 3 months. She left us on 21 October and subsequently jetted off to America for her son's wedding. Kay received many kind words when she e mailed many of you to say that Faye Williams has joined us and has the title of Business Support Officer. Faye has the same phone number 01733 863744 and is contactable full time on faye.williams@peterborough.gov.uk

With so many changes at present it is hard to keep up to date with whom we should be making sure we have on our distribution list for this newsletter. If you know of any colleague who does not receive this please let me know. Equally if you get this and it is no longer of interest please let me know.
Judy.jones@peterborough.gov.uk

Front Door Arrangements

PSCB are organising a workshop to look at what Ofsted refer to as "front door arrangements". The purpose of the workshop is to review the experience of agencies both as referrers and receivers of referrals.

PSCB is aware that locally and nationally there are continuing issues surrounding thresholds, the use of the Common Assessment Framework, referral mechanisms and in Peterborough there is an additional debate about the integration of the vulnerability matrix and the use of a single service referral form.

We hope that this workshop will give an opportunity for those nominated to attend to enter into a practice debate which can influence the practice of all agencies.

Featured in this issue:

- NHS Reforms
- The Munro Review
- Safegaudring Trafficked Roma
- Children & Families
- Ofsted: Learning from SCR's
- Loughborough University Research
- Outstanding LA's 2009
- Forthcoming Training Events

Web Site

As you know we have our own web site now www.peterboroughlscb.org.uk which will be refreshed by TRI-X in November. It is still a work in progress however if there is anything which you would like to see on it do please let us know.

Over the next few weeks Faye will be sending out the details to our board members and group members of how they can be logged in to the secure area where we will post minutes and papers in the fullness of time.

The success of the site will really be down to all of us

An appeal court has ruled that local authorities must provide accommodation for all 18-year-old young people who are leaving care, including asylum seekers.

The case, brought by an asylum seeker from Eritrea, focused on whether the provision of accommodation to a care leaving asylum seeker should be the responsibility of the local authority or the National Asylum Support Service.

The court ruled that under The Children Act 2004, the local authority has responsibility to ensure that accommodation is available where the welfare of the young person requires it. This will impact on care leavers, including those seeking asylum or leaving custody, who are unable to find accommodation through other housing providers.

Research Reports

The Department for Education has released 2 research reports.

"**Building on the learning from serious case reviews**" A two year analysis of child protection data base notifications (2007-9) ref DFE-RR040 and "**Learning from Serious Case Reviews**" Report of a research study on the methods of learning lessons nationally from serious case reviews ref DFE-RR037.

Message from Safeguarding Group

Following a recommendation from a recent Serious Case Review, we are drawing to your attention that, by virtue of the approval of the Health Care and Associated Professions (Miscellaneous Amendments and Practitioner Psychologists) Order 2009 (S.I.2009/1182), a statutory register of Practitioner Psychologists was opened on 1 July 2009.

It will be an offence for anyone to use any of the stipulated titles (e.g. Registered Psychologist, Clinical Psychologist) without being registered with the Health Professions Council. All psychologists wishing to use a protected title have until 30 June 2012 to apply for registration.

The Health Professions Council (HPC) is now the appropriate regulatory body for psychologists carrying out risk assessments on adult sex offenders. This will provide an important safeguard for children and we recommend that until June 2012 people should not be commissioned for such work unless they are included in the HPC's register or are entitled to do so.

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NHS Reforms

The Department of Health has published a short document on the implications of its plans for NHS reform on children's health services. The paper responds in part to Sir Ian Kennedy's review into NHS services for children, and follows the publication of an NHS White Paper in July and subsequent consultation documents.

Much of the document revisits proposals set out in the NHS White Paper - including GP commissioning, information for patients, Health Watch and a stronger strategic role for local authorities - highlighting how these measures can have a positive impact on the health of children and young people. However, it also provides some additional information about government's approach:

It rejects the notion of "creating a single organisation with responsibility for all of the public services that support children and young people", at the national or local level, as a means of securing integration across those services. This is likely to be in response to Sir Ian Kennedy's recommendation that a 'dedicated Local Partnership' for children's health and other services be established in every local area

