Derby Safeguarding Children Board

Annual Report 2012 - 2013

Preface

The Children Act 2004 (Section 14a) requires LSCBs to produce and publish an annual report on the effectiveness of safeguarding in the local area.
The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles.

The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period.
(Working Together 2013, Chapter 3, paragraph 17)

The report should demonstrate the extent to which the functions of the LSCB as set out in Working Together 2013 are being effectively discharged.
The statutory functions of the LSCB are to:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of Working Together to Safeguard Children 2013;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

The report should also list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training. All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.

This is a public report that will be formally presented to the City Leadership Board and to the Children, Families and Learners Board, the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and wellbeing board.

Contents Page

1. Chair's Foreword

1.1 Welcome to this Annual Report for Derby Safeguarding Children Board which sets out the work undertaken during 2012-13. The report highlights important developments and aspects if good practice in safeguarding across the city. It is particularly pleasing to be able to report on the Ofsted inspection judgment that local authority safeguarding services in the city are good. Although the inspection focused primarily on the local authority it also reflected good multi-agency working and the report commented very positively on the work of the Safeguarding Children Board. Pleasing as it is to have this endorsement of both the Board's work and that of safeguarding services, the Board is not complacent and remains determined to drive further improvement.

1.2 The Board identifies areas for improvement through a variety of review and audit processes. Over the past year we have undertaken two Serious Case Reviews (SCRs); one into the tragic death of a baby and another into the tragic death of six children in a fire. These reviews are completed and recommendations are already being implemented. The Board is resolute that it wishes to publish these reports as soon as possible and is only delayed by current legal constraints.

1.3 During 2013-14 we will ensure that all learning from our audit and review activity, and that from other national SCRs and research activity informs and changes local practice. We will also continue to focus on the impact of early intervention, the domestic violence strategy, and child sexual exploitation and the extent to which practice in those areas reflects a "think family" approach with the child at the centre.

1.4 I would like to thank everyone in Derby for their continuing commitment to safeguarding children. We can only be successful in protecting children if everyone from frontline practitioners to chief executives give safeguarding the priority it demands.

Christine Cassell
Independent Chair

2. Introduction

2.1 This report is the annual review of the work of the DSCB for the business year 2012/2013.

2.2 The purpose of this Annual Report is to:

- provide an outline of the main activity and achievements of the Derby Safeguarding Children Board (DSCB) during 2012/2013
- provide an assessment of the effectiveness of safeguarding activity in Derby
- provide the general public, practitioners and main stakeholders with an overview of how well children in Derby are protected
- identify gaps in service development and any challenges ahead
- priorities for action 2013/2015

2.3 The DSCB has two objectives, as detailed in the Children Act 2004 and Working Together 2013 and this report details the progress against each of these objectives, as follows:

- to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority; and
- to ensure the effectiveness of what is done by each such person or body for that purpose.

The body of the report falls into two main sections to reflect these two objectives.

2.4 "Safeguarding and promoting the welfare of children" is terminology used throughout this report. Working Together 2013 defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

"Safeguarding children - the action we take to promote the welfare of children and protect them from harm - is everyone’s responsibility. Everyone who comes into contact with children and families has a role to play."

3. Coordinating Local Work to Safeguard and Promote the Welfare of Children.

3.1 This section sets out what the Derby Safeguarding Children Board has achieved to co-ordinate what is done by each person or body represented on the Board to safeguard and promote the welfare of children in the Derby.

3.2 Our priority actions for **2012 - 2013** were to:

Analyse the effectiveness of arrangements in place to prevent and respond to domestic violence and its impact on children and young people.

Promote consistent and robust Early Intervention arrangements and assess whether local arrangements are improving the safety and positive outcomes for local children and young people.

Extend the local information that helps to keep children safe in Derby online to the public and professionals with the revision of the Derby Safeguarding Children Board website.

3.3 Progress against these priorities:

- The ***domestic violence strategy*** has been established by the Derby and Derbyshire Domestic Violence and Sexual Violence Leadership Group. There is an agreed action plan which is co-ordinated with the City and County and with adult's services, and there is effective sharing of information and joint activity. Some progress has been made in some areas but overall this has been slow. Lack of a service for perpetrators remains problematic but negotiations are currently underway and funding is available for a service in Derby, probably by the end of 2013. The recording of domestic violence as a factor in child protection plans has improved and so this can now be a more reliable measure. Derby and Derbyshire have an agreed response for 16/17yr olds affected by DV from or to a partner.

  Performance and outcome data is reviewed quarterly but it is not reliable as a measure of outcomes for children, largely because of the estimated significant under-reporting of DV. Crime figures and Child Protection figures show a continued rise but this is interpreted as greater reporting rather than greater incidence.

  The DSCB worked with the NSPCC to evaluate the effectiveness of referral processes where concerns are emerging about domestic violence in a family. A successful joint project piloted the use of the Failure Modes and Effects Analysis (FMEA) method of analysis (further detail in section 20)

  The police and children social care departments in Derby and Derbyshire are collaborating to develop multi agency safeguarding arrangements to analyse and respond with partners to domestic violence incidents that have been brought to the attention of the police. The DSCB will be working in the coming

year to ensure that these important developments work well with the specific work carried out within child protection processes to keep children safe.

- The DSCB has continued to receive regular updates on the development and progress of the ***early intervention*** arrangements and has seen a rise in the use of the Common Assessment. . This remains an area for improvement. Good progress was identified during scrutiny of arrangements by Ofsted in December 2012.

- Action has been taken to update and extend the DSCB website that now includes additional guidance, training information and links to the web based child protection procedures.

3.4 Additional actions in the **2012 - 2013** business plan focussed on improving the working arrangements of the Board included:

Consultation with children, young people (including those who have been missing) and their families.
Consultation arrangements have been the focus of activity by the local authority and are reported on further in section 6. Young People were successfully involved in discussion about the review and development of future DSCB training and this will be the focus of further activity in the coming year. The unannounced Ofsted inspection made specific comment on the arrangements for consultation with children who have been missing and further detail is provided in section 13.

Embedding up to date and effective policies and procedures across the all agencies.
The DSCB published a web version of the safeguarding children procedures and has established an action plan jointly with the Derbyshire LSCB to implement the new arrangements set out in Working Together 2013.

The DSCB signed off the following new or revised policies and procedures
- Section 3 Early Intervention and Social Care
- Ofsted Notification of Serious Childcare Incident guidance
- Criteria for policy, procedures and guidance document consideration at Policy & Procedures group
- Delivery protection plan
- Home visits guidance
- Female Genital Mutilation
- Allegations against staff, volunteers and carers

Establishing representation from lay members on the DSCB.
Long term sickness of a member of the DSCB team delayed the recruitment process which had to be de-prioritised against other DSCB activity during the year.

Promoting awareness of and reviewing arrangements for Child Sexual Exploitation

Progress has continued to raise awareness and ensure effective arrangements are in place. The Ofsted inspection in December 2012 stated **"**Work to manage and address issues of child sexual exploitation (CSE) is robust and effective with full engagement of all partner agencies at both strategic and operational levels." (Further comment is included in section 21)

Promoting awareness of private fostering and monitor rate of referrals and the outcomes for children and young people.
The DSCB scrutinised arrangements at the end of 2012 and further comment is made in section 15.

Developing arrangements to report allegations about staff and volunteers with partner agencies and improve the timeliness of action taken in respect of the concerns

The Safeguarding Procedures were amended to take account of changes introduced in the Government guidance to schools published in 2012. These have been confirmed as joint arrangements with the County. A training programme has been incorporated into the DSCB portfolio, and workshops provided for all CYPD staff. Improvements have been made in the recording arrangements for allegations. Staff capacity was increased to deal with managing allegations, and the timeliness of these investigations improved significantly. All this is reflected in the annual report which is presented to the Workforce Group.

Incorporating the learning arising from the review of the effectiveness of training and embed consistent and robust training and development pathways.
The multi agency involvement in the training pool continued to provide effective training with good feedback from participants. The project to establish and embed robust training pathways commenced in 2013 and will be reported on in Autumn 2013.

Embedding consistent early intervention and robust safeguarding audit arrangements across the education sector*.*
Termly meetings have been established with education sector providers to ensure that throughout the sector there is coordinated development of early intervention and safeguarding arrangements in Derby. A successful Safeguarding Conference was held for the Education Sector and progress has been made to establish shared revised standards for the audit or arrangements in individual settings.

Embedding consistent and robust S11 audit arrangements across all agencies.
S11 reports were received from partner agencies and Health partners continued to quality assure their services using the *Markers of Good Practice*. (Further comment is included in Section 25)

4 Governance and Accountability

4.1 The governance arrangements for the DSCB were reviewed following publication of Working Together 2013 at Board meeting in March 2013 and will be ratified in June 2013.

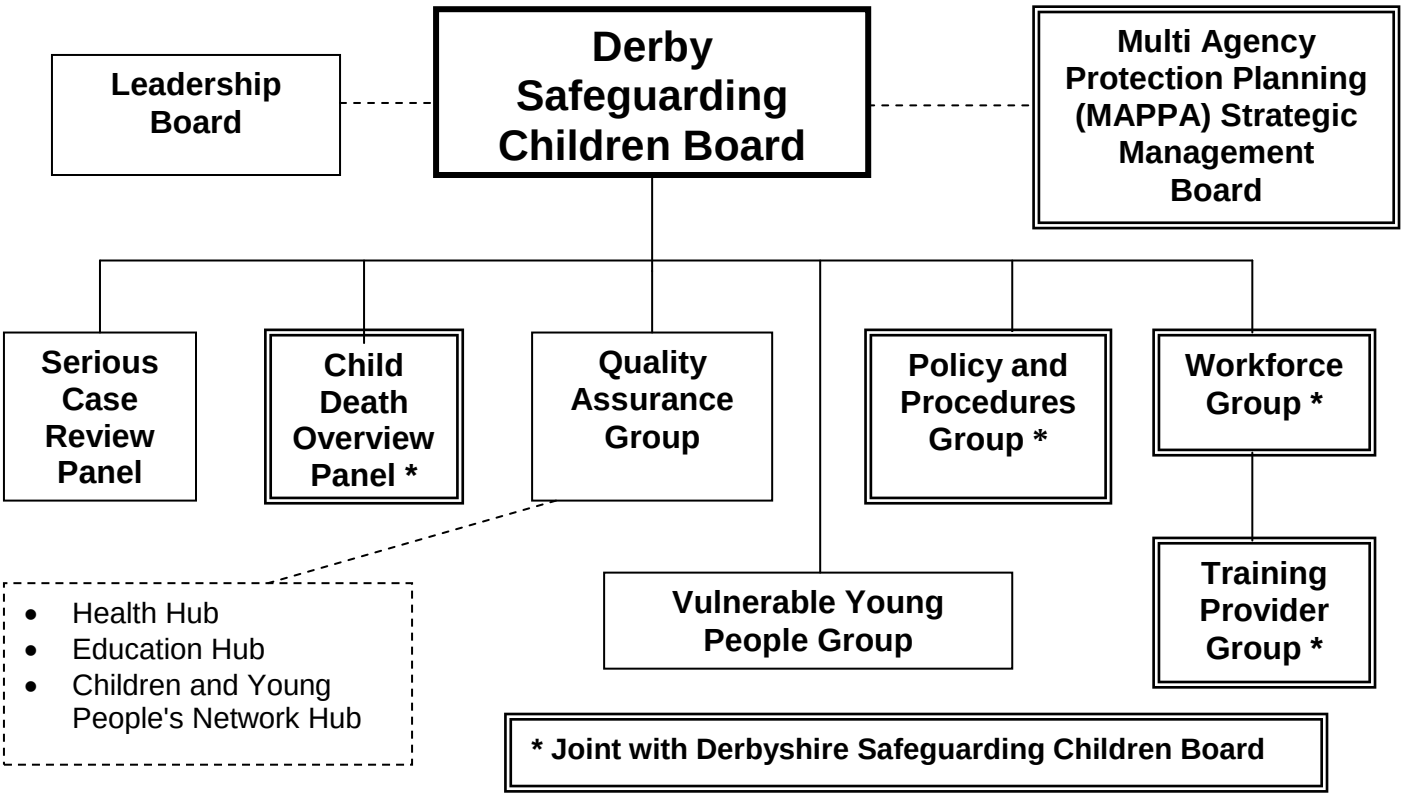
4.2 Each subgroup is chaired by a member of the Derby Safeguarding Children Board or in the case of the subgroups with shared membership with Derbyshire LSCB, the chair person is a member of either Board.

4.3 The Workforce Group was established to ensure suitable arrangements are in place to recruit, supervise and take action where concerns arise about staff. The Workforce Group will commission the training to be delivered by the multi agency Training Provider Group.

4.4 The Vulnerable Young People Group was established during the year to promote co-ordinated, multi-agency developments in relation to vulnerable young people in Derby encompassing:

- Child Sexual Exploitation
- Missing Children
- Children who self-harm, including substance misuse
- Young people associated with serious youth violence
- Young people vulnerable to radicalisation and terrorism
- Young people who offend
- Young people who are persistently homeless

The Derby Safeguarding Children Board Standing Subgroups



5 Relationship to the Derby City and Neighbourhood Partnerships Boards with responsibilities for children and families

5.1 The responsibilities of the DSCB are complementary to those of the Derby City and Neighbourhood Partnerships Boards with responsibilities for children and families to promote co-operation to improve the wellbeing of children in Derby. (These include the Leadership Board; Children, Families and Learners Board; Health and Well-being Board; Safe and Strong Communities Board)

5.2 The DSCB role is to ensure the effectiveness of the arrangements made by wider partnership and individual agencies to safeguard and promote the welfare of children. The DSCB reports directly to the partnership Leadership Board and to the Children, Families and Learners Board, but is not an operational sub-committee of either.

5.3 External scrutiny of the joint arrangements, by Ofsted, reported that "Governance arrangements between the Derby Partnership Board and DSCB are good, formally detailed and understood by all partners. This accountability arrangement results in the widest possible strategic engagement for the DSCB as the partnership includes representatives from industry and the local press as well as chief executives of key partner agencies. The children and young people's scrutiny board demonstrates a good focus on child protection and regularly holds officers to account at performance surgeries.

5.4 The Derby Children and Young People's Plan during 2013 – 2015 includes the priority issues raised by DSCB to keep children and young people safe through making sure that they have access to good quality services at the earliest opportunity, reducing the likelihood of them being exposed to or participating in 'risky' behaviours.

