

# Derbyshire **Safeguarding Children** Board

## Annual Report 2017 – 2018



## **Contents**

<b>1</b>	Chair's Foreword and Introduction	<b>2</b>
<b>2</b>	Characteristics of Derbyshire	<b>4</b>
<b>3</b>	Derbyshire Safeguarding Children Board Strategic Objectives 2017-18	<b>5</b>
<b>4</b>	Priority area: Online safety	<b>6</b>
<b>5</b>	Priority area: Neglect	<b>7</b>
<b>6</b>	Priority area: Early Help	<b>9</b>
<b>7</b>	Independent Review of Child Protection Processes	<b>10</b>
<b>8</b>	Lessons from learning reviews	<b>12</b>
<b>9</b>	Training and workforce development	<b>15</b>
<b>10</b>	Safeguarding audits	<b>18</b>
<b>11</b>	Child Death Overview Panel	<b>19</b>
<b>12</b>	How children influence decisions made about them	<b>21</b>
<b>13</b>	Future Priorities	<b>23</b>
	Appendix 1- Derbyshire Safeguarding Children Board Membership	<b>25</b>
	Appendix 2 – DSCB Structure	<b>27</b>

## Chapter 1. Chair's Foreword and Introduction



I am pleased to introduce this Annual Report on the work and effectiveness of the Derbyshire Safeguarding Children Board for 2017/18. Whilst I only took up the role of Independent Chair on 1st March 2018, the hard work and commitment of all Board members over the previous eleven months was abundantly evident and I thank them for that. In particular, I must acknowledge the considerable contributions of my predecessor, Chris Cook, and the Interim Board Manager, Jane Lakin, not only in driving forward essential safeguarding priorities, but also in assisting my induction into the role.

The Safeguarding Children Board is the key strategic partnership tasked with coordinating and ensuring the effectiveness of local working to safeguard and promote the welfare of children and young people. It holds agencies to account, individually and collectively, for their safeguarding practice and their role in the delivery of the Board Business Plan. The membership of the Board during the year 2017/18 is set out at Appendix A.

The publication of this report is later than would be ideal and I am committed to publication of the report for 2018/19 being no later than September 2019. This will be particularly timely, as the review of our multi agency safeguarding arrangements, required by Working Together 2018, must be agreed and implemented by that date. The review commenced during the early months of 2018, working closely with Derby City Safeguarding Board, and has been progressing in a most constructive manner. The arrangements of the Child Death Overview Panel (CDOP) are also subject to review and will be addressed within the same timescale.

Given the timing of this publication, it is appropriate that reference is made not only to actions and impacts in 2017/18, but also to issues addressed and completed in the current year (2018/19). I hope that the relevant timescales are clear in what follows.

During the year 2017/18 the Board has focussed on the following areas, each of which is described in more detail in the body of the report: on-line safety; neglect; and Early Help. All three of these remain priorities, not because our joint initiatives and commitments have been lacking, but because they continue to be challenging in Derbyshire and across the country. In addition, we have continued to give priority to arrangements for child protection, particularly at conferences – increasing participation from children and multi-agency safeguarding partner representatives, scheduling and provision of reports – in order to secure the widest possible

information on which to make effective decisions in the interests of the children concerned. Enabling children to contribute to and influence decision-making is central to our work. Learning from audits and reviews has been important to how we maintain and improve multi-agency working and sharing of information.

Priorities for 2018/19 are highlighted and, as we move towards the new safeguarding arrangements in light of Working Together 2018, we will continue to develop a framework which enables us to evaluate the impact of the work of the Board and its safeguarding partners.

Having acknowledged the work of two specific Board members earlier, I must express my appreciation also of all other members, who have maintained and expanded their commitment and engagement during a year of some challenge and change; 2018/19 is even more challenging. With their support and that of a professional support team, those challenges will be met. I commend this report to you.