- Primary Care Trusts' and Strategic Health Authorities' cooperation and safeguarding duties under the Children Act 2004 will be transferred to GP commissioning consortia, and the consortia will be required to become members of Local Safeguarding Children's Boards
- Arrangements for joint working across the new local health and well-being boards and children's trusts will be left to local discretion
- Local HealthWatch will be expected to promote the voices of children, young people and families to inform health commissioning and ensure shared decision-making about their care
- Health Visitors, Children's Centre outreach services and voluntary organisations will have a role to play in helping families navigate the healthcare system
- Government will seek to use the NHS Outcomes Framework to provide incentives to GP commissioning consortia to prioritise children and young people's services
- Government is thinking through how the NICE quality standards, which will underpin the NHS Outcomes Framework, can reflect key issues for children's health, including: transition, safeguarding, promoting the voices of young children and those who are severely disabled, arrangements for looked after children and the impact of parental health
- Government is exploring the practicality of implementing a national signposting service to help practitioners identify others working with a vulnerable child so that they can share information (replacing Contact Point).

While it is not a formal consultation document, the paper provides a set of 'engagement questions' to guide ongoing dialogue between government and the children's and health sectors

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2011 Census

Please remember that the 2011 census is being held on 27 March 2011. It is vitally important that everybody who is eligible completes it as the funds which government allocate to Peterborough for a variety of services is based on population data. The previous census was 2001 and we know that the city has grown since then but there has not been an equivalent increase in funds.

For more information http://census.gov.uk

Munro review: social workers fail children due to focus on rules

Social workers are failing to meet the needs of children because they are too focused on complying with regulations and meeting targets, according to the first instalment of Professor Eileen Munro's review of children's social services in England, published on 1 October.

The scoping report puts forward initial observations that will be tested by the review over the next months.

Munro found that:

- Compliance with regulation and rules often drives professional practice more than sound judgement drawn from the professional relationship and interaction with a family.
- Social workers are frequently blamed when children are harmed.
- Serious case reviews have not fostered a learning culture which supports improved practice.
- A lot of data is collected which describes performance but not what matters; this consumes a disproportionate amount of time and resources.
- The performance and inspection systems do not adequately examine the quality of direct work with children and young people or its impact.
- The Integrated Children's System (ICS) does not help enough in the creation of chronologies.
- Social workers spend too much time completing documentation.
- The assessment framework is inefficient and does not easily facilitate professional judgement about risk.
- Universal services do not currently offer comprehensive early specialist support.
- There is evidence of inconsistency and uncertainty amongst professionals in universal services in responding to contacts and referrals about vulnerable children and young people.
- Munro also expressed concern about the impact of delays in the family courts on the welfare of children and professionals becoming demoralised as organisations fail to recognise the emotional impact of the work they do.

"I want to be clear from the start that there are no simple quick-fix solutions to improving the child protection system," Munro said. "A key question for the review is why the well-intentioned reforms of the past haven't worked. Piecemeal changes have resulted in a system where social workers are more focused on complying with procedures. This is taking them away from spending time with children and families and limiting their ability to make informed judgements.

"Professionals should rightly take responsibility when things go wrong, but they need more freedom to make decisions, more support and understanding, and less prescription and censure. Too often social workers are either criticised for breaking up families or for missing a case of abuse. But the system they work in is built around predicting a parent's ability to look after their child, which is never certain."

The government also published two research reports on serious case reviews, which have fed into Munro's review. The research shows that there is too much emphasis on getting the reports right than learning lessons from them.

Substance Misuse

The British Association of Social Workers, the charity Drugscope and social care organisation Turning Point in warning of a long-standing knowledge gap in the social work profession.

Calls are growing for compulsory training for social workers on substance misuse amid concern that families receive inadequate support to overcome drugs and alcohol.

The high proportion of child protection cases where drug or alcohol misuse is a factor is one of the main drivers behind the campaign.

This issue was highlighted by Drugscope in a consultation for a new drug strategy for England and Wales, due to be launched by the Home Office in December. The charity said all social workers working with families should be required to have substance misuse training as part of their professional development.

Just recently I saw a great poster by FRANK entitled **drugs: the facts**. It gives a brief "what is it? and "effects and risks" in an easy to follow poster. If you need any posters or advice contact 0800 77 66 00 or frank@talktofrank.com

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Child protection scheme rolled out to more forces

A scheme that allows parents to find out whether people with access to their family are sex offenders has been extended to a further 11 police forces from 1 October.

The child sex offender disclosure scheme provides members of the public with a way to check whether people who have contact with their children are a possible risk. The police will pass on information if it will help keep a child safe.