5.5 The Children and Young People's Plan sets out one significant aspiration and this is "Working Together to Narrow the Gap". This means "Working together to target services effectively towards vulnerable groups including; children in care and children living in poverty to increase their opportunities, reduce inequalities and improve outcomes against the Boards' three priority outcomes." One of these three priority outcomes is ***"More children and young people being safe".***

5.6 The Independent Chair attends the Children, Families and Learners Board (CFLB) and reports on safeguarding issues at each Board meeting.

5.7 The Director of Children's Services is a member of the DSCB and reports on Children, Families and Learners Board (CFLB) matters to all DSCB meetings. The DSCB seeks to provide challenge and scrutiny to the work of the CFLB ensuring that in the commissioning, planning and delivery of services, the safeguarding of children is paramount in the CFLB's decision making.

5.8 The DSCB has ensured that is included as part of the consultation of the development of the Children and Young People's Planning 2013 – 2014 participating in the priority setting in May 2013.

6 Participation of Children and Young People

6.1 The DSCB draws upon the work of the Derby City Council (DCC) and members of the Children and Young People's Network to help inform it about the views of children and young people about the services they receive.

6.2 The DSCB has continued to actively engage young people in the CSE strategy during the past year (The monitoring and audit section illustrates this in more detail). Additionally the DSCB has consulted with young people over the design and content of DSCB training.

6.3 The DSCB has been kept informed of the action being taken by the Local Authority to "Strengthen the arrangements for user engagement in Child Protection processes to ensure their views and experiences are sought in order to inform service delivery and development". (An action arising from the Ofsted inspection of Safeguarding and Looked after Children Services in November 2011)

6.4 Child Protection processes were mapped to identify where the voice of children and young people are heard along that process.

6.5 Participation standards (draft) have been developed by the Derby Children and Young People's Participation Network in conjunction with young people to provide a consistent best practice approach to working with children, young people and their families. Future work to launch the standards and embed them in local partnership working arrangements (from early intervention through to child protection processes) will be undertaken. The impact of involving children, young people and their families will be evaluated and the DSCB will be kept up to date with the findings.

6.6 A separate project commenced to strengthening engagement with Children in Care through their Independent Reviews. A revised Review Form that every child/young person in care completes was introduced in January 2013 and the views of children and young people will now be able to be analysed more effectively. Analysis of the piloting of the form is being undertaken in summer 2013 and the outcomes will be reported to the DSCB.

6.7 Subsequent inspection by Ofsted in 2012 noted the progress that has been made stating "good quality commissioned advocacy service effectively supports children involved in child protection processes and powerfully represents their views and feelings at case conferences."

6.7 The Children in Care Council (CiCC) is a group available to all children and young people who are looked after by the local authority. CSV supports young people by providing a monthly meeting where they can discuss issues which effect children and young people in care and care leavers. CSV give them a voice as a consultative group which influences services and those who make decisions about the services. The young people also have the opportunity to attend various training which will enhance their confidence and empower them.

6.8 CSV have worked in consultation with the children and young people in care to develop a Pledge. The Pledge is a working document and applies to all staff of Derby

City Council. The CiCC are monitoring to ensure that all staff work at all times within the Pledge.

6.9 The CiCC have also been and met with the children's rights director in West Bromwich and took part in a "Question and Answer" Session, all of this helped build confidence and encourage the young people to feel empowered.
They have also made a film, which is to be given to every child as they come in to care to stop them being afraid of what is happening and tell them who is involved in their lives.

6.10 The CiCC have been involved in consultation with young people, for example, the commissioning of services and, from 01/04/13, will be participating on the corporate parenting board and attending home inspections with the Councillors. As a result of this young people have been able to identify priorities such as making personal computers available to children in care, plus the access to websites, the need for more black and ethnic minority foster carers and these have been passed onto relevant professionals.

6.11 During 2012 the Education Hub worked closely with the NSPCC to promote the ChildLine Schools Service launched across Derby and Derbyshire to help primary schools protect pupils. Parents are consulted about their child's involvement in the assemblies that help younger children understand abuse and how they can stay safe. Delivered by volunteers, the ChildLine Schools Service programme uses assemblies and workshops to encourage children to recognise situations where they may need help and to highlight ways they can get support. The sessions are sensitively tailored to ensure topics are covered in a way that children can understand, and have been approved as suitable for nine to 11-year-olds by child protection specialists.

6.12 By the end of March, 15 active volunteers had delivered to over 88 schools in Derby and Derbyshire reaching 5,105 children. A further 60 schools are scheduled for delivery and the programme is on track in reaching all primary schools by 2016.

6.13 A snapshot was taken of the views about their experience of 50 children who had experienced the sessions. The children were overwhelmingly positive about what they heard, some were familiar with the messages " very fun and I knew most of it but I didn't mind to lean it again because childline can tell u more", " I found it very interesting finding out what people can and cant do", " I really enjoyed the visit because I learned a lot more than I already knew so it was really interest". Other comments included: "they were very clear and explained what to do if you feel upset or scared", "Very good and they did a great job explaining and showing us about whats safe or not :)" and " I like the way you put it I thought it was easy to understand."

7 Policy, Procedures and Practice Guidance

7.1 The Education Hub reviewed national exemplars of child protection policies and procedures and launched a local exemplar child protection policy for all education settings in Derby and published it on the DSCB website.

7.2 The development of the web based safeguarding children procedures included revisions to the Early Intervention and Social Care section. This section ensures that there are strong consistent links between early intervention and child protection procedures and includes guidance about thresholds. In addition two new sections on Female Genital Mutilation (FGM) and Allegations against staff Volunteers and Carers were incorporated into the procedures.

7.3 In addition to the new policies and procedures (listed in paragraph **?**), the new areas of guidance under development jointly with the Derbyshire LSCB include:

- Missing Children
- Establishing a model of assessment for Early Intervention
- Safe sleeping arrangements
- Rapid response protocol to the sudden death of children
- Domestic Violence

7.4 Work has been carried out to develop Pre Birth Assessment processes across Derby and Derbyshire that will be implemented this year. In addition the DSCB agreed to a request by Loughborough University for DSCB partner agencies to participate in the development by the university of a pre birth assessment model and tool. ***This will be an action for the coming year***

Improve the coordination of pre birth assessments for vulnerable families

7.5 An action plan has been confirmed to ensure that the changes brought about by the implementation of Working Together 2013 are prioritised and this includes the publication of a "Threshold" document and Assessment Protocols. The completion of the action plan will be reported on to the DSCB over the next year. ***This will be an action for the coming year***

Ensure that robust arrangements are in place following publication of Working Together and associated National Guidance, that approved guidance is embedded in partner agency practice and assess and monitor the impact of organisational change on safeguarding arrangements.

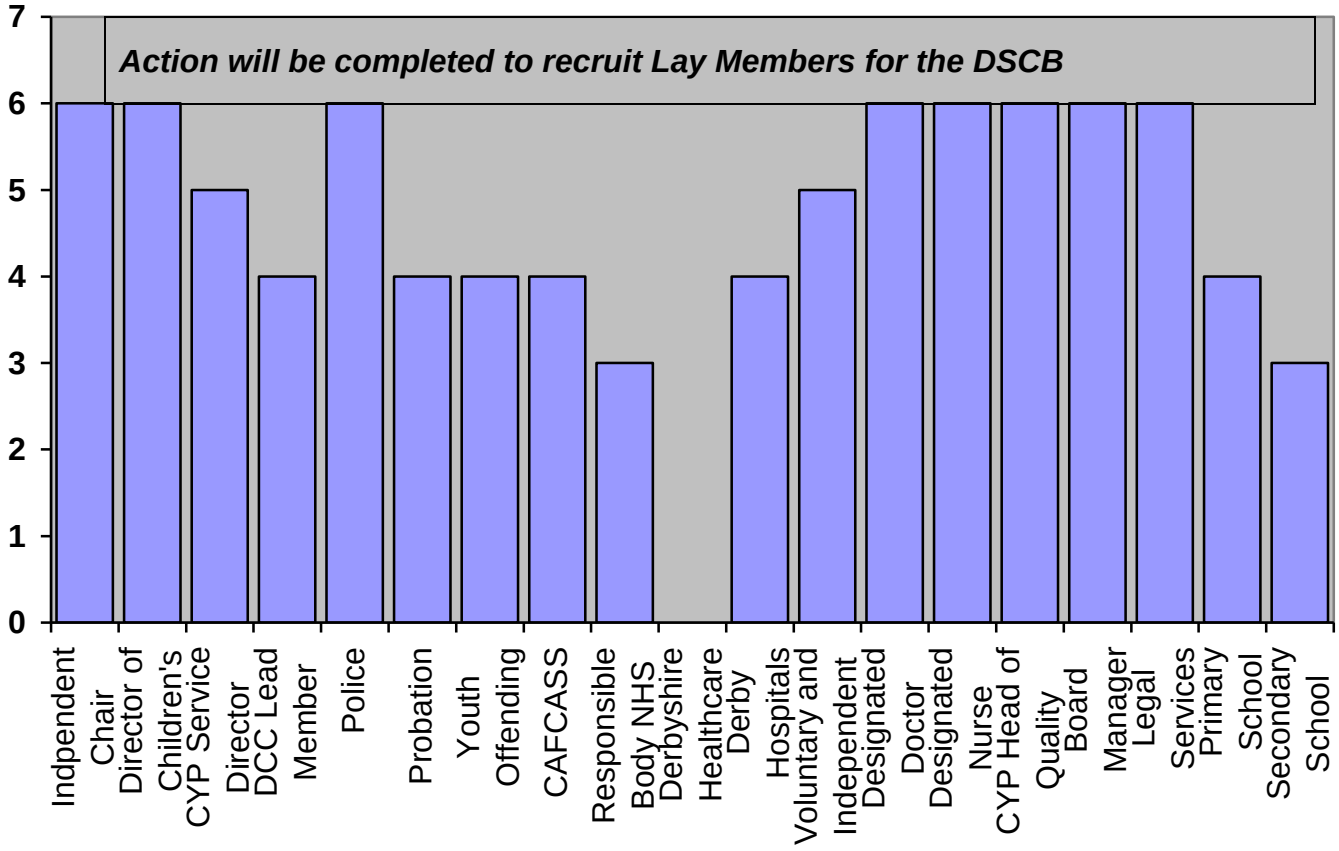
8 Membership of the DSCB and subgroups

8.1 The DSCB membership list for 2012 - 2013 can be found at Appendix 1. There has been consistent representation of the DSCB from most agencies with membership occurring at the right level of seniority and remaining stable, taking into account individual officers changing roles/jobs.

8.2 Representation on the DSCB from lay members has been delayed over the last year following long term sickness occurring alongside the impact of serious case reviews on the capacity of the DSCB team members. **Plans are in place to commence recruitment in summer 2013.**

8.3 The DSCB holds meetings on a quarterly basis with additional extraordinary meetings being convened where necessary.

8.4 Analysis of the attendance set out in the chart below indicates that in comparison with last year representation from schools has improved at the board meetings. The Vice Chair (Quality Assurance Chairperson) has been present at all meetings. The attendance of the Derbyshire Healthcare Foundation Trust has been raised by the Independent Chair with the Chief Executive who has assured that that this will be addressed.



9 Budget

9.1 To function effectively the DSCB needs to be supported by member organisations with adequate and reliable resources. The budget allocation by agency was agreed as set out below specifically for 2012/2013.

The total budget to support DSCB activity in 2012 - 2013 was £178 384

Agency	**Amount**
CYP	98 111
NHS Derby City	
(on behalf of Health Services in Derby/Derbyshire)	42 812
Derbyshire Constabulary	21 406
Derbyshire Probation Service	7 135
Derby Community Safety Partnership	7 135
CAFCASS	550
Shortfall of contribution from Reserve	1 234
Total contributions	**178 384**

Total Budget	178 384
Actual Expenditure	200 594
Balance from Reserve	22 211

9.2 The overspend was anticipated and arising from the costs associated with the serious case reviews that commenced in 2012 and the three conferences. The balance of costs was drawn down from DSCB reserves.

9.3 Budget allocation for 2012 - 2013 was:

	Budget	**Expenditure**	**Variance**
Employees Sub Total	162 428	165 264	- 2 836
Premises Costs Total	600	500	100
Transport Sub Total	1 500	723	777
Supplies and Services (Including Training Costs)	13 856	34 487	- 20 631
Total	178 384	200 974	- 22 590

9.4 The DSCB agreed to ongoing partner contributions from 2013/2014 in the following proportions:

Derby City Council	55%
Health - Derbyshire Healthcare NHS Foundation Trust / Derby Hospitals NHS Foundation Trust / Southern Derbyshire Clinical Commissioning Group	24%
Derbyshire Constabulary	12%
Derbyshire Probation	4%
City and Neighbourhood Partnership	4%
CAFCASS (Ongoing negotiations are being undertaken to explore the difference between locally and nationally agreed funding contributions)	0.3%

10 DSCB Effectiveness

10.1 The DSCB undertook a self assessment in February 2013 of its effectiveness using the publication Good Practice by Safeguarding Children Boards (Ofsted 2011). Key elements identified progress and areas for further development. These included:

- **Governance**

DSCB has an effective independent chair with a breadth of experience. Further progress is anticipated in relation to the coordination of activity of the Derby and Derbyshire LSCBs as a result of the independent chair carrying out the role for both partnerships. Development an implementation of the Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Board(HWBB) raise challenges for future

governance and partnership arrangements. The DSCB is represented through the Health Partners who sit on the CCGs and the Director of Children's Services who sits on the HWBB. Members of the DSCB recognise the need to develop the communications strategy further and ensure that there is clarity about what the DSCB does and the difference that is made with professionals and the community. The DSCB must ensure that Lay Members are recruited urgently. Further liaison will be needed to ensure that the Police Crime Commissioner and the work of the DSCB are suitably engaged.

- **Partnership Working**

Partners on the DSCB have remained fairly stable and this has helped partnership working whilst acknowledging letters are sent chasing up appropriate representation. Given reduction in resources globally, it is anticipated that greater attention will be needed to consider organisational change and this is likely to raise appropriate challenges between DSCB members about the impact. This has happened recently with DSCB representation being made in respect of proposed changes to support services for child sexual abuse in Derby. It is recognised that there has been progress in strengthening the links between the work of the Quality Assurance Group, Workforce Group and Policy and Procedures Group. It is suggested that opportunities should be further explored to work with regional partners on joint developments that help share the demand on resources.