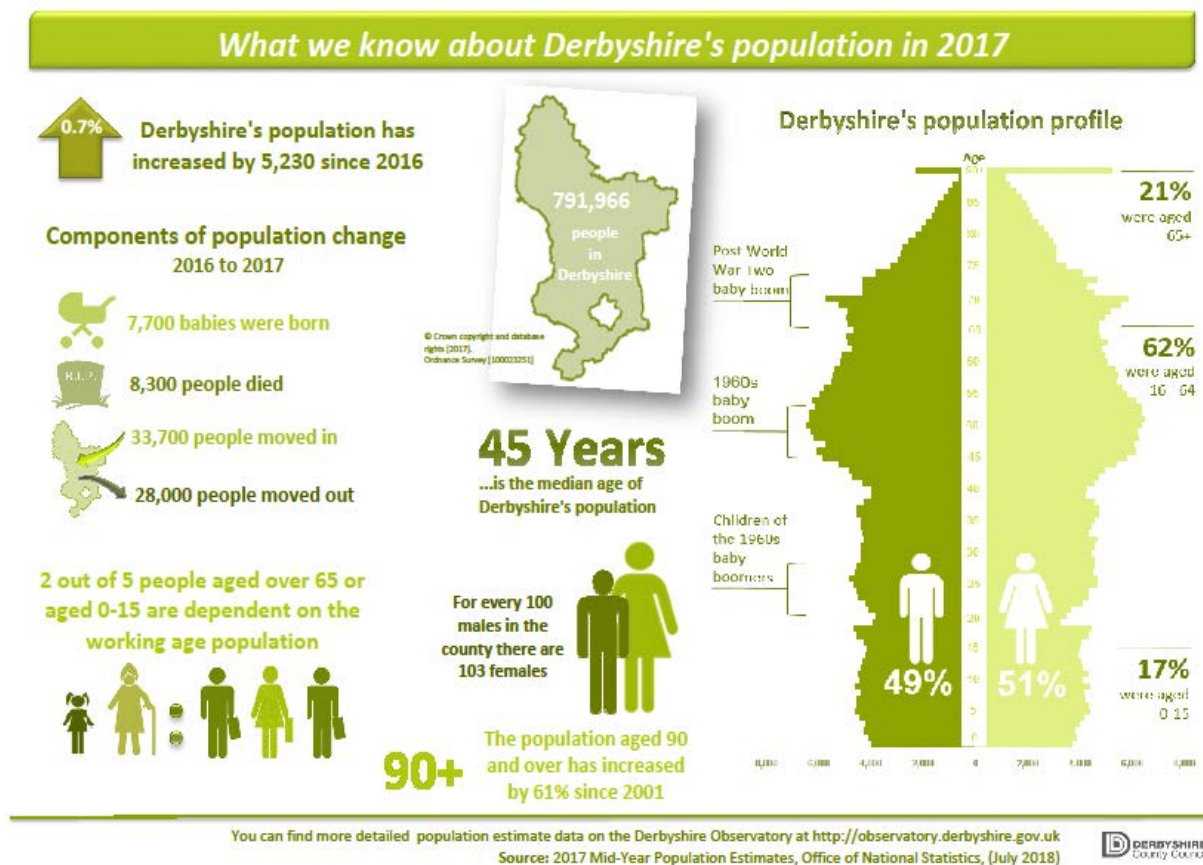
**Steve Atkinson**

**Independent Chair**

**Derbyshire Safeguarding Children Board**

## Chapter 2. Characteristics of Derbyshire and the demographic context of the Derbyshire Safeguarding Children Board

Derbyshire is a large diverse county which encircles the unitary authority area of Derby City. Around a quarter of Derbyshire is made up of large sparsely populated rural areas alongside a number of heavily built up towns. Derbyshire's 0-19 population is approximately 170,000 (22% of the population). Levels of deprivation, outcomes and life chances for children and young people are generally good, but there are variations across the county. Derbyshire's Black and Minority Ethnic and English as an Additional Language populations are significantly lower than England as a whole. A large part of the North and West of the county falls within the Peak District National Park.



### Positive indicators

- 93.4% of 16-17 year olds engaged in education and training, higher than the national average.
- Significantly fewer 16-17 year olds Not in Employment Education or Training ('NEET') or 'not known' than the England average

- Significantly fewer first time entrants to the criminal justice system than the England average – 169 per 10k population vs 327 per 10k nationally
- Lower than average hospital admissions of children due to injury
- Healthier birth weights than the national average; fewer babies born with low birth weight.

### **Risks and challenges**

- Increase in children subject to child protection plans – 971 by the end of 2017/18, compared with 554 at the end of 2010/11 – an increase of 75% and higher than both the England average and our statistical neighbours.
- Increase in vulnerabilities identified for teenagers – hospital admissions due to substance misuse (ages 15-24) and self-harm (ages 10-24) are higher than the England average and although hospital admissions in relation to alcohol use have improved, the rate is higher than the England average.
- The rate of children in need (as defined by the Children Act 1989) during 17/18 increased by over 30% to 355 per 10k population, from 271 per 10k population in 2010/11, higher than both the England average and statistical neighbours.

## **Chapter 3. Strategic objectives of the Derbyshire Safeguarding Children Board**

The strategic objectives for the DSCB from 2016-2018 were:

- Promote, monitor, coordinate and evaluate multi-agency effectiveness in safeguarding children and young people across the child's journey
- Strengthen and support a competent and equipped workforce that is committed to learning and developing safeguarding practice with assurance that safeguarding is everyone's responsibility.
- To evidence the impact of DSCB

The Board set out the following additional aims for 2017/18:

1. Continue to promote online safety initiatives, including the involvement of young people within the scoping and development of this aim;
2. Improve the response to situations of neglect;
3. Ensure the extensive use of early help assessments across all agencies.



During 2017/18, the Board also commissioned an independent review of child protection processes, in response to a significant rise in the numbers of children becoming subject to child protection plans.

Through the activity of its subgroups, development and delivery of focused action plans, completion of learning reviews, workforce development and audit activity, progress has been achieved as outlined in the Chapters below.