The scheme is expanding to 11 additional forces, taking the total number of areas covered to 24. The remaining forces will come onboard by next spring.

The new forces are:

- Staffordshire
- Sussex
- Leicestershire
- Wiltshire
- Cheshire
- Durham
- Northumbria
- Dorset
- Lincolnshire
- Surrey
- Gloucestershire

New Website to Protect Children

A new website - Parents Protect! (new window) - set up by Stop it Now! UK and Ireland and the Lucy Faithfull Foundation has also been launched to raise awareness of the issue of child sexual abuse. It provides parents and carers with information that will help protect children.

New Legislation

The single equality act came into force on 1 October. An event is being planned by Peterborough City Council's diversity team for January 2011 for all to learn about the new act and its impact

Evaluation of PSCB Training

The PSCB is in the process of evaluating the impact of the safeguarding training that we deliver and in particular the effect that it has on changing peoples practice. We sent out 400 evaluation questionnaires and 117 have been completed and returned to us. We will now collate this information and use it to inform the PSCB training. Thank you to everyone who took the time to complete the form and return it.

ORAL LIQUID COUGH MEDICINES

Oral liquid cough medicines containing codeine: should not be used in children and young people under 18
Codeine has been used in medicines for many years for cough suppression and pain relief. Medicines that contain codeine for the relief of dry, non-productive coughs are available over the counter in pharmacies in the UK. All products containing codeine indicated for cough are sold or supplied under the supervision of a pharmacist (Pharmacy (P) legal status).

A UK review of scientific evidence has concluded that the risks associated with over-the-counter oral liquid cough medicines containing codeine outweigh the benefits in C&YP under 18 years. Therefore:

- Over-the-counter oral liquid medicines containing codeine should no longer be used to treat cough in children and young people under 18 years.
- All over-the-counter oral liquid codeine medicines will be supplied in child-resistant containers.

http://www.mhra.gov.uk/Safetyinformation/Safetywarningsalertsandrecalls/Safetywarningsandmessagesformedicines/CON096796

FUTURE PLANS; WATCH THIS SPACE

Tri x are developing a series of questionnaires for the web site called "The Knowledge" which should be available in December. There will be an icon on the home page to follow.

WHAT IS 'The Knowledge?'

'The Knowledge' is a series of questionnaires designed to help you and your managers be reassured that key policies and procedures are fully understood.

Anyone can try the questionnaires - they are freely available to all.

However, you may be requested to complete a questionnaire by your manager/supervisor or as part of a recruitment/induction programme.

Once it is developed there will be instructions prior to actually undertaking one of the modules which are: Referrals; Initial Assessments; Strategy Discussions/Meetings; Section 47 Enquiries; Child protection Conferences; Core Groups**.**

Joint Working

Having Flick as the Independent Chair for Peterborough and Cambridgeshire is already bringing dividends in joint working. Ian Baillie from the Police has agreed to chair a joint Policy, Practice and Procedures group. In practice this will mean far more consistency in guidance for our partners who cover both LSCB areas such as Police, Probation, the Cambridgeshire and Peterborough Foundation Trust and Cafcass.

A joint e safety group has also been established.

The two LSCB staff teams will also be meeting regularly to "share the load" this should mean that between us we can provide a more timely service.

In addition to the 2 LSCB's working together we have held the first of our annual meetings with the Children's Trust Partnership Board where we began to look at the priorities for Peterborough's safeguarding strategy. We are meeting again in November to flesh this out.

Safeguarding Trafficked Roma Children and Families

The following information provides an update on behalf of Operation 'GOLF' to all Directors of Children's Services and LSCB Chairs in England to inform them of the heightened concern regarding the risk to Roma children and families around human trafficking. The concern stems from a number of police operations carried out in Romania and the UK.

In 2007 the Romanian National Police opened an investigation into the trafficking from Romania of Roma children for forced criminality and other forms of exploitation across Europe. They identified that the gang responsible and the child victims all originated from a single town in south-east Romania.

The Romanian police identified that over 4 years the gang moved 1,107 children from this town into Western Europe. There is evidence that most of these children were exploited by being forced to beg or steal in a number of European countries. It was established that the proceeds of this criminality was then being routed back into Romania to benefit a few crime bosses, also from the Roma community.

