April 2007

Peterborough Safeguarding Children Board Newsletter

Message from the Editor

Hope you had a good Easter break.

This newsletter has a focus on the most recent Serious Case Reviews as we are aware that many of you feel you do not receive adequate feedback. The summary included within this newsletter will, I hope, go some way to keeping you better informed.

As you will see, there have been a number of changes within our small team, however it is 'business as normal'.

Once again thank you to Hannah Campling for putting this newsletter together for us.

If you have any comments please email Judy Jones: judy.jones@peterborough.gov.uk

Welcome

Barbara Trevanion New PSCB Chair

Barbara comes to our team with knowledge of working in Peterborough and experience of chairing Cambridgeshire Local Safeguarding Children Board. She started on 1st April 2007

Julie Solley PSCB Training and Development Manager Maternity Cover

Julie has a long history of Child Protection Work in Peterborough with the Police and Youth Offending Service and is currently at New Link. She joins us in April for 2 days a week for 12 months while Jo Bramwell is on maternity leave. We look forward to having her as part of the team.

Fiona Taylor: PSCB Inter-agency Trainer

We also officially welcome Fiona Taylor who joined us on 7th February 2007. Her role is to deliver free child protection training to Peterborough agencies. Anyone who would like more information or to talk with Fiona should contact Hannah Campling on 01733 748271 or email Fiona: fiona.taylor@peterborough.gov.uk.

April 2007

Congratulations!

To Jo Bramwell who left us on 14th March to start 12 months maternity leave. Emilia Jane Bramwell was born on 16th April. We wish her lots of luck and look forward to seeing the new addition to the Bramwell family.

New leaflets:

In the previous newsletter it was mentioned that two new leaflets were in the process of being released. Both are now available on our website at www.peterborough.gov.uk by following the links through Health and Social Care to Peterborough Safeguarding Children Board's own website. The leaflets can then be found under publications.

The first was regarding Sexual Exploitation and looks like this:

The second provides information on the expectations of Child Protection Conference attendees and looks like this:

New Guidance:

Procedures: the new Core Inter-agency Safeguarding Procedures are now available on our website, via the Peterborough City Council Website. Please contact Kay Mayor on 01733 746028 or kay.mayor@peterborough.gov.uk if you have not yet received your copy either in hard copy format or on disc.

A small group has developed a protocol and practice guidance for undertaking pre-birth risk assessments. This will be available in May and will be circulated widely so it can be inserted into the PSCB Procedures.

In addition you can see from the details below that we are launching the local guidance for working with sexually active young people under 18 years, in conjunction with Peterborough Primary Care Trust. The guidance will also be widely circulated and should be inserted into the PSCB Procedures.

'What to do if…'

We have received copies of this updated guidance which we will be circulating over the next few weeks. It can also be downloaded from: www.everychildmatters.gov.uk

LAUNCH

Guidance for Professionals Working With Sexually Active Young People Under the Age of 18 in Peterborough

14th May 2007
John Clare Theatre

Please email Hannah Campling hannah.campling@peterborough.gov.uk or 01733 748271 and indicate which session you would like to attend by Friday 4th May 2007

14th May 2007

9:30am- 11:30am
OR
12:00pm -2:00pm
OR
2:30pm – 4:30pm

Please note: it is only necessary for you to attend ONE session.

Safer Parenting Handbook

The Portuguese version as mentioned in our January Newsletter is now available on the website. If you would like a hard copy please contact Kay Mayor

We still have copies of the English version. Please contact Kay Mayor as above if you require any copies.

RESEARCH

The NSPCC has produced a short leaflet for professionals working with families entitled 'Understanding the Links – Child Abuse, Animal Abuse and Domestic Violence'. It is available on our website and can be downloaded from www.nspcc.org.uk/inform

Have you seen the DfES Research Report RR750 "Could Abuse be linked to Accusations of 'Possession' and 'Witchcraft'? The research was commissioned as a result of 2 high profile cases (Victoria Climbié and child B) where adults believed that a child in their care was a "witch" or "possessed by evil spirits". In an attempt by the carers to remove the "evil spirit", these children were subjected to serious physical and emotional abuse. The summary as below can be found at www.dfespublications.gov.uk or on our website.

WITCHCRAFT SUMMARY

This report concerns the frequency and severity of child abuse linked to accusations of "possession" and "witchcraft". It identifies key features common to these cases, draws conclusions and makes recommendations.

The report is based on desk research and discussions with social workers, school teachers, police officers, voluntary workers and others who had knowledge of aspects of the subject. An important feature has been collecting and examining reports of cases that occurred since January 2000, analysing the often limited information recorded and drawing conclusions from this material.

The belief in "possession" and "witchcraft" is widespread. The UK is not alone in seeing cases of this nature; cases have been reported worldwide. The children discussed in this report came from a variety of backgrounds including African, South Asian and European.