- **Engagement with Young People**

The DSCB uses partner agencies to help understand what children and young people think about the services they receive and there has been significant progress with the engagement of young people vulnerable to child sexual exploitation. Set against this is the recognition that there is a need to engage and consult with young people and their families directly so that they are involved in the work of the DSCB.

- **Business planning and relationship between DSCB and the Children Families and Learners Board**

Joined up priorities identified by DSCB partners and subsequent planning of services around Child Sexual Exploitation have led to the implementation of new arrangements of the last 18 months. Evaluation of these arrangements has demonstrated the effectiveness and improvements made to outcomes for children and young people. There is the need for the DSCB and CFLB to work to improve the coordination of activity around two key areas "Think Family" and domestic violence.

- **Quality Assurance**

External scrutiny by Ofsted of audit arrangements was helpful and has identified both effective practice and some areas for action that will be linked to the development of the multi agency safeguarding arrangements and the responses to domestic violence referrals. This sits alongside extensive work being undertaken to review referral processes using the FMEA model of research with university and NSPCC partners. DSCB members agreed that the development of an Audit Programme that has a clear focus on demonstrating "impact" would extend the quality assurance further.

- **Learning from Serious Case Reviews**

In respect of some SCRs there is clear evidence of change and improvements for children and young people. There is also recognition that learning and change has

happened but it is more difficult to demonstrate the impact on outcomes and that this is a challenge for quality assurance. Currently there is significant activity around serious case reviews and it is felt that learning from these and other local reviews will be the focus of work for the coming year. The proposed use of a learning platform for serious case reviews and local learning is being considered by the Derbyshire LSCB. Derby LSCB will need to consider this if it helps to more effectively engage audiences with learning.

- **Multi agency training and learning**

Multi agency training continues to be well regarded and there is significant commitment from partner agency training pool members to work alongside DSCB staff to deliver effective training. The recent use of e learning to deliver private fostering training was good. Some challenges remain to ensure the joining up of the City and County training priorities. Areas emerged for the further development of suitable training such as on line abuse and dealing with perpetrators. Additionally the use of more flexible approaches to training such as regular briefing sessions alongside more advanced training would potentially extend the quality of what the DSCB offered.

- **Measuring impact**

Sub groups have continued to be active in developing and producing what is needed but there needs to be a focus on measuring the impact of DSCB activity as well as activity of partner agencies. Current focus on SCRs is clearly affecting this. Measuring impact should also include early intervention measures and essentially monitoring the impact on safeguarding arrangements of organisational changes.

11 Inter Agency DSCB Safeguarding Training

11.1 Working Together 2013 states LSCBs should "monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children."

11.2 At the end of 2012-2013 the responsibility for fulfilling this and other functions in relation to safe working practices across all partner agencies in Derby and Derbyshire was undertaken by the newly established Workforce Group. This new group extended the role of the previous Training, Learning and Development Subgroup whose remit did not include recruitment and managing allegations of staff. The new group has a more holistic and whole system responsibility for safe working.

11.3 The Workforce Group has begun the ongoing commissioning of the Training Providers Subgroup from Spring 2013.

11.4 External scrutiny by Ofsted of the work of the Training Learning and Development Subgroup was positive in respect of action taken in relation to Child Sexual Exploitation stating: "Extensive, good quality training of the workforce by both in house and commissioned services has raised the profile of child sexual exploitation in the city."

11.5 During 2012-2013, the DSCB has continued to provide a full multi agency training programme, has quality assured single agency training and has worked with young people to begin to engage them in the development and updating of courses.

11.6 Significant challenges arose as a result of the long term sickness of the DSCB training coordinator and this had an impact on the delivery of some of the courses. It is a credit to the multi agency training pool and the commitment of individual trainers and their agencies that the potential impact and disruption to the delivery of training was kept to a minimum.

11.7 During the year ***78*** (68) courses were delivered and **1489** (*1247*) participants booked courses, **1319**(*1127*) ***attended courses***. **170** (*120)* participants failed to take up their place. Of these **32** (*115*) participants cancelled their places with notification whilst **138** (5) did **not notify** the board. (Previous Year Figures in brackets).

Total number of courses delivered	**78**		
Total number of courses cancelled	**15**		
	TOTAL	**Derby based practitioners**	**Derbyshire based practitioners**
Total number of booked (places allocated)	**1489**	**1400**	**89**
Total number of attendees	**1319**	**1252**	**67**
Total number cancelled places	**32**	**31**	**1**
Total number of DNA without notice	**138**	**117**	**21**

11.8 Analysis of the significant increased rate of cancellation without notice indicates a number of factors may be prevalent. The long term sickness of the training coordinator meant that the follow up enquiries with of people who did not turn up and their managers was not followed through. Feedback from staff different agencies reported a trend of urgent requirements by managers to cancel their attendance at short notice. This will be a focus for improvement in the coming year.

11.9 Feedback sheets indicate a continued view that the quality of the training is good along with the delivery. The full analysis of the data will be undertaken and contribute to the plans in the coming year to take forward the arrangements for the ongoing evaluation of training on practice that were similarly delayed by the absence of the Training Coordinator

11.10 The DSCB held a conference to launch the guidance for practitioners and managers from all agencies to help support young people who self harm. The conference was very well attended and received. Additionally the DSCB participate in a joint "Think Family" conference with Derbyshire LSCB and both Derby and Derbyshire Safeguarding Adult Boards. This successfully raised the profile of "Think Family" and work is ongoing to ensure that this brings about the intended

improvements in working arrangements for families in Derby and Derbyshire. ***This will be an action for the coming year***

Liaise with the Safeguarding Adult Board and evaluate Think Family arrangements to ensure action is coordinated where adult behaviour or need presents a risk to children

12 Action taken on Priority Issues in Safeguarding

12.1 The DSCB received external feedback from the Ofsted Inspection about the effectiveness of action taken on priority issues and comment is included in the relevant sections of this report below.

13 Missing Children

13.1 The Ofsted inspection examined progress made by the multi agency arrangements in respect of missing children and commented: "The robust multi-agency children missing protocol is supported by monthly meetings involving a range of agencies including the police to evaluate the data on missing children. Those who regularly go missing are known and are allocated a key worker from MAT who knows the young person well and helps prevent further incidents of going missing. Any child subject to a child protection or child in need plan is seen within 24 hours of their return.

13.2 During the year April 11 to March 31st 2013 there were a total of **654** (699) missing episodes recorded of children and young people and detailed below. (Previous year's figure in brackets)

2012/2013	Total number missing	Missing from DCC Children's Homes	Missing from Independent Homes	Missing from Foster care
Q1	180	13	12	Figure not available
Q2	188	19	9	13
Q3	162	21	14	8
Q4	124	19	10	9

13.4 There has been a decrease in missing episodes from both DCC and Independent Homes; this has been due to more effective support packages being deployed and a more flexible approach in how staff work with children and young people. Staff carry out comprehensive risk assessments when a child is absent and take a more proactive stance in looking for absent children before they report them to the Police as officially "missing".

13.5 Follow up interviews with children who have been missing have been increasingly successful and the Runaways staff have been very proactive in engaging these children. Common indicators of domestic stress are being found to be prevalent and a notable number of children are living in households where income has been reduced significantly which may be a contributory factor leading to increased tension in their homes. The Police Central Referral Unit provides more comprehensive background information about children who have been reported as missing. This has allowed the Runaways teams to intervene earlier and with a lot more back ground information which helps towards a more comprehensive assessment and swifter plan of intervention.

14 Child Sexual Exploitation

14.1 The Ofsted inspection examined progress made by the multi agency arrangements in respect of missing children and commented: "The council and its partners demonstrate a very good understanding of potential risk to children and young people of sexual exploitation and have a range of effective targeted services in place. These include group and individual programmes provided by Safe and Sound that evidence positive impact and good outcomes for children and young people. "

14.2 To ensure that the progress of the CSE strategy arising from the Serious Case Review in 2009 was being sustained and arrangements robust the DSCB commissioned independent research to evaluate the impact of arrangements in Derby. This project started before the inspection and a wider analysis was undertaken. The findings and further detailed comment are set out in section 24.

Ongoing action for the coming year will continue to support vulnerable young people

Promote awareness of the risks of Child Sexual Exploitation, Missing children, Online abuse and Perpetrators of sexual abuse and ensure that local arrangements focus on improving outcomes for children and young people

15 Private Fostering

15.1 A private fostering arrangement is one that is made privately (i.e. without the involvement of a Local Authority) for the care of a child under the age of 16 (under 18 if disabled) with someone other than a parent or close relative for 28 days or more.

15.2 The DSCB has a responsibility to oversee private fostering arrangements within Derby and monitor the Local Authority's compliance with their duties and functions. In discharging this responsibility, an annual report is presented to the DSCB Quality Assurance Group by the Local Authority Officer with lead responsibility for private fostering.

15.3 The DSCB has sent letters to all schools and GPs to remind them of their responsibilities, circulated an E learning took about private fostering and has requested that the Local Authority develop a web page about private fostering on the council website. Further detail is set out in section 21.

16 Allegations against staff, carers and volunteers

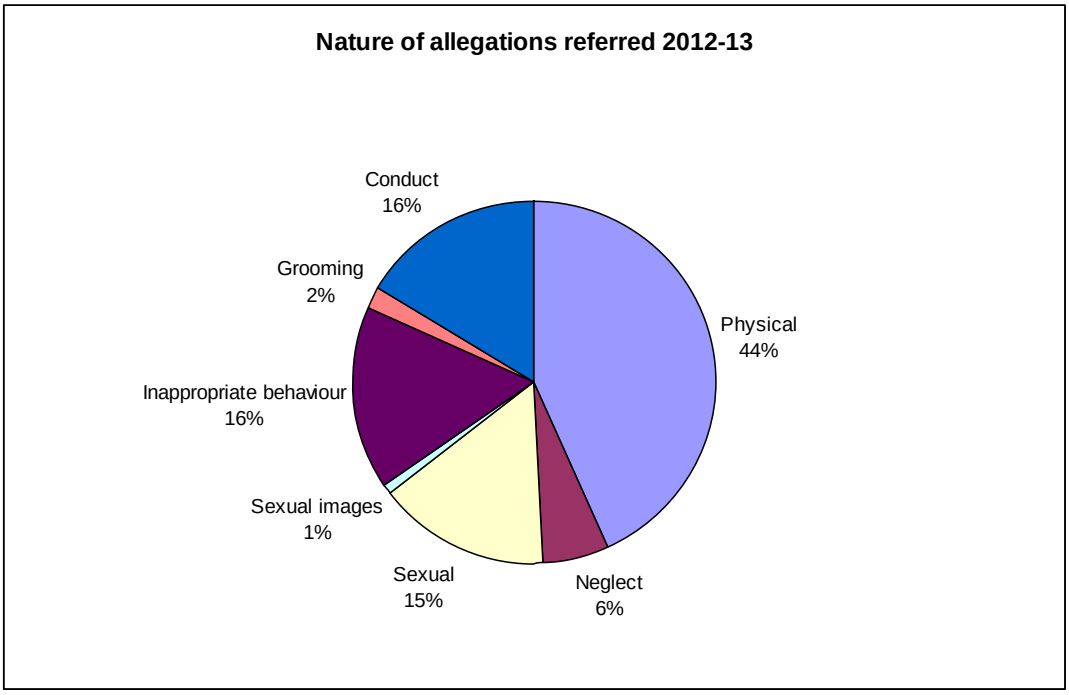
16.1 Working Together 2013 states that LSCBs have responsibility for ensuring there are effective inter-agency procedures in place for dealing with the ”investigation of allegations concerning persons who work with children"

16.2 All partner agencies of the DSCB have a Named Senior Officer with responsibility for dealing with allegations. In addition, the Local Authority Designated Officer (LADO) manages and oversees all individual cases. The LADO provides advice and guidance in relation to allegations as well as monitoring the progress of cases to ensure that they are dealt with as quickly and consistently as possible.

16.3 In practice, the Child Protection Managers deal with allegations against staff and volunteers on a day to day basis. This includes supporting those settings with the development of policy, practice and training that arise as a result of an allegation or concerns

16.4 There were 104 referrals to the LADO (01/04/12 - 31/03/13). This is compares with 102 referrals in the previous year

16.5 Previous national guidance (Working Together 2010) set out timescales for the resolution of cases and the DSCB identified that this was an area for improvement. 74% of cases were resolved within one month, compared to 51% last year and the recommendation in Working Together 2010 of 80%. 94% were resolved within 3 months (86% last year, 90% recommended)