In 2008 a Joint Investigation Team was set up by the Metropolitan and the Romanian Police to combat this gang under the name of OPERATION GOLF. On 8th April 2010, 26 gang members were arrested in Romania and charged with trafficking 181 children out of Romania for the purposes of criminal exploitation.

The investigation has revealed that in many cases the parents of the children were/are complicit in their trafficking and continued exploitation. In other cases the parents may have been subject to debt slavery and coercion.

Within the UK a number of the child victims have been found living in a variety of domestic circumstances - some with parents, some with extended family and others placed with 'families' to which they are not related.

This update is to assist you to respond in partnership with the police if, in the course of their investigations they identify children or families in your local area who may have been trafficked.

It should also be born in mind that the method of exploitation adopted by this gang should not be seen in isolation and other children in similar exploitative situations who are not part of this specific investigation may well be encountered.

A planning tool adapted from the London Safeguarding Children Board trafficked children toolkit to assist in developing your response to safeguard and protect Roma children and families is available at: www.londonscb.gov.uk/trafficking

In case of any queries relating to:

- Operation GOLF – contact: colin.carswell@met.pnn.police.uk
- Planning tools – contact: philip.ishola@harrow.gov.uk
  mike.scott@londoncouncils.gov.uk

For further information on training related to safeguarding child victims of trafficking, including training on identification and assessment tools, contact:

ECPAT UK, Karen Sizeland. Training Manager 020 7233 9887 training@ecpat.org.uk

Learning Lessons from Serious Case Reviews: interim report 2009 - 10

Serious case reviews are local enquiries into the death or serious injury of a child where abuse or neglect is known or suspected to be a factor. They are carried out by Local Safeguarding Children Boards so that lessons can be learned. Ofsted has published two previous reports about serious case reviews, the second of which covered the reviews evaluated between April 2008 and March 2009. The report, entitled Learning lessons from serious case reviews: year 2, analysed the 173 reviews evaluated during that 12-month period.

This report covers the evaluations of a further 85 reviews completed in the six months between 1 April and 30 September 2009. As in the two previous reports, this one brings together findings in relation to the practice issues arising, the lessons learnt and the conduct of serious case reviews. It identifies issues which require further consideration by Local Safeguarding Children Boards.

Previous reports have criticised the quality of a large proportion of serious case reviews. However, an evaluation of the 85 latest reviews indicates an improvement in the proportion of reviews that Ofsted has judged to be adequate or better, and a reduction in the proportion judged to be inadequate. Of the first 50 reviews completed to 31 March 2008, 20 were judged to be inadequate, 18 adequate and 12 good. Of the 173 reviews completed in the period from 1 April 2008 to 31 March 2009, 59 were judged to be inadequate, 74 adequate and 40 good. The latest period contained a higher proportion of adequate or good reviews. Of the 85 reviews completed in the latest six-month period to 30 September, 17 were judged to be inadequate, 38 adequate and 30 good.

While this progress reflects the high level of attention that has been given to these reviews, nationally and by most Local Safeguarding Children Boards, it is still of concern that 17 reviews during this period were found by inspectors to be inadequate. Every review of a serious incident should be carried out to the highest standard.

Although this interim report covers only half a year, there are some important findings.

Key findings

- Only 25 of the 85 reviews were completed within six months. Forty-one were completed within a six to 12 month period. Thirteen reviews took between one and two years to complete and six took more than two years.
- Of the 106 children who were the subjects of the reviews, 45 were under one year old, and a further 29 were aged between one and five years old.
- The characteristics of the families in these reviews were similar to those found in previous reports. The most common issues were domestic violence, mental health problems, and drug and alcohol misuse. It was not unusual for more than one of these characteristics to exist in any one family. The incidence of these factors was more frequent in cases where children had died than in non-fatal cases.

- Some parents were themselves receiving services, especially from adult social care, adult mental health and substance misuse services. Front-line workers in these teams were not always sufficiently aware of child protection procedures and responsibilities in relation to the children of their clients.

- Physical abuse was the most common characteristic of the incidents reviewed.

- Only a minority of the children, 41 out of 106, were in contact with social care services at the time of the incident under review.

- A common finding was that none of the main agencies had a complete picture of the child's family and a full record of the concerns. Holistic assessments of risk were not made routinely. Agencies tended to respond reactively to each situation rather than seeing the whole context.