Seventy-four cases of abuse clearly linked to accusations of "possession" and "witchcraft" were identified. To safeguard against double-counting, only cases for which there were identifying factors were analysed. Therefore, this report only analyses thirty-eight of these cases. It should be noted that prior to enquiries only fourteen cases were clearly identified and new cases were being reported right up to the date of publication of this report.

The number of cases of child abuse linked to accusations of "possession" and "witchcraft" so far identified is small compared to the total number of children abused each year.

In the year to 31 March 2005, 30,700 children were placed on child protection registers in England. There were 72,100 child protection enquiries in England in the year to 31 March 2004.

The abuse in question occurs when an attempt is made to "exorcise" the child. The abuse consists of severe beatings and other premeditated cruelties such as starving, burning and isolating the child. The perpetrators are usually carers – often not the natural parents – and the abuse usually occurs in the household where the child lives. As a last resort the child may be abandoned overseas. Their further history is not known.

There appear to be common features between cases, for instance, a child being scapegoated, family structure and disability. By recognising these patterns and links it may be possible to identify children at risk early and prevent cases from escalating.

The recommendations address gathering better information about cases, drawing up guidance about handling cases, monitoring the movement of children and protecting children in places of worship.

REPORT ON SERIOUS CASE REVIEWS

FROM: **Judy Jones, PSCB Policy Officer**
DATE: **21 March 2007**

1.0 BACKGROUND

1.1 Since March 2004 Peterborough (ACPC) now Peterborough Safeguarding Children Board (PSCB) have held five Serious Case Reviews (SCR) and three Management Reviews.

1.2 Working Together 2006 and Peterborough Inter Agency Safeguarding Procedures state that Serious Case Reviews must **ALWAYS** be held when a child dies and abuse or neglect are known or suspected to be a factor in the death. In addition PSCB must **CONSIDER** holding a review:

- where a child has sustained a potentially life threatening injury or serious impairment of health or development through abuse or neglect
- where a child has been subjected to a particularly serious sexual assault
- when their parent has been murdered and a homicide review is being initiated

- where the child has been killed by a parent with mental illness; **AND**
- the case gives rise to concerns about interagency working.

1.3 The practice of PSCB has also been to hold Management Reviews where cases do not meet the criteria above but where the case does give rise to concerns about interagency work.

1.4 This report will briefly summarise the headline recurring themes.

2.0 SERIOUS CASE REVIEWS

2.1 The circumstances leading to the holding of the most recent serious case reviews were as follows:

- Brain injury and other physical injuries to a baby of 21 days (**completed July 2004)**
- Vaginal Injury to a girl of 23 months (**Completed January 2006**)
- Death of a new born baby (**Completed September 2006)**
- Serious long term neglect/sexual exploitation of sisters aged 16yrs 10 months and 15 years 6 months (**Completed December 2006**)
- Death in a house fire of 2 brothers aged 18 months and 7 months (**Completed March 2007)**

3.0 MANAGEMENT REVIEWS

3.1 The circumstances leading to the holding of the most recent management reviews were as follows:

- Injury and healing fractures to a baby of 6 months (**completed November 2005)**
- Serious long term neglect/birth of a baby prior to young woman's 16th birthday (**Competed January 2007)**
- Death of a girl of 5 years as a result of HIV/AIDS (**Completed December 2006)**

4.0 PROCESS

4.1 Agencies that have had involvement are required to complete a management review to summarise their contact with the child/family. A template is provided which directs authors to interview staff involved analyse all the information gathered and make recommendations for improvements to their own agency's procedures and practice.

4.2 An independent overview author is also commissioned to provide a report for PSCB which scrutinizes all the information contained within the various agency reports, analyses practice and compliance with procedures and makes recommendations for PSCB to highlight with its partner agencies.

4.3 All agencies are required to develop action plans to progress the recommendations. These action plans are monitored and audited by the Serious Case Review Group.

4.4 All reports and action plans are forwarded to the Commission for Social Care Inspection for their consideration and comment.

5.0 THEMES

5.1 Each review has its own unique features leading to specific recommendations for example:

- revisit the HIV/AIDS policy
- develop guidance for pre birth assessments.

Nevertheless there a remarkable similarity in the themes which are identified by the various independent overview authors.

5.2 **The themes can be grouped as follows:**

1. **Assessment/Risk Analysis**
2. **Chronologies/Family Histories**
3. **Lack of Child Focus**
4. **Information Sharing/Communication**
5. **Quality Assurance/Audit/Supervision**
6. **Training/Recruitment**

5.3 **Assessment and Risk Analysis**.

Workers from many agencies have been noted as collecting information without then asking "what does this information tell me about the potential risks to this child?" The dimensions of the Assessment Framework have been mechanistically used however significantly the dimension of Family and Environmental factors has been routinely missed**. Analysis and evaluation are essential components of assessment** and until all the information has been collected it is not possible to undertake a proper risk analysis. Reviews have shown that decisions are being made on the basis of flawed assessments. **This has lead to the clear recommendation about the need to embed the Common Assessment Framework and CAF form into all agencies practice and to ensure that all are clear about how the CAF interrelates with initial and core assessments.**

5.4 **Chronologies and Family Histories**.