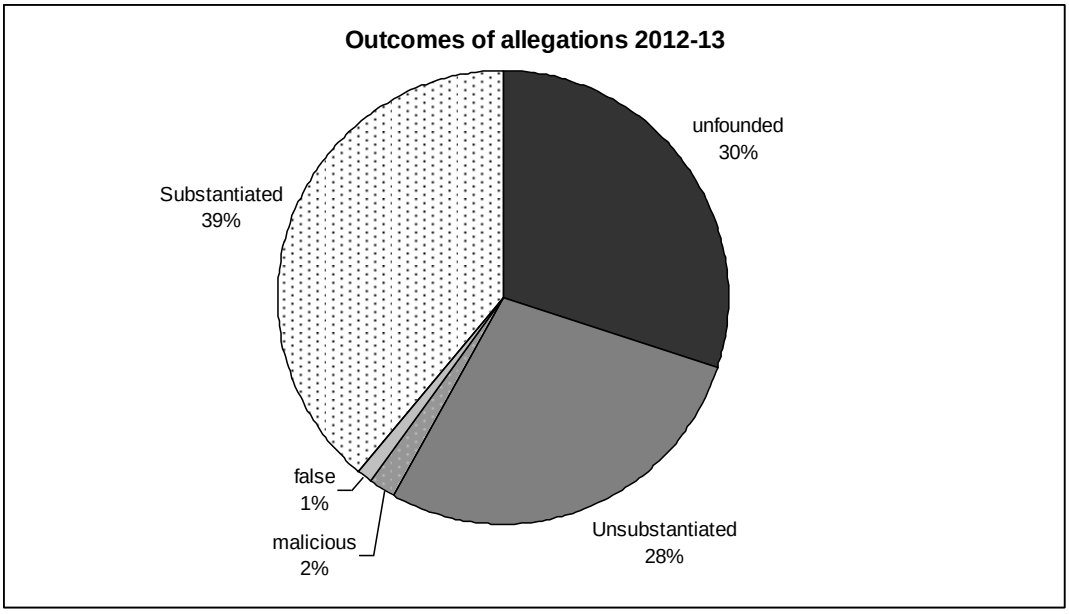


The resolution (outcome) of allegations

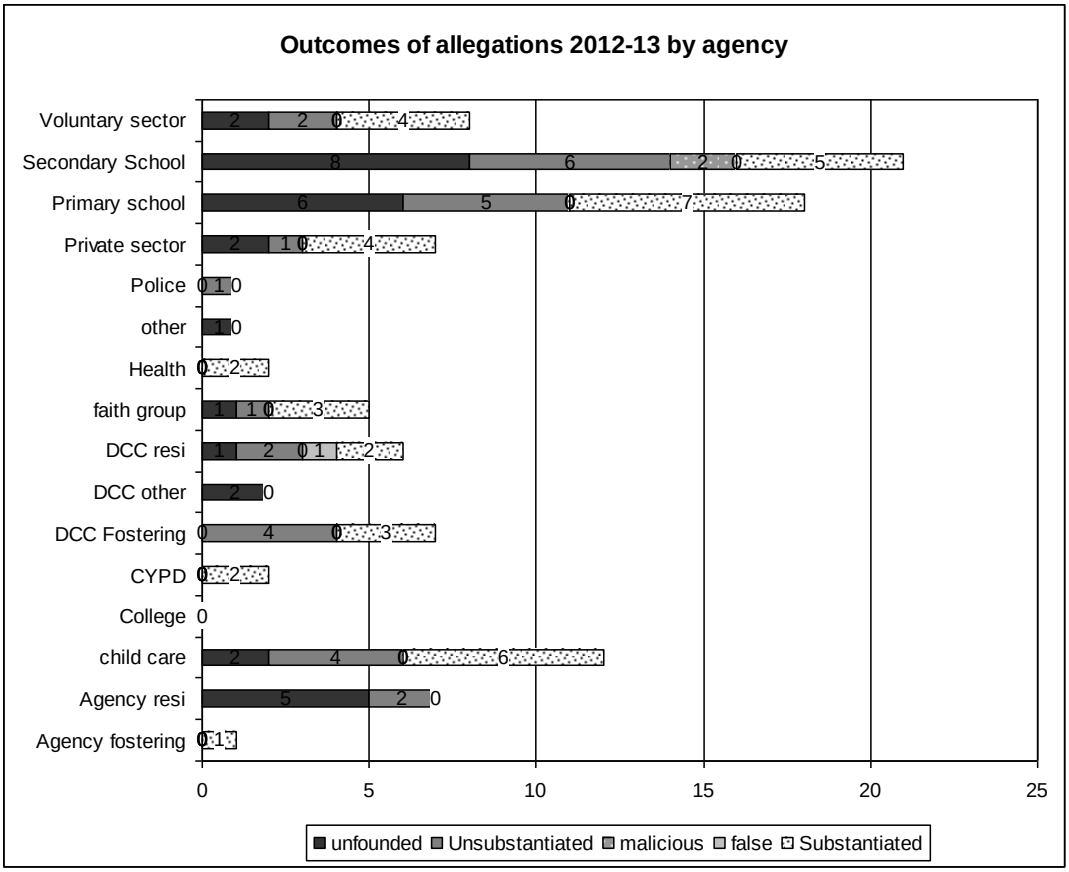
Resolution categories have been changed in 2012 in line with Government guidance, so cannot be directly compared with last year. The proportion of allegations which were substantiated, however, has dropped from 50% to 39%.

The guidance is as follows:

- ***Substantiated:*** there is sufficient identifiable evidence to prove the allegation;
- ***False:*** there is sufficient evidence to disprove the allegation;
- ***Malicious:*** there is clear evidence to prove there has been a deliberate act to deceive and the allegation is entirely false;
- ***Unfounded:*** there is no evidence or proper basis which supports the allegation being made. It might also indicate that the person making the allegation misinterpreted the incident or was mistaken about what they saw. Alternatively they may not have been aware of all the circumstances;
- ***Unsubstantiated:*** this is not the same as a false allegation. It means that there is insufficient evidence to prove or disapprove the allegation. The term therefore does not imply guilt or innocence.



The majority of substantiated cases (30) are dealt with through informal action by the employer; only 6 resulted in disciplinary action and only 3 in dismissal or de-registration. There is however a problem in tracking some action by employers, who do not always confirm the outcome of Hearings and appeals. Information from the Police with regard to prosecutions, convictions and civil SOPOs is also incomplete. This all needs to be tightened up to ensure reliable data is available.


Outcomes of allegations 2012-13 by agency
Voluntary sector
Secondary School
Primary school
Private sector
Police
other
Health
faith group
DCC resi
DCC other
DCC Fostering
CYPD
College
child care
Agency resi
Agency fostering
0
5
10
15
20
25
unfounded
Unsubstantiated
malicious
false
Substantiated

17. Monitoring the Effectiveness of Local Work to Safeguard and Promote the Welfare of Children

17.1 This section sets out the monitoring activity of the Derby Safeguarding Children Board on the effectiveness of safeguarding activity in the city.

18 The Quality Assurance Group (QA Group)

18.1 The Quality Assurance Group is responsible for coordinating the monitoring and evaluation of the effectiveness of the local arrangements to safeguard and promote the welfare of children and advise partners and the Children, Families and Learners Board on ways to improve.

18.2 The Quality Assurance Group reviewed its own effectiveness, structure and processes. The Education Hub, CYP Network and Health Hubs continued to meet regularly and report via representatives to the QA Group. Members of the Community Safety and Local Authority Hubs joined the QA Group meeting to facilitate a greater engagement across agencies and more efficient use of time.

18.3 The QA group reviewed how the outcomes for vulnerable young people were being met and how the complex strategies affecting many young people were joined up. The QA Group identified that an improved and more joined up strategic oversight of vulnerable children could be achieved through the creation of a Vulnerable Young People's Group. The Board agreed and commissioned the new group to have responsibility for:

- Child Sexual Exploitation
- Missing Children
- Children who self-harm, including substance misuse
- Young people associated with gang activity
- Young people vulnerable to terrorism
- Young people who offend
- Young people who are persistently homeless

18.4 The main focus of activities of the QA group during the year included:

- The review of arrangements by the Local Authority Designated Officer (LADO) in respect of allegations against staff and volunteers.
- The FMEA Analysis of referral processes for domestic violence and abuse (see below)
- The review of Private Fostering arrangements (see below)
- Section 11 or equivalent agency quality assurance (see below)

18.5 The focus for audit this year has been the completion of a Learning Review and actions arising from this. An additional learning review was commenced alongside the two Serious Case Reviews. An audit programme for the coming year has been approved by the Board as part of the QA work plan. External scrutiny of the audit arrangements was encouraging. Ofsted reported that "Multi-agency case auditing is effective, routinely undertaken and appropriately focused on child protection."

19 Allegations against staff, carers and volunteers

19.1 The electronic recording system has been adapted so that all allegations now have a record created which allows the referral, communication, decision and minutes of meetings to be held electronically in one place. These records have restricted access where they involve Council staff. Sampling of the records has shown the business process requires amending to ensure the outcome of the LADO investigation is recorded on the original contact. Unfortunately the system still does not allow reporting so a separate database has also been maintained, with refinements to improve tracking.

19.2 Allegations are all recorded and followed up as above, evidencing effective multi-agency work to investigate concerns. Many individuals have been supported to improve their practice with children and a small number have been removed from the workforce due to concerns.

20 Failure Modes and Effects Analysis (FMEA)

20.1 During 2012 QA group members and frontline practitioners undertook an innovative project in partnership with the NSPCC and academic facilitators. The project took a multi-disciplinary, multiagency approach to systems analysis.

20.2 Failure Modes and Effects Analysis (FMEA) is a systematic, prospective quality assurance methodology used to identify potential vulnerabilities in complex, high risk processes and to generate remedial actions before they result in adverse events.

20.3 FMEA was originally developed by the military, and improved by engineering and other programmes and further enhanced by the car maker Toyota. Professor Eileen Munro identified the use off FMEA as a potential method for learning about the effectiveness of child protection and safeguarding multi agency systems. It is an approach that works on the premise that individuals are not entirely free to choose between good and problematic practice, and that overall performance is linked to features of individual tasks, tools, and local environment and more organisational factors.

20.4 The FMEA undertaken within Derby was an innovative use of the process of analysis, applying FMEA to children's safeguarding processes for the very first time.

20.5 The process identified for analysis using the FMEA was the process for recognising a child exposed to domestic abuse within Derby.

20.6 The FMEA generated an understanding of areas within the process of decision making about domestic violence where there **could** be errors. Corrective actions were identified that could be applied to the process of identifying a child in Derby exposed to domestic abuse.

20.7 The members of the multi agency team in Derby have considered the findings of the FMEA project and are drawing up an action plan to ensure that priority improvements are made.
What difference did the FMEA make?

20.8 The joint project with the NSPCC to carry out the FMEA made an important contribution to learning in child protection and addressed some of Professor Munro's challenges to explore the use of systems approaches. It was useful on a number of levels and provided:

- actions for the DCSB to improve its response to children exposed to domestic abuse. These will be reported upon in the coming year.
- a useful and detailed window on multidisciplinary work and provided rich information, critical to understanding practice and developing capacity to identify unintended problems, perceptions and recurrent issues..
- important learning about the potential use of the FMEA process to consider the development of new systems, for example the development of the multi agency safeguarding arrangements to consider referrals by the police of domestic abuse to prevent system errors at an early stage before full implementation.

21 Private Fostering

21.1 The Annual Report on Private Fostering reported to the DSCB in December 2012. The report provided details of the number of Private Fostering arrangements made to the Local Authority and the statutory responses to these.

21.2 Overall numbers of privately fostered children in Derby have decreased since 2007 with slow increases emerging in 2010. At 31 July 2012 there were 8 privately fostered children known to the local authority which confirms a slow but steady increase since 2009 and maybe attributable to the recent publicity campaigns and integration of private fostering within all multi agency training courses.

21.3 There were 9 new notifications during the year compared with 5 new notifications in 2011/12 and 2010/11.

21.4 However, overall, it is concluded that efforts to raise awareness of professionals responsibilities has had less than the desired impact and numbers of unknown Private Fostering arrangements remains an issue for Derby.

21.5 The Board agreed that a specific letter was sent from the Board to GP's and schools to raise awareness of this issue and suggest that admissions and registration processes are reviewed to ensure that they ascertain parental responsibility and take account of the possibility of a private fostering arrangement. ***The impact of the action will be reviewed in the coming year.***

Audit the steps that each agency has taken to identify whether parents or carers have parental responsibility as appropriate and ensure that referrals are made to the local authority.

Ongoing arrangements to monitor and audit priority areas

22 Early Intervention

22.1 The DSCB continued to receive updates on the early intervention strategy and the development of Multi Agency Teams that provide early multi agency engagement with families requiring additional support.

22.2 The Local Authority has identified the need to establish more detailed analysis of the impact of early intervention arrangements delivered through the multi agency teams (and referred to in the section 11 audit). The DSCB will continue to scrutinise the development and outcome of this analysis.
This will be an action for the coming year

Report on the effectiveness of early intervention and child protection arrangements to safeguard children and young people.

22.3 Specific relevant comment by Ofsted in relation to early intervention include:
"Locality based teams with co-located MAT enables professionals to have good access to each other's expertise and share knowledge about vulnerable families within localities. This ensures better coordination of services to meet the needs of vulnerable children, young people and families."
"The early help offer from children's centres is targeted at the most vulnerable families within their areas. Children's centre staff and leaders know their communities well and participation and take up data shows that centres are well used by families who have historically been difficult to engage. "

22.4 Ofsted identified that there had been improvement in the number of common assessments (CAF) completed and the local authority has invested in recently appointed CAF advisers, who have offered good support to schools.

22.5 The DSCB had raised concerns with the Children Families and Learners Board in 2012 about the level of the use of the CAF and it is encouraging that such progress was evident.

22.6 Ofsted reported that agencies have "a good shared understanding of thresholds and they are consistently applied. The early help offer is good, easily accessible and provides effective early identification of children and young people of all ages who may need additional or targeted support."

22.7 The DSCB will continue to scrutinise the understanding and application of thresholds as part of the implementation of the "Threshold Guidance" that will be published in 2013.

23 Domestic Violence

23.1 As part of the domestic violence and sexual violence strategy in Derby the Freedom Programme was run with mothers at risk or experiencing domestic violence. The programme provides support over a number of weeks in a one to one basis and in groups. There are childcare facilities provided at a number of venues where the programme is run across the city. 47 women successfully completed the programme and there is a waiting list for future programmes.

23.2 Feedback from women, on different programmes, was consistently positive with comments in feedback such as: "I know what warning signs to look for so that I don't end up in that situation again", "If I was to come to another relationship with domestic violence I would be able to recognise", "My circumstances were from a previous relationship but it helped me avoid this situation for the future for my child's sake."

23.3 The Freedom Programme demonstrated that it made a positive difference to the women who attended and those who were able to complete the course. All evaluations stated that the participants would recommend this course to other women and in answer to the question as to whether the Freedom Programme made any kind of difference to how the participants view and act in the relationships in their lives, comments included: "Yes I see things or notice things I wouldn't have before", "Yes. Not only has it made a major difference for me, I can now help family and friends if I see any warning signs from their partners", " It has opened my eyes and made me more aware."

23.4 The Freedom Programme (either in groups or on a one to one basis) continues to be a priority in children's centres. An additional training programme across localities will be delivered to ensure a sufficient number of staff are able to deliver the programme. Secondary schools remain a priority to deliver freedom to young women in addition to work in crèches with children that also focuses on children remaining safe. There remains a gap in the provision of work with male offenders.

23.5 The DSCB is now able to more accurately identify when domestic violence is as a serious factor for those children who become subject of child protection plans have been improved during the year. The figures illustrate that over the last three quarters that around 38% of the most serious cases include significant domestic violence. (See Appendix ??)

23.6 The Criminal Justice Board and Partnership Agencies provide figures to the DSCB on a quarterly and annual basis. The CJB reports that the estimated number of adult female victims, based on research evidence, in Derbyshire (including Derby) would be around **17-23,000 female victims**. The police DASH risk forms for domestic violence incidents show around **10,000** individual female victims per year. This is around half the number research suggests is likely to be expected.

23.7 Over half of the police recorded domestic violence incidents show that there are children within the household. This is **5,000** households where incidents have been reported to the police. Based on the estimated victimisation rates and assuming the same proportion of households with victims who have not reported the incident to the police have children there are another **5,000** households with children experiencing domestic violence who are not known to the police.

23.8 There is no current information available on households not known to the police where domestic violence is affecting the lives of children and the extent to which those households are receiving appropriate support and services.