- There was sometimes a lack of focus on the child when working with the family, including a failure by professionals to communicate directly with, or observe, the child so that they could understand the child's daily experience of life.

- There were examples of poor communication and information sharing between agencies, inadequate identification of child protection needs, errors by individual staff, poor assessments leading to inappropriate plans, and inadequate management oversight and decision-making.

- Local Safeguarding Children Boards are often still not paying sufficient attention in the review process to the race, language, culture, religion and disability of the children and their families. More effort continues to be needed to find effective ways of engaging children and families in the review process where this is practicable and appropriate.

The Evaluation of Arrangements for Effective Operation of Local Safeguarding Boards in England

Loughborough University Research

After what seems a very long wait the above research (which was commissioned by the DCSF and DoH) was published in August. It does seem rather out of date as we have all moved on significantly however there is a useful summary of findings such as:

- Professionals at the strategic and operational levels are embracing the notion that safeguarding is a shared responsibility rather than one confined to social care
- The time and resources required to undertake a serious case review has inhibited capacity to move forward
- Engagement and consultation with children and young people is underdeveloped
- Boards spent a considerable amount of time negotiating and securing contributions towards the operation of the work of the LSCB
- The most effective size of the Board is between 20 and 25 members
- Securing appropriate levels of participation in LSCB meetings is a challenge

The full report is available from http://publications.education.gov.uk

Ref DFE-RR027
ISBN 978-1-84775-788-3

Outstanding Local Authority Children's Services 2009

Summary

In December 2009, Ofsted published its children's services assessments for local authorities in England. Inspectors judged 10 children's services to be performing excellently, the highest of four ratings. This report highlights aspects of best practice within these high-performing local authorities, and each has contributed a case study.

As said in Her Majesty's Chief Inspector's Annual Report in 2009, in these highest-performing local authorities, the overall effectiveness of a very large majority of inspected services and settings was good or excellent.1 Children had a good start in early years provision and most continued to do well throughout their education. These local authorities had strong management arrangements, especially in children's social care, and there were many examples of the good involvement of children and families in making decisions about the services that affected their lives.

Excellent children's services ensure that, wherever possible, each child receives a service which meets her or his particular needs so that all children thrive and make good progress. Furthermore, there is a high level of good or better provision for children and young people whose circumstances may make them more vulnerable. Local authorities judged as excellent had a good track record of closing the gaps in outcomes between these children and others of the same age. They take the views of young people, parents and carers whom they serve very seriously and find creative and innovative ways of meeting their needs.

Above all, it is consistency and ambition that have led to improved outcomes. While excellent authorities already do the things that they should be doing very well, they know that there is always more to do. Aspiration and tenacity are strong features of the way that they are led and managed.

The main characteristics of the best-performing authorities show:

- consistency in practice that is driving real improvement of local services
- a clear focus on the children and young people who need support most and on their progress and development
- a deep understanding of local children, families and communities.

Each of these characteristics is considered in more detail in the report and illustrated by the case studies.

This in-depth understanding of local children, families and communities has two key elements. The first is the 10 authorities' use of information about performance and progress with a focus on the needs of children, young people and the services provided for them. The second is how their engagement of children, young people, their families and communities influences and improves services.

The 10 children's services also have a sustained and consistent approach to practice that is driving improvement in local services. They scrutinise their performance and ensure consistent practice through robust performance management and quality assurance arrangements, including in the services commissioned by them, and learn from other sources of evidence to improve what they do. Strong and effective partnerships are seen as crucial. They challenge local providers of services to make further improvements, and they welcome external scrutiny. Above all, they have high expectations of and ambition for all children in their authority; they set challenging targets and, even when these are met, they aspire to achieve more.

The authorities make a difference by improving outcomes for all children and, in particular, for those who are more vulnerable. There is evident commitment to ensuring that all children and young people succeed. They focus on continuing improvement for all and focus on the children and young people that need support and improvement most. They ensure that support is designed around the needs, progress and development of individual children; they have a strong emphasis on prevention and early intervention, turning this from an ambition into actual practice; and they adapt their services to reflect the particular backgrounds of different groups of children and communities. Where the authorities do not provide the services themselves, they commission them from other providers in the private and voluntary sector, ensuring that the services are of high quality to meet the needs of the children and young people they serve.