Chronologies of significant events coupled with information gathering of family histories should be an integral part of case recording. **Without these workers can operate on an individual incident basis and not recognise patterns which could lead to heightened concern**.

In several of the reviews there was a good deal of information known about family members which would have added greatly to the analysis of risk and would have radically affected planning. Family histories are clearly of increased importance when assessing young (teenage) parents. **This has lead to the recommendation that chronologies and family histories must be an integral part of practice.**

5.5 **Lack of Child Focus.**

Reviews have shown that workers have shown an overemphasis on the needs of the adults and have not taken the views of children and young people into consideration. With young children who have not yet developed language, observation should be used to contribute to an assessment of appropriate development. Conversations with children and observations must be routinely recorded. Ironically with older teenagers reviews have seen an over reliance on an assumption that as they were "street wise" they could look after themselves without actually assessing their level of cognitive abilities.

This has lead to the recommendation that the question should always be asked "What would it feel like to be a child in this family?"

5.6 **Information Sharing/Communication.**

Agencies have not always shared the information which they have or the information has not been communicated effectively. Telephone messages or emails cannot take the place of a written referral. In addition there has often been an assumption that someone else will make a referral. **It is the responsibility of the person with the concern to make a referral or discuss within their own agency as to the way forward**. There is evidence also that professionals do not escalate concerns when they are not satisfied with services offered or decisions made.

Many case reviews have involved agencies who provide services for adults and there is evidence that the effect of adult behaviors or needs has not routinely lead to a questioning of the impact on the children of the family. **This has lead to the recommendation that there is clearly a need for protocols to be established between adult services and specialist services to ensure good information sharing and partnership working**.

The use of data sharing systems between police and specialist services is an aspiration.

5.7 Quality Assurance/Audit/Supervision.

The role of Managers with respect to the supervision of staff and the quality of plans is a significant concern and seen as one missed opportunity to challenge poor practice. It has been noted that interventions have not always been based on the clear aims and objectives of what is to be achieved or what needs to change to reduce risk**. It has been suggested by one overview author that within Peterborough there may not be an accepted culture that the maintenance of standards in child protection is the responsibility of all agencies. Therefore it has been recommended that this is highlighted by PSCB**. This is now clearly stated in the new Inter Agency safeguarding procedures. Records of supervision notes should be on file with a clear note of accountability and responsibility in order for an audit trail to be established**.**

The Quality Assurance Group (PSCB) is currently developing an interagency audit tool which will be used to audit a selection of case files on a regular cycle where several agencies have been involved. This will enable us to see if thresholds are being consistently applied.

5.8 Training/Recruitment

Case reviews highlight the importance of training linked to staff development and effective management. **Both managers and practitioners need to be provided with the tools to develop the necessary competencies for effective practice**. **It has been recommended that through regular appraisals appropriate training can be identified and the effect on practice monitored**. A greater use of research findings and use of messages from local case reviews should be available for staff. Regular audits will also highlight specific training needs.

The above must be viewed within the wider workforce development agenda and an acknowledgement that these case reviews were held in the context of all agencies experiencing staff shortages and difficulties in recruitment. Some staff therefore were going beyond their agency specific role however they were not adequately supported to do so.

6.0 CONCLUSION

Serious Case Reviews allow us to take a critical in depth look at interagency practice in Peterborough and as a consequence enable us to develop appropriate strategies to address the issues highlighted.

The task for all agencies is to ensure that the learning from reviews is effectively communicated to all staff and is seen to make a difference to the outcomes for children.

As members will be aware the JAR judgments make reference to these themes and therefore the 3 identified work streams are giving an added impetus to improve the standard of inter agency child protection work.

7.0 RECOMMENDATIONS

All members of this board read the executive summaries of the serious case reviews which can be found at - www.peterborough.gov.uk – follow the links via Health and Social Care to Peterborough Safeguarding Children Board.

All members enquire of their agency as to what management actions were undertaken.

NB: A more detailed compilation of these Serious Case and Management Reviews is available on request from Judy Jones at judy.jones@peterborough.gov.uk

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Other news:

- Work is in hand to develop a protocol for dealing with unexpected child deaths. A draft protocol has been circulated for comment. The protocol will cover Peterborough and Cambridgeshire and is the first step in developing the broader Child Death Review Panel and associated arrangements which must be in place by April 2008.

- Fiona and Hannah are attempting to conduct a survey on child protection training being delivered by agencies in Peterborough, including the voluntary sector. Anyone with information on child protection training that is being delivered within a club or group within Peterborough should contact Hannah Campling on 01733 748271 or hannah.campling@peterborough.gov.uk

- Judy attended the Youth Council on 20th April 2007. It is likely that a sub group will be established which we can liaise/consult with.