23.9 Plans are in place to introduce a multi agency safeguarding arrangements to improve the effectiveness of responses to domestic violence referrals from the police. Further action will be needed to improve the referral rates from other agencies and within the community

Repeat Offenders

23.10 The police have identified 15136 referrals and of these 1306 perpetrators have more than three referrals. Initial action will focus on those top 50 repeat offenders. For example are they subject to Individual Offender Management and do they meet the Integrated Domestic Abuse Programme (IDAP) threshold. This is an ongoing piece of work and will be assessed over the coming year.

Honour Based Violence and Forced Marriage within Derby and Derbyshire

23.11 Between April 2010 and September 2012 there were 128 recorded cases of Honour Based Violence (HBV) and Forced Marriage (FM) of which 126 contain details for analysis. There were a few repeat cases but the vast majority were unique. Of these 101 were Derby City based, 8 in Derbyshire County and 17 from other force areas. However many of the cases were complex and had links to many other areas with extended family across the UK and the world and with much movement between locations. Further information about the extent that children and young people are victims will be analysed over the coming year.

Multi Agency Risk Assessment Conference (MARAC)

23.12 Following a decrease in numbers in 2011/12 there has been a rise in 2012/13 of the use of MARAC to just below the total for 2010/11. Repeat rates are still decreasing and this should be seen as a positive trend that the MARAC process is reducing risk to victims.

23.13 Ofsted commented that "The multi-agency risk assessment conference (MARAC) provides robust, effective information sharing and action planning to respond to high risk domestic violence incidents. The conference is well attended by partner agencies including both statutory and voluntary sector workers and a cross section of adult and children's professionals. Action planning is strongly focused on the outcomes for children (where appropriate), and is clearly recorded with timescales and expectations for action from partners. "(January 2013)

24 Child Sexual Exploitation

24.1 In the second year of the CSE services there have been 170 (217) early concerns being raised about children or young people and *possible* links and vulnerability to exploitation. Consideration of these early concerns resulted in 130 (105) meetings being held involving different agencies. *(Previous Year Figures in brackets*)

Auditing whether the CSE meetings and strategy meetings are making a difference to outcomes for young people

24.3 The continued involvement of young people in the arrangements to keep them safe has remained a key factor in improving their outcomes. The Child Protection Manager (who has responsibility for the CSE strategy) has visited and spoken to 100% (94%) of young people who have been subject of concerns and 60% (51%) of the meeting have been attended by young people. 77.5% (89%) of the meetings have been attended by the parents.

24.4 The involvement of the young people has been a cornerstone of the success in this strategy. Evaluation forms for young people indicate that they find CSE meetings very positive. Of the young people who attended meetings, 100% felt listened to (100%), 92% (89%) found the meetings supportive, 100% (100%) have a better understanding of CSE issues and 96% (94%) agreed with the CSE plan agreed at the meeting.

24.5 The analysis of the levels of risk to young people on engagement to the strategy shows that there is a significant reduction for the majority of young people. Out of the young people assessed as high risk at their initial meeting, 54% have already had the risk removed or reduced within 3 months (45%) and 9% (18%) have been escalated to Child Protection because they have met the significant harm threshold and there are additional issues to be addressed.

24.6 The Ofsted unannounced inspection reported that "Children and young people at risk of, or being, sexually exploited benefit from highly effective work coordinated through the child sexual exploitation (CSE) strategy that is overseen by a dedicated and specialist Child Protection Manager. The young people and their families are fully engaged in strategy meetings, plans and reviews. Evidence demonstrates the successful reduction of risk and disruption of harmful activity. "

24.7 "The council and its partners have taken a highly proactive and robust response to CSE and have developed a CSE risk assessment toolkit which is an excellent guide and support for practitioners in all services. It ensures a consistent high quality response for young people at risk. An exemplar of a good quality action plan is included and strategies for intervention and disruption of risky activities are set out clearly."

24.8 "Multi-agency strategy meetings chaired by the specialist CSE Child Protection Manager demonstrate very good practice and the full engagement of young people and their families. Resulting action plans are of very good quality and include practical actions to address all areas of risk and support for the whole family. Actions are allocated to individuals, have detailed timescales and reviewing arrangements. In other cases strategy discussions and meetings are timely, include partners as required and clearly determine actions to be taken to promptly assess risk. However, recording of strategy discussions is not well supported by the electronic case file system and details can be difficult to find. Children and young people are well supported in child protection processes through a commissioned advocacy service which very powerfully represents their views and feelings."

24.9 "The CSE strategy is robust, of very good quality and has a proven impact on reducing risk and protecting vulnerable young people. Extensive, good quality training of the workforce by both in house and commissioned services has raised the

profile of child sexual exploitation in the city. Partner agencies are fully engaged as evidenced by the successful appointing of 30 CSE champions in a wide range of agencies who offer consultation and advice to professionals. Two further learning reviews have been independently commissioned to ensure that actions taken have had the optimum impact for young people at risk from, or involved in, the prosecution of CSE perpetrators."
(January 2013)

25 Future work of the QA group

25.1 The QA Group has a work plan linked to the Board Business Plan. Work identified for the coming year includes:

- The QA group has commissioned a report from the Disabled Children's Service on how they are meeting the requirements of the Ofsted report *Protecting Disabled Children; a thematic report* and will review the findings.
- Case File Audits are planned to look at pre birth planning, following implementation of pre birth assessment arrangements, to determine what difference has been made to improving arrangements.
- Audit work in relation to Learning Reviews and Serious Case Reviews
- Audit of the implementation of the multi agency safeguarding arrangements and the impact of the domestic violence and sexual violence strategy.

This will be an action for the coming year

Undertake quality assurance activity in the following areas: annual case file audit; arrangements to keep disabled children safe; the impact of the revised pre birth multi agency arrangements; the impact of the implementation of the multi agency safeguarding arrangements and the impact of the domestic violence and sexual violence strategy

26 Serious Case Review Panel

26.1 The Serious Case Review (SCR) Panel is responsible for undertaking reviews of cases where abuse or neglect of a child is known or suspected, a child has died or a 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.

26.2 The SCR Panel ensures that:

- relevant cases are considered and serious case reviews are carried out according to regulations and guidance
- all organisations carry out their roles in respect of serious case reviews
- action plans from serious case reviews and local multi agency reviews are implemented, monitored and evaluated.
- staff in all agencies are aware of the outcomes of serious case reviews and their part in action plans
- learning is disseminated across partner agencies

26.3 Ofsted reported that "Clear evidence of its effectiveness and its learning from recent serious case reviews has underpinned all service developments and is demonstrated both at strategic and operational levels." (January 2013)

26.4 The DSCB commissioned an independent review of the impact of learning arising from the review BD09. The review found that "There is evidence of a robust set of arrangements that seek to safeguard children and young people from abuse through sexual exploitation that is driven through a clear strategy that sets out how agencies work together to identify and safeguard those children and young people at risk, and identify, disrupt and prosecute those who seek to abuse them.

26.5 The review continues: "A comprehensive training programme ensures workers across organisations have the necessary awareness and skills. The network of 'champions' ensures that sexual exploitation, and related issues, has a high profile in organisations and provides a vehicle for advice, support and information sharing. The role of lead child protection manager is invaluable in driving and coordinating the work and ensuring that all elements of the system are effective and joined up. Derby benefits from the current post holders specialist knowledge of the subject and participation in the national agenda as well as the commissioned specialist services."

26.6 The DSCB commissioned a learning review in respect of the effectiveness of arrangements re CSE witnesses following the completion of the Court Trial and will be reported on in September 2013.

26.7 Between 01/04/12 and 31/03/12 two Serious Case Reviews were initiated following the tragic deaths of children in different families. Both cases are highly complex, have required the significant investment of resources and became a significant focus of the work of the DSCB from May 2012.

26.8 In addition, the Serious Case Review Panel commissioned a learning review. The findings of this review identified learning about the arrangements for assessing the welfare of unborn babies. An action plan was put in place and protocol setting out the multi agency arrangements for both children and adults services is in the process of development and implementation. The DSCB has agreed for the University of Loughborough to use Derby as a pilot area for the development of pre birth assessment tools. This innovative development sits alongside the work to develop pre birth arrangements and will provide an important contribution when completed. ***This will be an action for the coming year***

Extend learning arising from local reviews and the work of the Board and establish effective arrangements(including priority areas) for consultation with Children, Young People and Parents/Carers

27 DSCB training

27.1 The DSCB commissioned a project that will support Individual agencies to set out clearly defined pathways for safeguarding and child protection development and training. The pathways will be linked to the roles and responsibilities of key staff who

work with or provide support/ supervision and have a designated child protection role in the organisation.

27.2 At the end of the project (planned for September 2013) each agency will be able to demonstrate:

- Key staff and their roles
- The professional development that is required specifically in respect of child protection and including explicitly three areas: Domestic Violence, Parental Mental Ill Health and Parental Substance Misuse
- The plans to provide training on an ongoing basis (and plans for remedial training if needed)

27.3 In March 2013, the DSCB received feedback from a primary school illustrating views of children that illustrated the impact of training on staff. The children were reporting improved experiences at local faith settings to their school teachers. This was attributed to the work that had previously been undertaken to provide training to those faith settings and a positive change in practice as a result.

27.4 During the year the DSCB training function was significantly affected by long term sickness absence. One of the impacts of this was the reduced capacity to follow implement the further evaluation of the impact of training on practice on a regular basis. ***This will be an action for the coming year***

Establish consistent and robust safeguarding training and development pathways within agencies and ensure that single agency and multi agency training is quality assured.

28 Child Death Overview Panel (CDOP)

28.1 The Child Death Overview Panel (CDOP) covers Derbyshire County and Derby City. CDOP reported to the DSCB on a quarterly basis during the year and has continued to have multi agency representation.

28.2 The panel has three main functions:

- To maintain and report on a database of all deaths of children and young people aged 0 to 17 years (inclusive).
- To oversee the investigations into these deaths.
- To learn lessons from these investigations, identify where there may be preventable causes and disseminate those lessons to Safeguarding Boards and other relevant stakeholders in Derbyshire County and Derby City.

28.3 The panel is not directly responsible for the investigations themselves, but key figures involved in the investigations attend the panel's meetings. The work of this panel has been mandatory since April 2008.

28.4 There was an increase in the numbers of unexpected and unexplained deaths during the year. Although investigations into these are not yet complete it would appear that unsafe sleeping continues to be a problem. CDOP will be scrutinising

these deaths when the investigations are complete and any urgent matters that require the DSCB's attention will be brought for consideration.

28.5 CDOP identified the following issues for consideration by the DSCB and these will be included in the forthcoming action plans for the subgroups:

- Enable access to the Child Health systems (including GP systems and information on primary care giver) for midwives and health visitors
- Reduce young people's involvement in gangs
- Improve the use of the CAF by midwives
- Improve early identification of vulnerable mothers

(Action has commenced in respect of the last two bullet points as part of the development of the pre birth assessment protocol)

28.5 During the year a new chair for CDOP was appointed and the annual report was presented to the DSCB in June.

29 Partner Agency Safeguarding Reports (S11) Audit and Analysis

29.1 The DSCB received audit reports carried out using section 11 of the Children Act 2004 from the following agencies: Children's Social Care; Youth Offending Service; Derbyshire Healthcare Foundation Trust; Police; Probation; CAFCASS. The Derby Hospitals Foundation Trust submitted the *Markers of Good Practice* self audit tool that is comparable with the section 11 audit.

29.2 The following examples of individual agency improvement were identified:

- **Children's Social Care**
  The Council is developing systems to capture centrally information relating to induction and training of all staff to improve local inconsistencies. Recruitment training and the safeguarding training needs of senior staff is being reviewed. Work is on-going with regard to collating views of children and young people in order to evaluate services and inform service planning alongside the full implementation of the engagement strategy. The arrangements for taking forward relevant recommendations/requirements of the DSCB have been reviewed and in future these will pass through the Performance Improvement Board for a formal, recorded response and monitoring. Procedures are under review to reflect the development of services such as the Multi-Agency Teams. The audit identified that clarification was needed in relation to operational social care service representation in DSCB sub groups given pressures on resources.
- **Youth Offending Service**
  The audit noted action was required to include reference to safeguarding in the Head of Service job description and that training pathways for YOS staff should include specific attention on Parental Substance Misuse and Mental Ill-health. Some further work was identified to support staff to use a learning styles questionnaire prior to using interpreters to inform type of intervention with young people so that they are able to communicate in their preferred language
- Both Children's Social Care and YOS noted recent developments in council-wide training on data protection / information sharing being rolled out to all

staff and completion monitored to improve standards and practice. Additionally both audits identified the need to evidence the assessment of the potential impact on safeguarding when organisational changes are made.

- **The Derbyshire Healthcare Foundation Trust**
  The audit identified planned activity to raise the awareness of Safeguarding Children and Think Family practices, in particular parental mental health, substance misuse and domestic violence. Other development included that of the CAMHS Teams and a model of working with Senior Managers (integrating systemic and advanced safeguarding practices). Action was being taken to promote further a culture of listening to and engaging in dialogue with children and young people. Families will be presenting their views at the Trust Leadership Forum and young people will be invited to validate in house safeguarding children training. Policies and procedures are being reviewed following the update of the national guidance. Some development had been identified around thresholds from a multi agency perspective. Action is being taken in respect of the "Think Family" agenda that aims to help in the provision of integrated and co-ordinated services. Significant developments have taken place in developing Core Care Standards and there are development plans for advancing safeguarding supervision in key clinical areas.
- **Probation**
  The audit identified the need to look at reviewing how staff are kept up to date with the findings from serious case reviews and how action can be taken to ensure staff are clear about the circumstances in which a referral to the Vulnerable Children's Panel (and multi agency teams) is necessary through the policy and procedures group.
- **The Derby Hospitals Foundation Trust**
  The *Markers of Good Practice audit* was completed and identified action being taken to resolve staffing issues would help to improve safeguarding supervision and peer audit of safeguarding arrangements. Action was being taken to ensure policies updated and care pathway arrangements in place in respect of domestic violence and fabricated and induced illness.
- **Education Settings**
  DSCB staffing difficulties impacted upon the development of an audit tool suitable for use in schools and education settings. The checklist of school arrangements against both OFSTED and S11 requirements was updated and promoted across the education sector. The DSCB presented a half day conference for Headteachers and principals across the education sector and this included illustrations of good practice in relation to learning arising from serious case reviews and the use of audit tools.