## **Chapter 4. Priority area: Online Safety**

Partner agencies of the DSCB delivered a comprehensive plan of activity during 2017/18 to promote online safety and reduce the potential risk of harm associated with online technology. Our key achievements in this area were:

- Ensuring that all schools and colleges were supported to develop an online safety policy by providing access to an exemplar, which is regularly updated to ensure current themes are reflected. The annual safeguarding self-assessment and audit (as required by s175 of the Education Act 2002) has identified those schools who have yet to put a policy into place, which allows for further targeted support to be offered.
- The film 'Kayleigh's Love Story', a true story relating to a girl who was groomed online, has been rolled out to all Derbyshire Secondary Schools – a rolling programme of sessions to 36 schools was supported by the local MAT (early help) team, police and Safe and Sound voluntary sector staff. Feedback from the evaluation of the programme indicated that the majority of participating schools felt more equipped to deal with specific issues in safeguarding such as online safety and Child Sexual Exploitation, that designated safeguarding leads felt proud of having delivered curriculum-based safeguarding activity and that 76% of students would change their online activity as a result of the sessions.
- Ensuring that parents, carers, children and young people have access, via the DSCB website, to simple, understandable information regarding online safety including links to nationally recognised help and support.
- Introducing a new one-day 'online safety' training course for staff as part of the DSCB annual training programme
- Hosting a UK Safer Internet Centre Online Safety Briefing Session, attended by 218 delegates from a range of agencies.

- Supported primary schools to deliver an age appropriate curriculum around the potential risks of 'sexting'.
- Ensured all schools, colleges and residential establishments understand how to deal with 'sexting' incidents and how to manage digitally held material.
- Implemented a renewed multi-agency monthly review meeting in relation to Child Sexual Exploitation and Missing, ensuring that strategies are deployed to target and disrupt perpetrators of online abuse.
- Updated the Derbyshire prosecution policy and practice in relation to transmission of indecent images and the DSCB policy regarding children who pose a risk to others.

The areas we will focus on in the coming period are:

- Work with young people to build a better understanding and use of social media platforms and 'apps' to appropriately target online safety messages to children, young people, parents and carers.
- Participating in the Royal Foundation's 'Stop, Speak, Support' Campaign
- Ensuring online safety is addressed more consistently within the social work single assessment to open up discussions and support around this issue.
- Promoting and making best use of the 'Get Safe Online' resource page as a toolkit for parents and professionals
- Finalising and rolling out the harmful sexual behaviour strategy, addressing the issues relating to harm caused by children and young people, including online behaviour, which poses a risk to others.

## **Chapter 5. Priority Area: Neglect**

During 2017/18, the DSCB delivered a focused programme of activity to increase practitioner understanding of neglect, improve agency responses with the aim of identifying and responding to neglect in a timely and effective manner. Our key achievements in this area during 2017/18 were:

- Completion of an extensive multi-agency audit, including screening of 61 cases and multi-agency deep-dive evaluation of 28 cases, to identify key



learning themes across the multi-agency safeguarding partners, which has informed priority areas for practice development.

- Delivered a seminar regarding the audit findings to 120 staff from across all agencies to share learning and promote cascading across all staff.
- Addressed identified gaps in information sharing arrangements to ensure timely and informative sharing of information between key partners at an early stage.
- Relaunched the protocol for integrated working between Youth Offending Service (YOS), MATs and children's social care to develop a more collaborative and integrated approach to responding to neglect and to improve understanding of thresholds.
- Developed and launched the 'Graded Care Profile' tool for understanding neglect, rolling out an extensive training programme to practitioners across multi-agency partners including social work teams, health, schools and police. By April 2018 we had trained almost 650 staff.
- Reviewed and updated our escalation procedures, to support a culture of respectful challenge and authoritative practice.
- Delivered a one day neglect conference for 125 schools to promote understanding neglect, use of screening tools and improve access to support.
- Established a subgroup for our District Safeguarding Leads, to promote closer relationships with and understanding of the Board's priorities, including responses to neglect.

The areas we will be focusing on in the coming period are:

- Further developing practice improvement activity around the learning themes identified through the audit process.
- Reviewing the Graded Care Profile and creating a 'Derbyshire specific' neglect toolkit which reflects changes to the current GCP, research evidence and best practice locally.
- Reviewing and relaunching our e-learning programme, incorporating relevant sections on neglect

- Ensuring activity to develop the 'Was Not Brought' approach by all health providers is fully embedded
- Undertaking a gap analysis regarding our neglect strategy and revise in light of our recent activity and findings.
- Supporting the development of 'systemic lead' posts within children's social care, to embed systemic practice and reflective supervision in all social work teams.
- Reviewing guidance for managers and supervisors and ensure learning is embedded into supervision as well as practice.