The majority of local authority children's services have some good, even excellent, features, but excellence in these 10 authorities is marked by consistency: in the way things are done; in the quality of services offered to all children and young people; and in improving outcomes.

Learning from serious case reviews Report of a research study on the methods of learning lessons nationally from serious case reviews

Implications for policy and practice

1. This research has highlighted the value of a more participative approach to conducting Serious Case Reviews, rather than a focus solely on documentary review and one-way transfer of information through practitioner interviews.
2. There are many ways in which learning can be embedded throughout the process of carrying out a Serious Case Review; this may include workshops for involved practitioners, other front-line workers and managers at an early stage in the IMR process as well as subsequent briefing/workshop events. Approaches to learning can be included in the scoping of a Serious Case Review.
3. Clear briefings for IMR authors as to their role, along with training in facilitating learning as part of the process would enhance the value of learning at a local level.
4. Serious Case Reviews are stressful events for both practitioners and managers. They therefore need support throughout the process. Approaches to support can be included in the scoping of a Serious Case Review.
5. Learning from a Serious Case Review can be enhanced if all involved practitioners understand, from the beginning, the need for and purpose of the review. They should be informed that the emphasis is on learning lessons, but that this will include a critical reflection on both individual and organisational practice, and that if issues are identified requiring disciplinary action, these will be addressed through parallel processes. This briefing needs to be done with sensitivity and support for the individual.
6. Whilst there is flexibility in the methods used for analysis in Serious Case Reviews, the validity of the lessons learnt is enhanced if the methodology is clearly described in the review.
7. There is a need for further research to explore different methods of improving practitioner involvement in and learning from the Serious Case Review process.
8. Training materials and standardised templates for carrying out Serious Case Reviews can enhance standardisation and opportunities for national learning.
9. A scaled back approach to evaluating and reporting on Serious Case Reviews would make the process more supportive of learning. This could include abolishing the summative grading of Serious Case Reviews in favour of more supportive formative feedback.
10. The breadth and depth of learning from national analyses of Serious Case Reviews could be enhanced by an expansion of the current notification database to include an electronic repository of anonymised overview reports together with IMRs, chronologies, genograms and action plans for all Serious Case Reviews.

11. The authors of this study suggest a revised system of national analysis which we believe would provide a more robust and flexible approach to national learning along the following lines:

    -A research team commissioned for a longer period of at least 5 years to provide an observatory/reporting functiononal Serious Case Reviews; this research team would have responsibility for annual reporting of the numbers, patterns and key learning from Serious Case Reviews, and would have access to data that will enable data on Serious Case Reviews to be linked to and compared to data from Child Death Overview Panels, and to wider data on children's safeguarding; this research team would also have responsibility for reviewing any national implications of recommendations from Serious Case Reviews;

    -A national steering group established to oversee the work of the research team and to advise on further thematic analysis of the data;

    -The data or subsets of the data would be made available to bona-fide researchers with relevant and appropriate proposals to undertake thematic analysis, under the direction and approval of the national steering group; the national steering group could recommend specific themes for analysis that are considered to be of national importance; these could then be commissioned by the Department for Education, or funded proposals sought from elsewhere.

12. There was considerable enthusiasm for national studies of good practice in safeguarding. This is currently part of the ongoing Safeguarding Children research programme within the Department for Education and the Department of Health. Results from this should help to balance the negative impact of focusing on what goes wrong.
13. Timely and accessible dissemination of learning from Serious Case Reviews would be enhanced by open publication of the key lessons learned from national analysis on a website. This would require close collaboration between the Department for Education, Ofsted, and any research team involved in national analysis.
14. Findings from research on Serious Case Reviews need to be presented in a variety of formats to reach different audiences, including practitioners, policymakers and researchers. This could include easily readable newsletters or briefing papers, more substantive research and publications in peer reviewed scientific journals. A strategy for dissemination should form a substantial part of any research proposal.
15. Learning from Serious Case Reviews should be embedded in a range of training materials that could be made available to local trainers.