30 Monitoring Effectiveness through External Inspections

30.1 Ofsted undertook an unannounced inspection of Local Authority arrangements for the protection of children between 3 – 12 December 2012 and the resulting Report was published on 21 January 2013. The full report is available using the link http://www.ofsted.gov.uk/local-authorities/derby .

30.2 The overall effectiveness of the arrangements to protect children in Derby is judged to be **good**.

30.3 Specific comment was made about the effectiveness of the Derby Safeguarding Children Board as follows:

"The Derby Safeguarding Children Board (DSCB) is appropriately constituted and has very effective governance arrangements. The multi-agency priorities of DSCB are appropriate and are set out in detail in their good quality annual report and business plan. A strong, independent Chair has led the Board through an impressive programme of policy and practice improvement by adopting an uncompromising approach to protecting children at risk of sexual exploitation. Learning from recent serious case reviews has underpinned all service developments and is demonstrated both at strategic and operational levels. Multi-agency case auditing is effective, routinely undertaken and appropriately focused on child protection. "

"The exceptionally strong, focused leadership of Derby Safeguarding Children Board (DSCB) has driven an impressive programme of policy and practice improvement by taking an uncompromising approach to protecting children at risk of sexual exploitation."

31 Demographic Data

31.1 Data: Source of Contacts, CAF and Referrals

	Contacts 2011 - 2012	CAF 2011 - 2012	Referrals 2011 - 2012	Contacts 2012 - 2013	CAF 2012-2013	Referrals 2012-2013
Police	2 544 (21.2%)	1	14%	3 546 (23.1%)	0	16%
School / Other Educational Organisation	1 547 (12.9%)	206	17%	1 475 (9.6%)	245	15%
Primary Health / Community Health	1 326 (11%)	94	8%	1 472 (9.6%)	156	10%
Secondary Health (A & E, Hospital)	443 (3.7%)		3%	384 (2.5%)		2%
Derby City Council	1 346 (11.1%)	121	24%	2 985 (19.4%)	120	35%
Other Local Authority	702 (5.8%)		12%	1 118 (7.3%)		10%
Other Legal Agency (Court, Probation, Immigration)	1 066 (8.9%)			1 249 (8.1%)		
Other Agency (including Voluntary Sector)	362 (3%)	23		262 (1.7%)	19	
Family / Relative / Self / Neighbour / Friend	1 463 (12.1%)		11%	1 720 (11.2%)		8%
Other including Concerned Individuals and agencies (housing)	619 (5.1%)	2	3%	711 (4.6%)		2%
Anonymous	139 (1.2%)			125 (0.8%)		
Not Recorded / Not Known	463 (3.9%)	13	8%	310 (2%)	4	3%
Number of section 47 enquiries			327			379
Total	**12 020**	**456**	**3842**	**15 357**	**544**	**2509**

31.2 Referrals

Derby had 2509 referrals during 2012-13 which is a reduction of almost 759 referrals compared to the previous year. Derby's rate of referrals is 436.8 per 10,000 population which is below the 2011-12 national rate of 533.5 and the comparator authority average rate of 609.4.

31.3 Section 47 enquiries and initial child protection conferences

The number of section 47 enquiries completed in Derby during 2012-13 has increased compared to last year. There has been a steady increase seen in the comparator authority average over the past five years whereas in Derby the numbers have been fluctuating with an average of 338 enquiries per year.
During 2012-13 Derby had 379 section 47 enquiries. 88.1% of these enquiries resulted in an initial child protection conference taking place. 99.4% of these conferences were held within 15 working days of the section 47 enquiry.

31.4 Data: Domestic Violence Victims

Police recorded domestic violence victim data for Derby City by gender and age for 2010 to 2013.

Derby City	10/11			11/12			12/13		
Age Group	**Female**	**Male**	***% Male***	**Female**	**Male**	***% Male***	**Female**	**Male**	***% Male***
a 15 and under	8	6	*43%*	10	7	*41%*	23	18	*44%*
b 16 to 17	3	2	*40%*	6	9	*60%*	31	14	*31%*
c 18 to 24	272	44	*14%*	313	59	*16%*	356	65	*15%*
d 25 to 34	477	71	*13%*	428	74	*15%*	437	73	*14%*
e 35 to 44	335	72	*18%*	334	69	*17%*	353	64	*15%*
f 45 to 54	199	56	*22%*	145	51	*26%*	155	61	*28%*
g 55 to 64	63	13	*17%*	29	20	*41%*	42	19	*31%*
h 65 plus	21	13	*38%*	9	8	*47%*	13	10	*43%*

31.5 CAADA DASH Evaluation Forms - Children involved in DV Incidents

One of the DASH questions is are there any children within the household.

Of the forms completed there were between 52% and 55% stating there were children within the household This proportion matches the estimates of around 50% of DV incidents having children either present or within the household based on Calls for Service and Record Crime analysis.

DASH Question 3 "Any Children" responses:

		Yes	**No**	**Not Known**	**Blank**	**Total**	**% Yes where known**
City	11/12 Q3+Q4	1479	1225	107	2	2813	55%
	12/13 Q1	807	691	46		1544	54%
	12/13 Q2	903	733	47		1683	55%
	12/13 Q3	802	751	46	2	1601	52%
	12/13 Q4	801	677	39		1517	54%

31.6 Children within Household by Risk Score

The question asking if there are children within the household is part of the risk assessment. Therefore as expected that the higher risk cases are more likely to have children within the household, however it is still useful to show the numbers involved. In 2012 there were 85 high risk cases with children within the household in the City and 136 in the County. For medium risk cases the numbers are City = 580 and County = 939 and for Standard risk cases City = 2183 and County = 5198.

31.7 DASH numbers of children within the household by risk score Jan 2012 to December 2012.

		Yes	No	% Yes
City	HIGH	85	34	71%
	MEDIUM	580	286	67%
	STANDARD	2183	2010	52%
	Not Known	5		100%
Total		2851	2330	
County	HIGH	136	62	69%
	MEDIUM	939	483	66%
	STANDARD	5198	4930	51%
	Not Known	7	5	58%
Total		6275	5475	

31.8 Female Victims aged 17 and under

Female Victims 17 and under were also read through and broken down into four age groups, under 3, 3 to 10, 11 to 15 and 16 to 17. These groupings were chosen after the crimes text had been read as the situations described were quite distinctive across the groups. Please see appendix for the full table breakdown.

- The under 3s groups although few in number were mostly (4 out of 5) hurt during an argument between parents. This shows the importance of identifying vulnerable infants in domestic violence cases.
- Within the 3 to 10 group 8 out of 13 were assaulted by the father (2 were step-father) and two were by the mother. There were also 3 where the child was injured during an argument between parents. Again this is a vulnerable group who often will not have their own voice or know how to contact organisations for help.
- Within the 11 to 15 group although again the father was the most common offender there is now a much wider range including brothers, sisters and other relatives. The mother is also increasingly an offender and sometimes it is both the mother and father together against the child. There are still a few cases of the child becoming a victim during arguments between parents although at this age often this is when the child will attempt to intervene often on the mothers side. In these cases the mother is almost always the natural mother although the father may often be a step-father or a new or ex-partner of the mother but not the child's natural father.
- The 16 and 17 year old group had the highest number of victims across all the age groups even though it is the shortest age band. Although this group included crimes similar to the younger group the majority were victims of current or ex partners. These were often arguments involving alcohol,

occurring in a range of locations including the victims home, the offender's home, pubs, in cars and on the street. What was noticeable was the number of incidents occurring in the offenders home where the offender is described as an ex partner, often when the relationship had finished months previously. This shows the importance of early interventions/advice in schools around relationships, what is not acceptable and what help is available.

31.9 Multi Agency Risk Assessment Conference (MARAC)

Following a decrease in numbers in 2011/12 there has been a rise in 2012/13 to just below the total for 2010/11. Repeat rates are still decreasing and this should be seen as a positive trend that the MARAC process is reducing risk to victims.

2012/13	Alfreton	Buxton	Chesterfield	South Derbyshire	County Total	Derby City
Number of Cases Discussed	91	79	165	44	379	168
Number of Repeat cases	15	10	25	3	53	19
% Repeats	*16%*	*13%*	*15%*	*7%*	*14%*	*11%*
Number of children in the household	101	85	164	56	406	242
Average children per case	*1.1*	*1.1*	*1.0*	*1.3*	*1.1*	*1.4*

2011/12	Alfreton	Buxton	Chesterfield	South Derbyshire	County Total	Derby City
Number of Cases Discussed	66	65	106	47	284	158
Number of Repeat cases	12	13	22	6	53	27
% Repeats	*18%*	*20%*	*21%*	*13%*	*19%*	*17%*
Number of children in the household	100	79	129	66	374	199
Average children per case	*1.5*	*1.2*	*1.2*	*1.4*	*1.3*	*1.3*

31.10 Police recorded domestic violence suspect data for Derby City by gender and age for 2011/12 and 2012/13.

Derby City Age Group	Female	Male	2011/12 % Male	Female	Male	2012/13 % Male
a 17 and under	3	13	81%	15	36	71%
b 18 to 24	21	158	88%	13	167	93%
c 25 to 34	18	195	92%	20	246	92%
d 35 to 44	22	125	85%	10	139	93%
e 45 to 54	11	50	82%	3	75	96%
f 55 to 64		11	100%	1	7	88%
g 65 and over		1	100%		5	100%
Total	**75**	**553**	**88%**	**62**	**675**	**92%**

31.11 Repeat Offenders

The police have identified 15136 referrals and of these 1306 perpetrators have more than three referrals. It has been decided to start by looking at the top 50 to see what the profile of these individuals is. This is an ongoing piece of work and will be assessed as it progresses.

31.12 Children Subject of Child Protection Plans (Year End Figures)

Child Protection Plans	Q1 12-13	Q2 12-13	Q3 12-13	Q4 12-13
Total number of children	217	208	229	225
CP Plans where domestic violence is a significant factor	26.2%	36.5%	38.4%	38.7%

In Derby, 225 children had a child protection plan as at 31st March 2013, this equates to a rate of 39.2 per 10,000 children.

Derby's figures continue to be in line with the comparator authority and national average. The actual number of children with a child protection plan at year end slightly reduced from 228 in 2011-12 down to 225 in 2012-13.

Derby had 302 children who became the subject of a child protection plan during 2012-13, of these 44 (14.6%) became the subject of a plan for the second or subsequent time. This compares to 13.8% nationally and 12.6% for our comparator authority average.
Derby had 305 children who ceased to be the subject of a child protection plan during 2012-13, of these 5 (1.6%) had been on a plan for more than two years. This compares to 5.6% nationally and 7.1% for our comparator authority average.

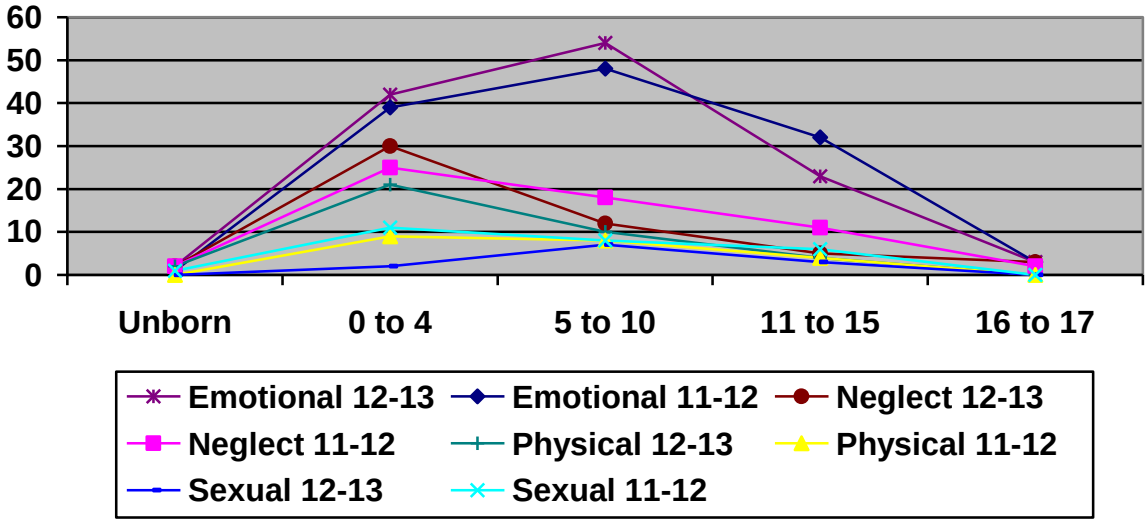
The data indicating the number of plans where domestic violence is a significant factor has improved and this has begun to illustrate a more consistent proportion where this is a factor. This compares to the previous year of 24%.

31.13 Category of abuse – breakdown by age groups

Main Category	Unborn	0 – 4	5 – 10	11 – 15	16 – 17	Total
Emotional Abuse *	2 (1)	42 (39)	54 (48)	23 (32)	3 (3)	124 (123)
Neglect	2 (2)	30 (25)	12 (18)	5 (11)	3 (2)	52 (58)
Physical Abuse	2 (0)	21 (9)	10 (8)	4 (4)	0 (0)	37 (21)
Sexual Abuse	0 (1)	2 (11)	7 (8)	3 (6)	0 (0)	12 (26)
Total	**6 (4)**	**95 (84)**	**83 (82)**	**35(53)**	**6 (5)**	**225 (228)**

(Previous Year Figures in Brackets)

*Domestic Abuse is recorded under this category



The overall figures comparing this year and last year have remained similar. The has been a shift in the number of plans for 11 – 15 year olds decreasing and an increase in plans for pre school age children. This might reflect a shift to seek intervention for children at an earlier stage in their lives, and a recognition that direct engagement with young people, rather than resorting to CP plans, may be more effective, and made more possible with the Youth multi-agency teams.

Children subject of Child Protection Plans with a Disability or Learning Difficulty

There are 12 children who have disabilities and are subject of child protection plans. This is in contrast to 21 children in the previous year. This is considered to be a relatively low number. Work has been undertaken with the Integrated Disabled Children's Service to ensure a consistent application of threshold, and first reviews of children in need will be undertaken by an independent CiN reviewing officer in future. A report has been commissioned from the service as to their safeguarding arrangements. No information has come to light however to suggest that disabled children are not being safeguarded, and repeated Ofsted inspection have highlighted good practice in the service.