## **Chapter 6. Priority Area: Early Help**

During 2017/18, the Board co-ordinated a range of activities to ensure children, young people and families were able to access early help to prevent problems escalating. Our key achievements in this area were:

- Focusing on quality of practice within Multi Agency (early help) Teams (MATs), including developing use of SMART plans, improved quality of recording, ensuring assessments take into account the lived experience of the child and ensuring quality direct work takes place with children and young people according to their identified needs.
- Delivering comprehensive training in use of the Graded Care Profile across the children's workforce, including with MAT teams and schools.
- Review of the early help assessment tool, in consultation with partner agencies, to enable a more focused approach and remove barriers to completion.
- Updating and revising the protocol between the MAT teams, YOS and Safeguarding Teams to ensure to promote greater collaboration, integration and co-ordination of activity
- Commissioning the development of a pathway to ensure effective early help arrangements are in place in schools
- Commencing the development of a health early help pathway

The areas we will be focusing on in the coming period will be:

- Increasing the use and quality of early help assessments within health agencies, implementing the health pathway.

- Launching the full suite of revised early help documents, jointly with Derby City Safeguarding Children Board
- Ensuring that schools are skilled and knowledgeable regarding the use of early help assessments
- Ensuring the importance of early help assessments, as identified through recent learning reviews, is promoted and understood across the children's workforce, including schools
- Supporting a full assessment of local need and review of early help, to minimise any negative impacts of changes to service provision and support transition to revised early help arrangements.
- Updating the overarching early help strategy with multi-agency partners, to shape the local approach and responsibility of all agencies in having a shared and consistent early help offer.

## **Chapter 7. Independent Review of Child Protection Processes**

In response to a growing number of children becoming subject to Child Protection Plan, during 2017/18 the DSCB commissioned an independent report into child protection processes. The independent reviewer conducted a focused, mixed-methods research project, out of which a set of recommendations emerged – these recommendations were accepted by the DSCB in September 2017 and a thematic Child Protection Improvement Group established to ensure they are delivered. Key areas of progress during 2017/18 were:

- Development of a revised set of standards and processes for child protection conferences
- A programme of observation of child protection conferences by the independent reviewer, head of service and partner agencies, exploring the following principles to inform future development: best practice, consistent use of the Stronger Families, Safe Children model within the conference process, clear identification of risk, use of professional challenge, improvement of the quality of social work reports, child's voice and lived experience, contribution of partner agencies, use of SMART (Specific, Measurable, Achievable, Realistic, Time-limited) and robust child protection plans.

- Observations of child protection conferences by multi-agency partners also evaluated individual agency contributions, to inform improvement activity.
- Working with partner agencies to ensure that their internal quality assurance processes address the quality and consistency of practitioners' input into child protection conferences.
- Significant investment to build appropriate capacity within the child protection service.
- Establishing a dedicated child protection conference manager for each area to promote local relationships and best practice
- Regular reporting to the DSCB regarding progress and barriers to improving the management of child protection conferences.
- Review and revision of conference documentation to support best information and planning for the child within the child protection process
- Standardising the child protection framework to focus on significant of harm and identification of risks.
- A programme of practice development for social work teams, led by the principal social worker
- Revision of guidance on the use of categories of abuse to ensure accurate reflection of risks and issues to be addressed

The areas we are focusing on in 2018/19 are:

- Improving the quality and analysis within child protection conference reports
- Improving the planning process for the child with one, more clearly set out, plan which follows the child's journey
- Improving attendance at child protection conferences and provision of reports to maximise the effectiveness of multi-agency planning which reduces risks
- Further streamlining arrangements for booking and managing child protection conferences
- Ensuring that children and young people are enabled to participate in child protection conferences in the most suitable way for them, to enable their views to influence decisions made about them.
- Embedding new escalation and dissent arrangements and monitoring any themes which are identified.

## **Chapter 8. Lessons from learning reviews**

During 2017/18, Derbyshire published a significant Serious Case Review, ADS14. The review was commissioned following the tragic death of a 21-month old baby in 2014. Copies of the full report and executive summary can be found on the Derbyshire Safeguarding Children Board website. The key lessons learned are described below.

### **Summary**

The case showed how difficult it is for agencies to retain a child-centred focus when the needs of a young parent facing domestic abuse continue to dominate. It also showed the importance of obtaining accurate pre-birth assessments especially around assessing the impact of parental mental health and drug use. Other issues included the requirement for outcome-focused children in need plans, which continually adapt to changing circumstances and for professionals to pay more attention to the role male carers are playing in a child's daily life.

### **Learn and Share**

There was good practice identified especially around multi-agency working and the commitment to stay with the case. Once the child was born there was appropriate identification of the growing risk of domestic abuse when mother's relationship with her then partner became increasingly violent, which culminated in care proceedings and the making of a supervision order. However, once the baby was returned back to mother's care and she commenced a new relationship, the indicators that risks to the child were once again increasing, were not fully recognised and the Children in Need plan did not specify clearly enough what good outcomes for the child would be, hence there was a delay in taking protective action soon enough.

### **Multi agency working**

The Serious Case Review identified the importance of authoritative practice by all professionals involved. They must take any non-engagement by a parent seriously and recognise the impact this has on the child. Home visits should be carefully planned, with purpose and authority.