PSCB Training Courses

Please see listed below some of the forth coming PSCB training courses that we still have spaces on

Course Date	Title
11th November 2010	Working Together to Safeguard Children
22nd November 2010	Safeguarding Children & Young People from New Arrival European Communities
10th December 2010	An Introduction to Safeguarding

For a booking form, more information on any of the courses please contact Charlotte Lucas on 01733 863747 or visit our website www.peterboroughlscb.org.uk

Building on the learning from serious case reviews: a two-year analysis of child protection database notifications 2007-2009

INTRODUCTION

Serious case reviews (SCRs) are local enquiries into the death or serious injury of a child where abuse or neglect are known or suspected. They are carried out under the auspices of Local Safeguarding Children Boards (LSCBs) so that lessons can be learnt locally. Every two years an overview analysis of these reviews throughout England is commissioned to draw out themes and trends so that lessons learnt from these cases can inform both policy and practice. This is the 5th such biennial analysis of reviews, and it presents an analysis of 268 serious case reviews undertaken in England relating to incidents which occurred during the period 1st April 2007 – 31st March 2009. 152 (57%) of the children or young people died and the remaining 116 were seriously harmed.

The current review complements the two earlier biennial reports undertaken by the same authors, covering 2003-2005 and 2005-2007. Over the six years we have built up a dataset of 618 serious case reviews relating to incidents which occurred between 1st April 2003 and 31st March 2009. Being able to carry out three consecutive biennial analyses has provided helpful continuity, and has enabled us to develop a close understanding of serious case reviews and of the different sources of information kept in relation to these reviews and the child at the centre of the process.

KEY FINDINGS

- There is a 43% increase in the number of deaths, and a 111% rise in the number of serious harm cases, which were subject to a serious case review between 2003-05 and 2007-09.
- The characteristics of the children, and their families, are very similar to those found in the earlier biennial reviews; there was, for example, a similar proportion of children with child protection plans, and a similar age range.
- Approximately half of all serious case reviews are in relation to babies under one year of age, underlining the importance of effective universal services provision for young children e.g. health visitors and early-years services such as Sure Start Children's Centres.
- A quarter of the reviews concerned older young people who are likely to pose a risk to themselves and/or others, and whose needs are not always recognised, or met.
- As in previous studies domestic violence, substance misuse, mental health problems and neglect were frequent factors in the families' backgrounds, and it is the combination of these factors which is particularly 'toxic'.
- While more than three quarters of the children were killed or harmed at home, just over one in five incidents (21%) took place in a 'community context'.
- The incident that prompts a serious case review is not always preceded by practice failings.
- Little difference was noted between those notifications for serious injury which became a serious case review and those which did not.
- New ways of thinking about safeguarding practice emerged from the analysis over the six years. Other recurring messages are reminders about what is known about good practice.
- The ecological transactional approach to analysing information provides a theoretical framework for thinking about the dynamics of interactions between children, carers and agencies and the way that different risk factors for harm combine and interact to influence children's development and safety.

PETERBOROUGH SAFEGUARDING CHILDREN BOARD

SUMMARY OF MEETING 30 SEPTEMBER 2010

Outlined below is a summary of agenda items discussed at the last meeting. Should any further details /information be required on an item please contact the named person.

1	**Outstanding Local Authority Children's Services**. This report highlights aspects of best practice in the 10 Children's Services judged by Ofsted in 2009	Judy Jones 863745
2	**Private Fostering Update.** Following on from the Climbie Enquiry new legislation requires the local authority to be notified if a child under 16 (or under 18 if there are learning difficulties) is cared for by someone other than a parent or close family relative. The Private Fostering Officer is now based with the Referral and Assessment Team	Janes van Vollenstee 864424
3	**Equality Impact Assessments** Following the Single Equality Act which came into force on 1 October we are reminded that all services should be carrying out equality impact assessments to ensure that policies do not have a detrimental effect on people depending on their race, gender, disability, age, religion or belief, or sexual orientation	Judy Jones 863745
4	**Summary of Ofsted Inspections** Members heard that 43% of inspection results were outstanding and 43% good. A very positive picture was presented	Mel Collins 863730
5	**Quarterly Statistical Report** A six monthly report was presented revealing an increase in activity	Lynn Chesterton 863748
6	**Serious Case Reviews** The Board signed off 2 SCR Action Plans. A 3rd was delayed until December	Judy Jones 863745
7	**Regulatory Submissions.** Members discussed a peer review surrounding the way the Police deal with rapes	Judy Jones 863745
8	**Children are Unbeatable Alliance** The Board agreed to support the aims of the alliance which seeks legal reform to give children the same protection under the law on assault as adults and promoting positive non violent discipline	Judy Jones 863745
9	**Date of next meeting** 25 November 2010 Bayard Place.	