Family Attendance In Conference / ACYP Meetings:

Total 'Chaired Sessions': 498 (604)
('Chaired Session' may be in respect of just one Child Protection Conference or Abuse by Child or Young Person (ACYP) Meeting, but may include siblings)

Family Present: **434 (**87.1%**)** compared to previous year 516 (85.4%)

Attendance by Young People and Children 4 years and over: **40** (41)

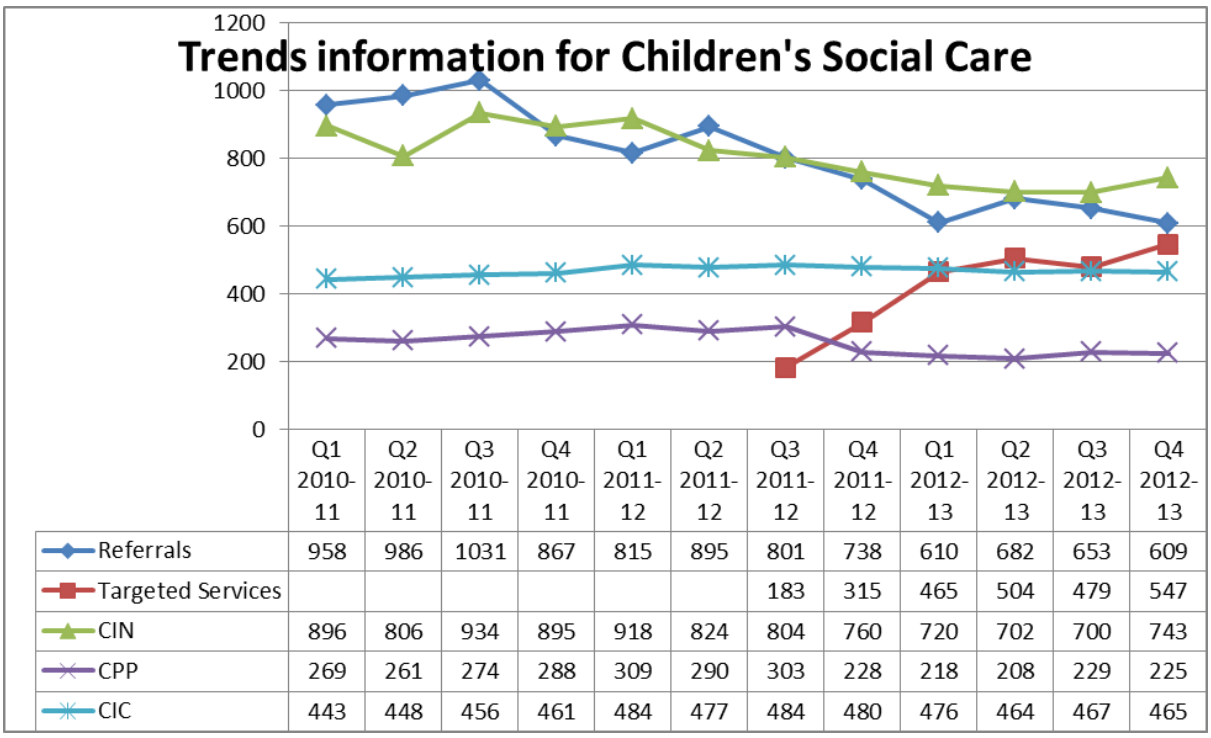
Attendance by Advocates on behalf of Young People and Children

Advocates attended on behalf of **36** young people and children

Comment
The collection of data is manual and over the coming year will be more rigorously monitored. Current figures of attendance by young people and children have not increased, however the number of advocates has increased.

32 Local Safeguarding Outcome Measures and Analysis 2012 - 2013

32.1 Early Intervention



	Q1 2010-11	Q2 2010-11	Q3 2010-11	Q4 2010-11	Q1 2011-12	Q2 2011-12	Q3 2011-12	Q4 2011-12	Q1 2012-13	Q2 2012-13	Q3 2012-13	Q4 2012-13
Referrals	958	986	1031	867	815	895	801	738	610	682	653	609
Targeted Services							183	315	465	504	479	547
CIN	896	806	934	895	918	824	804	760	720	702	700	743
CPP	269	261	274	288	309	290	303	228	218	208	229	225
CIC	443	448	456	461	484	477	484	480	476	464	467	465

Contacts with the Local Authority have increased significantly from 12 020 to 15 357 since last year and this is attributed to changes in local practice with more information sharing with the local authority by partner agencies rather than requests for services.

There has been a yearly increase in the use of CAF from 456 to 544
Examining trend direction and quality assurance findings from case audit will provide evidence for further analysis about this in the coming year as the Early Help assessment process is launched across Derby and Derbyshire. The DSCB will need to ensure that factors such as thresholds for services and for concerns about the welfare of children are being appropriately applied and this is evident in the effect on these trends.

The trend information indicates that there has been a reduction in referral rates that correspond to an increase in the engagement of targeted services through the multi agency teams.

Derby had 2141 children in need at 31st March 2013 which equates to a rate of 372.7 per 10,000 which is above the national (325.7) and statistical neighbour averages (353.2). This is a reduction of just over 200 cases compared to last year. This could be a result of the introduction of targeted services in Derby.

Derby's rate per 10,000 is now more in line with the 2011-12 East Midlands average of 372.0 per 10,000

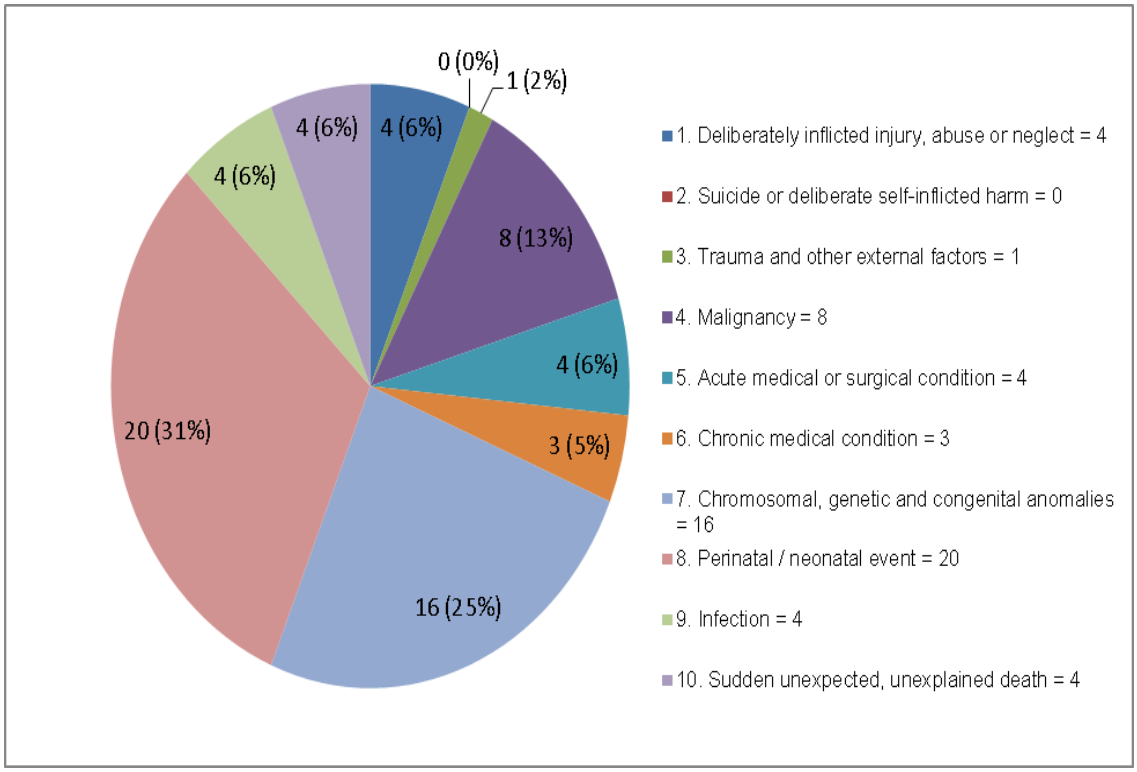
Derby had less episodes of need beginning in 2013 than in 2012.

Derby had 3706 episodes of need during 2012-13 which is almost 400 episodes less than last year. The comparator authority average for 2011-12 was 4775.

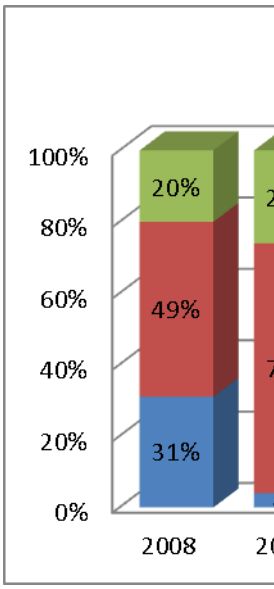
32.2 Child Deaths (by category) for Derby and Derbyshire

(Source CDOP Annual Report 2011)

Note: 3 cases have not yet been categorised so are not included in this chart.



32.3 Seeking to reduce child deaths



***No Modifiable factors identified** The panel did not identify any potentially modifiable factors
****Modifiable factors identified** The panel identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

	2008	2009	2010	2011
Total not classified	31%	4%	8%	5%
Total no modifiable factors identified*	49%	70%	72%	81%
Total modifiable factors identified**	20%	26%	20%	14%

The annual Child Death Overview Panel report (2011) identifies that there was a slight reduction in the number of deaths where one or more factors were present that could have modified or reduced the risk of future child deaths. This reduction may represent an improvement in action being taken to reduce child deaths.

The main modifiable factors identified are related to safe sleeping in babies and sudden infant death syndrome. Other modifiable factors relate to the preventability of unintentional injuries

32.4 Numbers of children examined for Child Sexual Abuse and Non Accidental Injury (Community Paediatric Service and Hospital)

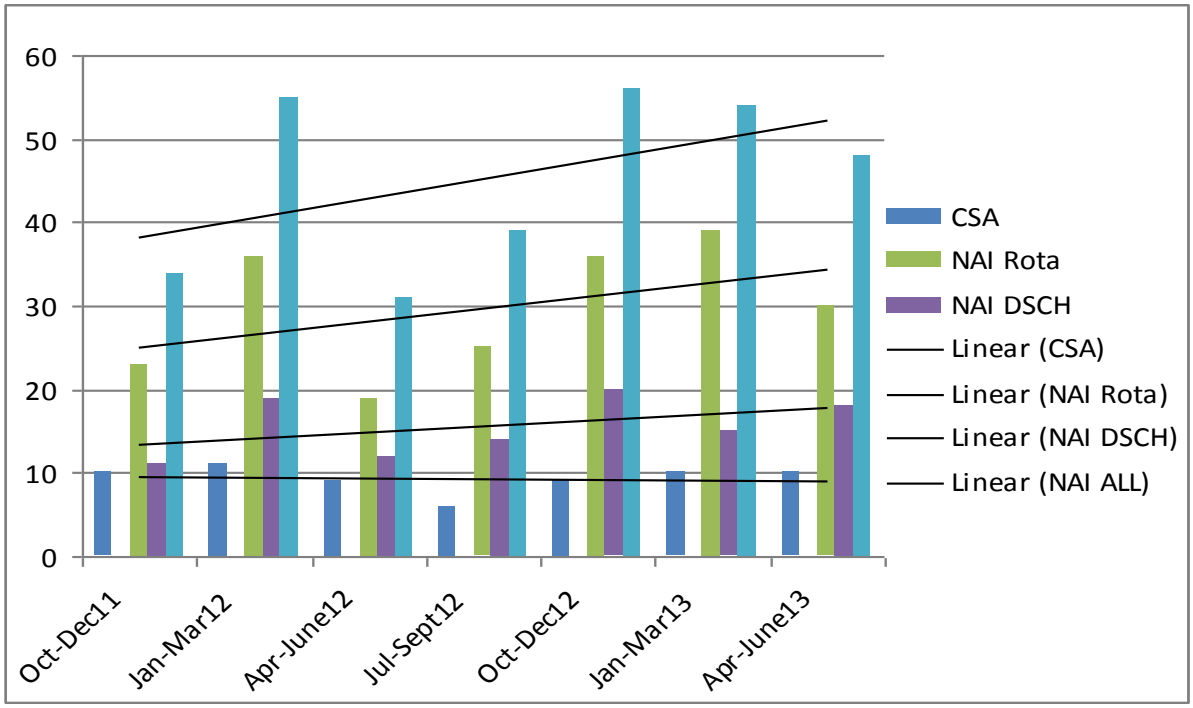
Table 1

	April 2007-March 2008	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012	April 2012-March 2013
Child Sexual Abuse (Community Paediatric Service) **Note: children seen for initial / follow up CSA Examinations**	62	45	79	62	67	45
Non Accidental Injury (Community Paediatric Service)	73	63	72	99	105	119
Child Protection Medicals (Hospital)	64	58	69	87	65	61

Analysis of the yearly statistics identified that the total of both initial and follow up Child Sexual Abuse medical examinations had been included in the table 1.

Statistics during 2012 – 2013 and trend information

	Oct-Dec11	Jan-Mar12	Apr-June12	Jul-Sept12	Oct-Dec12	Jan-Mar13	Apr-June13
CSA	10	11	9	6	9	10	10
NAI Rota	23	36	19	25	36	39	30
NAI DSCH	11	19	12	14	20	15	18
NAI ALL	34	55	31	39	56	54	48



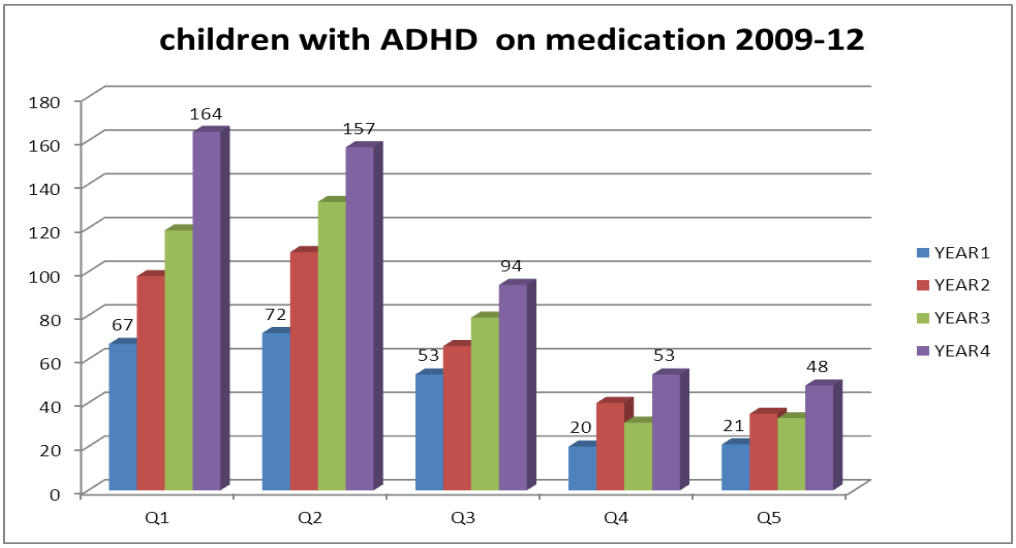
This year, the breakdown of statistics for **initial** Child Sexual Abuse medicals has been made available as this provides a clearer number of young people. The new data will provide quarterly and annual information that will illustrate trends more clearly.