Across all agencies, practitioners who were involved with the family were inclined to take what mother said at face value. An attitude of professional curiosity requiring practitioners to examine the lived experience of the child was often missing by all agencies. The needs of mother overshadowed the needs of the child frequently.

A comprehensive action plan was implemented to address the nine recommendations within the Serious Case Review and all activity completed by February 2018. This includes:

- Updating the DSCB policy and procedure 'Working with Substance Misusing Parents', including updated practice guidance regarding assessment of substance misuse issues
- Embedding a 'Think Family' approach across all agencies to support effective identification of issues and information sharing between relevant agencies
- Reviewing and updating supervision policies to address the need for authoritative, relationship-based practice
- Strengthening arrangements to ensure robust and outcome-focused management of supervision orders
- Ensuring appropriate identification, assessment and support of fathers/male partners, including changes to recording systems, provision of multi-agency training, dissemination of research
- Implementing changes across health settings to improve identification of abuse.

The full action plan can be viewed on the DSCB website.

The publication of ADS14 was accompanied by a range of learning opportunities for managers and practitioners, including a large scale learning event addressing the issues within this report and other reviews, both local and national, of significance.

In addition to the Serious Case Review, during 2017/18 the Board published the findings from four learning reviews which had been conducted as a result of serious incidents since 2014. The Board produced a summary of thematic learning from these reviews which was circulated to all partners to highlight the key areas for consideration in practice:

The Child Protection Plan is key. Reflect all possible risks in the Plan, including parental mental health or drug misuse.

Show that authoritative social work practice leads your child protection planning.

Be alert to and understand the signs of disguised compliance and do not be unduly optimistic about outcomes.

Ensure robust arrangements are in place to support children with Supervision Orders.

When a child subject to a Supervision Order returns to a carer who presents safeguarding concerns, consider a Child Protection Plan rather than a Child In Need Plan for the first six months.

This consideration should be recorded.

Where there are safeguarding concerns for children, fathers or male partners must be consulted, supported and assessed, even if they are not the primary carer.

Record a child's missed medical appointment as '*was not brought*' rather than '*did not attend*' so parental neglect is considered as a factor.

Medical staff must always consider abuse or neglect within their differential diagnosis.

Ensure new parents view the film 'Shaking Your Baby Is just Not the Deal', on DVD or on YouTube

Ensure the child's voice is clearly heard and use chronologies to record the child's '*lived experience*'.

All professionals should consider the need for an Early Help Assessment.

Seek leave to include relevant Family Court findings in the adult's medical records.

Undertake robust assessments of housing provision for vulnerable young mothers.

### **Key themes of Derbyshire SCR and SILRs:**

- The importance of authoritative practice
- Be alert to disguised compliance
- The importance of professional curiosity
- Be alert to the possibility of abuse
- All professionals to consider the need for an Early Help Assessment
- Hear the voice of the child
- Understand and record the child's lived experience
- Refer to [www.derbyshirescb.org.uk/policies-and-procedures.asp](http://www.derbyshirescb.org.uk/policies-and-procedures.asp) to guide practice



The DSCB hosted a conference in June 2017 to disseminate learning from local and national serious case reviews, attended by over 100 practitioners. The Board also provided keynote presentations on findings from recent reviews to the annual Local Family Justice Board conference.

During 2017/18 the Board commissioned two further Serious Incident Learning Reviews; one in relation to the death of a teenager directly related to morbid obesity, the other in relation to injuries sustained by a baby whilst subject of a child protection plan. The findings of these reviews will be published during 2018/19.

### **Aston Hall**

During 2017/18, the Board continued to engage in a learning and assurance review in response to the investigation of historical sexual abuse at Aston Hall Hospital. The report, commissioned from an independent author, was finalised in 2018/19 and, whilst not published within the timescale covered by this Annual Report, given the timing of that publication, it is appropriate to set out the conclusions here. The report concluded that

‘Children can be confident that, if a similar situation, such as occurred at Aston Hall, arose again, there is a clear and transparent route for them to raise their concerns and that those concerns would be taken seriously. Furthermore, there are robust and effective processes in place to identify concerns that are not reported by children’.

The report recommended a series of measures for ongoing assurance. These have been accepted by the Board in full and an action plan produced to ensure they are implemented. The report has been shared with all partner agencies, along with the Safeguarding Adults Board, and assurance sought that it has been disseminated to all staff.

A copy of the Aston Hall report and all recently published information from other learning reviews can be found on the DSCB website. Our learning and development programme and priority areas of action reflect the findings of our learning reviews and are regularly updated accordingly.