The trend for CSA examinations is more or less horizontal (fractionally down but unlikely to indicate statistical significance test) but the NAI's are all trending upwards with the community ones slightly more so than the hospital (again definitely no statistical significance in respect of difference between community and hospital and only time will tell if there is any other significance to it). The overall upward NAI trend looks significant and requires further scrutiny.

32.5 Children in Derby City diagnosed by Community Paediatricians with Attention Deficit Hyperactivity Disorder as a marker for emotional well being

Rationale:

- Research has shown that children who face difficult domestic environments are more likely to have poor concentration, poor impulse control and to respond to triggers in the environment that are not apparent to others
- Research into the early development of the brain gives a pathological basis for this as neural networks and pathways will develop abnormally in children exposed to a threatening, uncertain, uncaring environment
- Local evidence shows a significant association of ADHD diagnoses by community paediatricians with deprivation as measured by the Index of Multiple Deprivation (2007)



Q1-5 = Deprivation quintiles with Q1 being the lowest.

These data relate to the community paediatric service, which is the first line medical service locally in the ADHD pathway; only those cases with co-morbidity and/or complex therapeutic needs are referred to CAMHS services

This graph shows that the diagnosis of ADHD has been heavily skewed towards the lowest two quintiles for the four years over which the data have been collected. It also shows that the number of children diagnosed and placed on medication has risen over the four years and that the rise has been greatest in the lowest quintiles.

Earlier intervention and parenting support would be expected to lower the number of cases related to environmental stresses and reduce the gap between the centiles.

32.6 Children who are receiving School Action Plus specifically to address needs in relation to (a) Behaviour, Emotional and Social Difficulties and (b) Speech Language and Communication Needs

	January 2012	January 2013
Behaviour, Emotional and Social Difficulties	628	677
Speech, Language and Communication Needs	499	447

Figures in respect of Primary Need indicate baseline evidence

These two outcomes for children will continue to be monitored as a proxy indicator. The influence of environmental factors on these outcomes and the effectiveness of early help will be considered on an ongoing basis and triangulated with emerging data on the work of targeted services in the coming year.

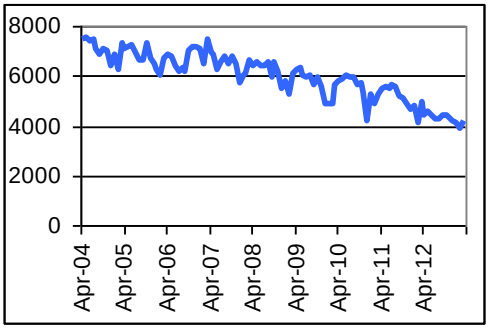
32.7 Domestic Violence Outcome Measures

Comparing 2011/12 with 2012/13 there has been:

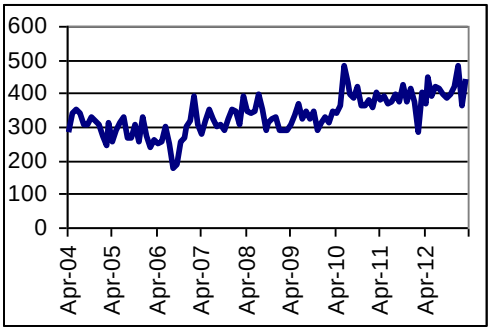
- an increase in the numbers of DV incidents;
- an increase in the number of recorded DV crimes;
- an increase in the proportion of all crimes that are DV related;
- a decrease in the number and proportion of Restorative Disposals; This has lead to a slight reduction in the positive outcome rate.
- a very slight reduction in detections, however this is within annual fluctuations.
- an increase in the number of MARAC cases (following a large decrease in 2011/12);
- a decrease in the rate of repeat cases at MARAC

POLICE	08/09	09/10	10/11	11/12	12/13	% Change 11/12 to 12/13
All Crime	73660	68005	65884	61483	51440	- 16.3%
Number of DV Incidents	17265	18087	18726	19673	20909	+ 6.3%
Number of DV crimes	4148	4212	4540	4649	4923	+ 5.9%
% of Incidents crimed	24%	23%	24%	23.6%	23.5%	- 0.1%
% All Crimes that are DV	5.6%	6.2%	6.9%	7.6%	9.6%	+ 2.0%

The charts below show that although all recorded crime numbers have been falling consistently from 2004 recorded DV offences have been rising from 2007 and this continues to be the case.



Police Recorded Crime (All Crimes)



Police Recorded DV Crimes

32.8 Domestic Violence Victims

There has been an increase in domestic violence incidents in comparison with the previous year and this is a significant issue for both the Police attending the majority of incidents, and the subsequent referrals to CYPD and Health Services.

Over the coming year the multi agency safeguarding arrangements are being established to improve the effectiveness of responses to domestic violence incidents by the police and partner agencies. Reporting in the coming year will reflect the new arrangements and the emerging impact on the welfare of victims and children.

32.9 Multi Agency Risk Assessment Conference (MARAC)

Following a decrease in numbers in 2011/12 there has been a rise in 2012/13 to just below the total for 2010/11. Repeat rates are still decreasing and this should be seen as a positive trend that the MARAC process is reducing risk to victims.

The Police are taking action to capture the data on repeat victims and repeat perpetrators and this should be available to the DSCB in the coming year.

This will provide an opportunity, alongside the other data, for the DSCB to monitor the implementation of the domestic violence and sexual violence action plan.

32.10 Children subject of Child Protection Plans

An analysis of children subject to plans was undertaken at the end of 2011-12. This a "saw-tooth" effect in relation to child protection plans and indicated that Derby significantly exceeded, at that time, the number of children who may be expected to be subject to plans, according to deprivation indicators and comparator figures (around 220-230). This and other evidence suggested that Derby was inconsistent in the application of threshold and use of child protection plans. Work to re-focus attention on threshold was undertaken and numbers dropped as a result, and have held reasonably steady over 2012-13.

It is notable that child protection plans for Sexual Abuse have decreased by more than half. This may in part reflect the development of the CSE strategy with the availability of earlier intervention and separate CSE meetings. Information from other sources does not suggest that otherwise sexual abuse is reducing, so this figure will need monitoring and if it continues, further analysis to understand what lies behind it.

32.11 Analysis of Demographic Data

Derby Population, Children receiving Targeted Services, Children in need, Children in Care and Children Subject of Child Protection Plans

Ethnic Group	Derby Population 2011 Census	Targeted Services	CIN	Children in Care	Child Protection Plans
Asian or Asian British	12.5%	5.1 %	8.4 %	2.4 %	15.5 %
Black or Black British	2.9%	4.3 %	3.8 %	3.2 %	1.3 %
Dual Heritage	2.9%	6.6 %	12.0 %	11.3 %	9.9 %
Not recorded	Nil	6.8 %	5.1 %	0.2 %	3.9 %
Other	1%	4.8 %	2.3 %	2.2 %	4.3 %
White British	75.3%	63.4 %	65.2 %	79.2 %	62.1 %
White Other	4.9%	9.0 %	3.1 %	1.5 %	3.0 %

((Figures as of April 2013)

The data identifies some statistically significant difference in the proportional representation of children from the Black and Minority Ethnic communities and their levels of service. Numbers of children who are subject of child protection plans are a small in total number therefore percentage variance may be significantly affected by small numbers of individual children.

The Local Authority has begun a study to determine in more detail underlying factors that may be affecting how services are accessed and received.

33 The DSCB Commentary on the Effectiveness of Safeguarding Arrangements in Derby

33.1 There continues to be demonstrable progress as the impact of the multi agency teams providing coordinated early help to children and their families. This appears to have had a positive impact at an early stage and reduced the referral of concerns to the local authority.

33.2 The further development of multi agency safeguarding arrangements to respond to concerns about children are being implemented in the coming year and the Derby Safeguarding Children Board will be taking an active role to ensure that these are improving outcomes for children.

33.3 The Derby Safeguarding Children Board is satisfied that there is sufficient evidence to indicate that there needs to be continued focus on the two key priorities of Early Help and Domestic Violence.

33.4 The Derby Safeguarding Children Board has also identified areas for further work and scrutiny with an emphasis on outcomes for children, young people and their families. These are set out below:

33.5 Action for the DSCB in the coming year

Ensure that robust arrangements are in place following publication of Working Together and associated National Guidance, that approved guidance is embedded in partner agency practice and assess and monitor the impact of organisational change on safeguarding arrangements.

Establish consistent and robust safeguarding training and development pathways within agencies and ensure that single agency and multi agency training is quality assured.

Audit the steps that each agency has taken to identify whether parents or carers have parental responsibility as appropriate and ensure that referrals are made to the local authority.

Report on the effectiveness of early intervention and child protection arrangements to safeguard children and young people.

Liaise with the Safeguarding Adult Board and evaluate Think Family arrangements to ensure action is coordinated where adult behaviour or need presents a risk to children

Improve the coordination of pre birth assessments for vulnerable families

Undertake quality assurance activity in the following areas: annual case file audit; arrangements to keep disabled children safe; the impact of the revised pre birth multi agency arrangements; the impact of the implementation of the multi agency safeguarding arrangements and the impact of the domestic violence and sexual violence strategy

Extend learning arising from local reviews and the work of the Board and establish effective arrangements (including priority areas) for consultation with Children, Young People and Parents/Carers

Promote awareness of the risks of Child Sexual Exploitation, Missing children, Online abuse and Perpetrators of sexual abuse and ensure that local arrangements focus on improving outcomes for children and young people

Recruit and select Lay Members for the DSCB

DSCB Performance and Outcome Measures 2012 - 2013

34 Derby Safeguarding Children Board Membership 2012 - 2013

Member	Role	Agency
Christine Cassell	Independent Chair	**Derby Safeguarding Children Board**
Andrew Bunyan	Strategic Director for Children and Young People	**Children and Young Peoples Services**
Liz Adamson (VICE CHAIR) * CDOP	Designated Doctor	**Derbyshire Healthcare Foundation Trust**
Councillor Martin Rawson (from June 2012)	Lead Member	**Derby City Council**
Jane Parfrement (from December 2012)	Director of Early Intervention and Integrated Safeguarding	**Children and Young People Directorate**
Mark Barratt (to December 2012)	Director of Specialist Services	**Children and Young People Directorate**
Nina Martin	Head of Service Quality Assurance	**Children and Young People Directorate**
Suanne Lim	Head of Youth Offending Service	**Derby City Council**
Cathy Winfield	Deputy Director of Nursing	**Derby Hospitals NHS Foundation Trust**
Lynn Woods	Chief Nurse and Director of Quality	**Southern Derbyshire CCG**
Paul Lumsdon	Chief Nurse and Executive Director of Nursing & Quality	**Derbyshire Healthcare NHS Foundation Trust**
Hannah Hogg	Head of Service (Children and Adults)	**Derby City Council Legal Services**
Judith Russ	Service Manager Derby Cafcass	**CAFCASS**
Andrew Stokes	Detective Superintendent and Head of Public Protection	**Derbyshire Police**
Rosemary Plang / Sara Win Win Sein	Director of Probation	**Derbyshire Probation**
Dawn Robinson	Head of Service - Prevent	**City and Neighbourhood Partnerships**
Jane Appleby	Lead Children, CAMHS and Safeguarding	**NHS East Midlands Strategic Health Authority**
Simon Emsley	Head teacher	**Schools - Primary**

Liz Coffey	Principal	**Schools Secondary**
Nathalie Walters	Representative for the Children and Young People's Network	**Safe and Sound Derby**
Ray McMorrow Designated Nurse (Adviser)	Designated Nurse	**Southern Derbyshire CCG**
Mark Sobey	Board Manager	**Derby Safeguarding Children Board**

***Liz Adamson represented the CDOP during the period of change of CDOP Chair**

Derby Safeguarding Children Board Membership 2013 – 2014

Member	Role	Agency
Christine Cassell	Independent Chair	**Derby Safeguarding Children Board**
Andrew Bunyan	Strategic Director for Children and Young People	**Children and Young Peoples Services**
Liz Adamson (VICE CHAIR)	Designated Doctor	**Derbyshire Healthcare Foundation Trust**
Councillor Martin Rawson (from June 2012)	Lead Member	**Derby City Council**
Jane Parfrement	Director of Early Intervention and Integrated Safeguarding	**Children and Young People Directorate**
Nina Martin	Head of Service Quality Assurance	**Children and Young People Directorate**
Suanne Lim	Head of Youth Offending Service	**Derby City Council**
Cathy Winfield	Deputy Director of Nursing	**Derby Hospitals NHS Foundation Trust**
Lynn Woods	Chief Nurse and Director of Quality	**Southern Derbyshire CCG**
Paul Lumsdon	Chief Nurse and Executive Director of Nursing & Quality Safeguarding Lead	**Derbyshire Healthcare NHS Foundation Trust**
Ben Anderson	Chair of CDOP and Consultant in Public Health (Lead for Child and Maternal Health)	**Derby City Council**
Janie Berry / Kaye	Director of Legal and	**Derby City Council**

Howells	Democratic Services / Principal Lawyer	**Legal Services**
Judith Russ	Service Manager Derby Cafcass	**CAFCASS**
Andrew Stokes	Detective Superintendent and Head of Public Protection	**Derbyshire Police**
Sara Win Win Sein	Director of Probation	**Derbyshire Probation**
Dawn Robinson	Head of Service - Prevent	**City and Neighbourhood Partnerships**
Simon Emsley	Head teacher	**Schools - Primary**
Liz Coffey	Principal	**Schools Secondary**
Anita Straffon	Vice Principal Learner Journey	**Further Education College**
Mike Walters	Representative for the Children and Young People's Network	**Relate Derby**
Michelina Racioppi Designated Nurse (Adviser)	Designated Nurse	**Southern Derbyshire CCG**
Mark Sobey	Board Manager	**Derby Safeguarding Children Board**