## **Chapter 9. Training and Workforce Development**

During 2017/18, the Derby and Derbyshire Safeguarding Children Boards updated our Joint Learning and Improvement Framework and used this to inform a Joint Training Strategy for 2017- 2020. These were used to inform and develop the 2017/18 training programme, along with training audit information from partner agencies, learning from national and local reviews and changes to national guidance and local priority areas of work. Our key achievements in this area during 2017/18 were:

- Delivery of a full programme of 78 multi agency training courses covering 22 different safeguarding topics.
- 5 new topics were included in 2017/18 in response to serious case reviews, board priorities and training needs analysis from partners.
- A total of 1,521 participants attended multi-agency training courses. The average attendance figure per course was 19.
- Training was delivered across the entire children's workforce; in addition to multi agency training, 661 childminders and early years' staff have attended safeguarding training this year and 77 sessions have been delivered directly to schools, involving a total of 3,683 participants from schools. This includes 23 dedicated courses for Designated Safeguarding Leads and 4 Governor sessions.
- Training has been co-delivered by a pool of trainers from a variety of agencies and services, reflecting the multi-agency nature of safeguarding work and ensuring training is underpinned by current professional expertise.
- In addition to face-to-face courses, the Board has provided e-learning packages in relation to key areas of safeguarding practice. During 2017/18, e-learning courses were completed by 1320 participants
- Level 1 and 2 training courses delivered by Board partners have been validated by the workforce development team to enable capacity within organisations to deliver safeguarding training.
- The Board continues to manage a list of validated trainers; on approval, providers are awarded a kite mark which assures organisations who are buying in training independently that the training is up to date and meets the quality requirements of the DSCB. During 2017/18:
  - 6 providers were validated and added to the approved list, 4 'in-house' organisations and 2 independent trainers;
  - 2 providers were revalidated, having previously been approved for 3 years
  - 3 applications from independent trainers were rejected due to not meeting the quality standard – resubmissions will be considered if improvements are made.

All our courses are evaluated and during 2017/18, as well as the course evaluation forms we completed qualitative follow up with practitioners by telephone to understand what difference the training had made in practice. Our evaluation activity established:

- Practitioners consistently felt that their confidence, knowledge and skills had increased following training
- Following training, no practitioners reported low confidence, knowledge or skills
- The overwhelming majority of participants evaluated courses as useful to their work, using effective methods, making a difference to diversity and would recommend the courses to colleagues.

Examples of follow up feedback:

*“I was visiting a family and someone else was there who dropped some information which made me curious. Police were not involved but after a small fact-finding mission regarding the potential CSE risks, police became actively involved. I was able to provide facts which enabled disruption, increased safety of the child and child’s friend who became more confident and protective of her vulnerable friend” (CSE recognising and reporting)*

*“I was working with two girls at the time of the course and had to involve the police regarding online safety as they were posting photos. After the course I was able to look at changing settings to keep them safe” (Online safety)*

We have identified the following priorities for 2018/19

- Ensuring all courses are updated in line with Working Together 2018 and Keeping Children Safe In Education 2018.
- Updating e-learning packages
- Developing webcasts for use in team meetings and with groups
- Ensuring training reflects learning from the most recent local and national serious case and learning/rapid reviews
- Continuing to offer validation to independent trainers and single agencies to support capacity to deliver high quality training across the children’s workforce.

## **Chapter 10. Statutory Safeguarding Audits**

### **Section 11 audits**

Derbyshire and Derby City Safeguarding Children Boards continued to work closely to gain assurance that local agencies are fulfilling their responsibilities to safeguard children and promote their welfare, as required by s11 of the Children Act (2004). A robust annual audit was completed using shared audit templates and a shared approach to assurance visits, including joint visits to providers covering both areas.

Completion of the audits was timely by all agencies involved; those returning a completed audit template were: Chesterfield Royal Hospital, Derbyshire Police, East Midlands Ambulance Service (EMAS), Derbyshire Health United, Derbyshire Community Healthcare Foundation Trust, each of the seven Derbyshire District Councils, Derbyshire County Council Children's Service, National Probation Service (NPS), Community Rehabilitation Company (CRC), Derby Teaching Hospitals NHS Trust, Ripplez (Family Nurse Partnership).

Providers were able to demonstrate robust safeguarding practice in most areas and, where improvements or development was required, demonstrated a clear understanding of the action needed. Progress will be monitored through the quality and performance sub-group and reported to the DSCB.

In light of the publication of the assurance report in relation to the Aston Hall historical sexual abuse investigation, as part of the s11 audit assurance visit each provider was asked, and was able to provide, assurance of measures they have in place to enable children and young people to speak up if they feel they are at risk and professionals to be confident in responding, both directly to children and in reporting issues themselves where necessary.

### **Section 175 audits**

All schools in Derbyshire are expected to undertake an annual safeguarding audit in accordance with s175 of the Education Act (2002) and Keeping Children Safe in Education guidance and to submit the audit along with an action plan. 2017/18 saw a decline in the submission rate by schools, from 239 returns in 2016/17 to 209 returns in 2017/18.

A snapshot analysis of the 2017/18 returns highlights the following strengths:

- Schools have confidence in implementing a comprehensive safeguarding policy & procedures;
- There is a focus on clearer leadership structures for safeguarding alongside the designated safeguarding lead role

- Schools ensure their staff are effectively trained to undertake safeguarding activity within their role;
- Schools report that confidence in tackling on-line safety, cybercrime and on-line grooming continue to increase;

Areas for development for 2018/19 include:

- Engaging with school safeguarding forums to promote the use of, and learning from, safeguarding audits
- Targeted engagement with support centres/Pupil Referral Units to address their safeguarding responsibilities
- Ensuring findings from the audits inform all relevant DSCB action plans, in particular in relation to Children At Risk of Exploitation.
- Ensure training reflects needs identified by schools and is further developed to address any gaps.
- Highlighting the links between s175 auditing and OfSTED requirements.
- Exploring options for an online audit tool to facilitate increased completion of the s175 audit

The education sub-group of the DSCB continues to work with schools to implement actions identified through the audit process and to increase the future completion rate. Where appropriate, the need for completing the s175 audit can be escalated through the involvement of the Education Improvement Service.

## Chapter 11. Child Death Overview Panel

A joint Child Death Overview Panel (CDOP) delivers the statutory child death review function of the Derbyshire and Derby City Safeguarding Children Boards. The overall purpose of the child death review process is to determine whether a death could have been prevented; that is whether there were modifiable factors which may have contributed to the death and where, if action could be taken through national or local interventions, the risk of future death could be reduced.

During 2017/18, CDOP reviewed 73 cases in total, of which 43 were children from Derbyshire. The tables below outline a breakdown of the cases grouped by age, gender and category of death.

Age Group	Number of Cases
0 - 27 days	27
28 - 364 days	8
1 – 4 years	8
5 - 9 years	
10 - 14 years	
<b>Total</b>	<b>43</b>

Category of death	Number of cases
Perinatal/neonatal event	20
Chromosomal, genetic and congenital anomalies	9
Infection	<5
Sudden unexpected, unexplained death	
Malignancy	
No data	
Chronic medical condition	
Known life limiting condition	
Undetermined	
Trauma and other external factors	
<b>Total</b>	43

The majority of deaths related to neonatal cases and the majority occurred within acute hospital settings.

A number of areas of thematic learning were identified during the year as follows:

- Safe sleeping
- Maternal obesity
- Sudden neonatal death in hospital
- Smoking in pregnancy

And follow up activity was undertaken around

- Cosanguinity
- Nappy sacks

Safeguarding issues were identified in 3.6% of the cases reviewed across the year and shared with the DSCB as required.

An example of shared learning between the CDOP and DSCB is around safe sleeping which has been an issue identified in both child death review and serious case review processes. A Safe Sleep Group has been established with the aim of reviewing current safe sleep training and advice and identify the most effective means to reduce the risks around co-sleeping.

Priorities for 2018/19 include:

- A full review of the CDOP in light of Working Together 2018 and revised Child Death Review guidance.

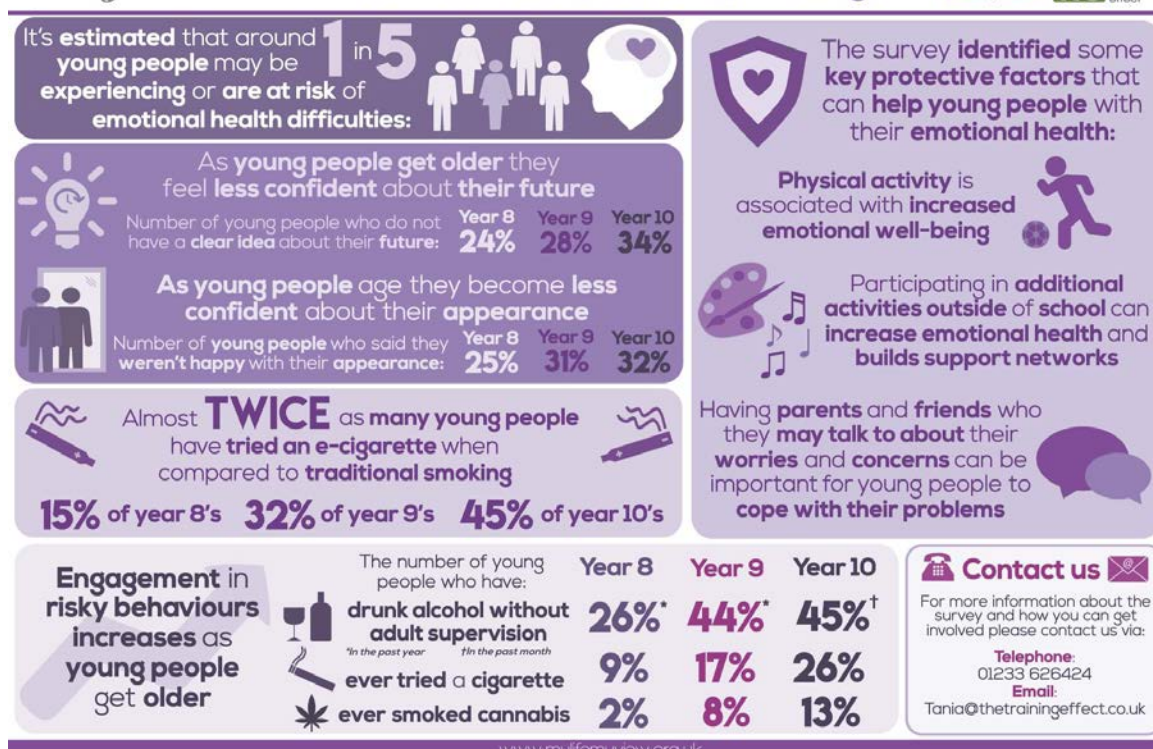
- Ensuring all historical cases are reviewed and implementing processes to ensure timely review of new cases
- Ensuring appropriate information sharing and links to learning between CDOP and Serious Case reviews.
- Conducting quarterly thematic review of cases to highlight common areas of learning.

## **Chapter 12: How children influence decisions made about them**

The partner agencies of the DSCB conducted a number of activities during 2017/18 to capture the voice and experience of children and young people. Examples of the work undertaken are:

- Derbyshire Health United have introduced a new 'app' to enable children and young people to feedback their experience in a familiar and accessible format.
- Derbyshire Healthcare NHS Foundation Trust have developed a young people's reference group to enable young people to participate across a range of organisational activity including recruitment, service development, and policy review, which has been recognised as a national exemplar of good practice
- Derbyshire Community Healthcare Services have redesigned their patient feedback forms in response to comments from young people and will be seeking to involve young people in the redesign of Chesterfield Children's Hospital
- Derbyshire County Council facilitates a regular 'Big Conversation', between the 'Our Voice' (children in care) group and key decision makers, holding senior leaders, including the lead Cabinet member for children, to account for their responsibilities as corporate parents and monitoring how they have responded to issues raised at previous Big Conversation sessions.
- Derbyshire County Council commissioned the 'My Life, My View' emotional well-being survey, which was completed by 3700 young people during 2017/18 academic year (see below).





- Derbyshire Youth Council (DYC) takes an active role in safeguarding activity. During 2017 they contributed to the development of feedback questions for young people following the roll out of Kayleigh's Love Story. The 2018-2020 manifesto for the current DYC, who came into post during March 2018, states 'The DYC will work with their partners to support positive outcomes for children and young people to improve physical, social and emotional well-being and safety'. The Independent Chair of the Safeguarding Children Board has attended Derbyshire Youth Council to speak with young people about their experiences and will be attending future sessions in relation to relevant themes.

Priorities for 2018/19 are:

- Ensuring that the learning from the Aston Hall assurance report ensures that the voices of children and young people are amplified
- Ensuring that children and young people are enabled to participate in child protection conferences in the most suitable way for them, to enable their views to be heard.

- Developing a more co-ordinated approach to participation of children and young people with DSCB activity, taking account of the expertise of individual partner agencies.
- Consulting with children and young people regarding the pending changes to the local safeguarding arrangements and understanding their views on how agencies should work together to safeguard them.

## **Chapter 13 – Future priorities**

During 2017/18, the DSCB reviewed its business plan and agreed the following priority areas for 2018-2021:

1. The prevention of child abuse by ensuring the effectiveness of the child protection processes within Derbyshire, particularly the timely identification of and prompt reduction of risk, by driving forward the recommendations of the 2017 independent review and ensuring impact. Ensuring that services are informed by and responsive to the voice and experiences of children and young people.
2. Ensuring the effective delivery of early help across the partnership including the prompt completion of Early Help Assessments and timely targeted intervention to address neglect and abuse.
3. Ensuring that children and young people are effectively protected from exploitation (including sexual exploitation) and emerging areas of vulnerability and risk e.g. County Lines and technology enabled abuse.
4. Ensuring that effective multi-agency safeguarding arrangements (MASA) are put in place for children and young people, drawing upon and linking with other boards operating across the safeguarding arena. Ensuring that these include robust governance arrangements.
5. Ensuring that an effective response to domestic abuse is achieved by cohesive planning across agencies.
6. Ensuring an effective response to substance misuse by children and young people, reducing the numbers adversely affected.

Underpinning the evaluation of how well the Board operates and delivers against its priorities is information and data on performance, which is reported to the Board at each quarterly meeting. Work is being undertaken in 2018/19 to further improve performance reporting and contributions from all agencies, building on the existing quality of some individual agency reporting mechanisms. This will extend the ability

of the Board to challenge all partners and their collective Safeguarding performance, using a more robust evidence base.



The DSCB also renewed identified the following strategic objectives:

1. To ensure that children in Derbyshire are safeguarded from all forms of abuse and exploitation.
2. Promote, monitor, coordinate and evaluate multi-agency effectiveness in safeguarding children across the child's journey.
3. Strengthen and support a competent and equipped workforce that is committed to learning and developing safeguarding practice.
4. To evidence the effectiveness and impact of the work of the DSCB.
5. Ensuring the wider community is aware and informed of safeguarding issues and equipped to react to these quickly and appropriately.

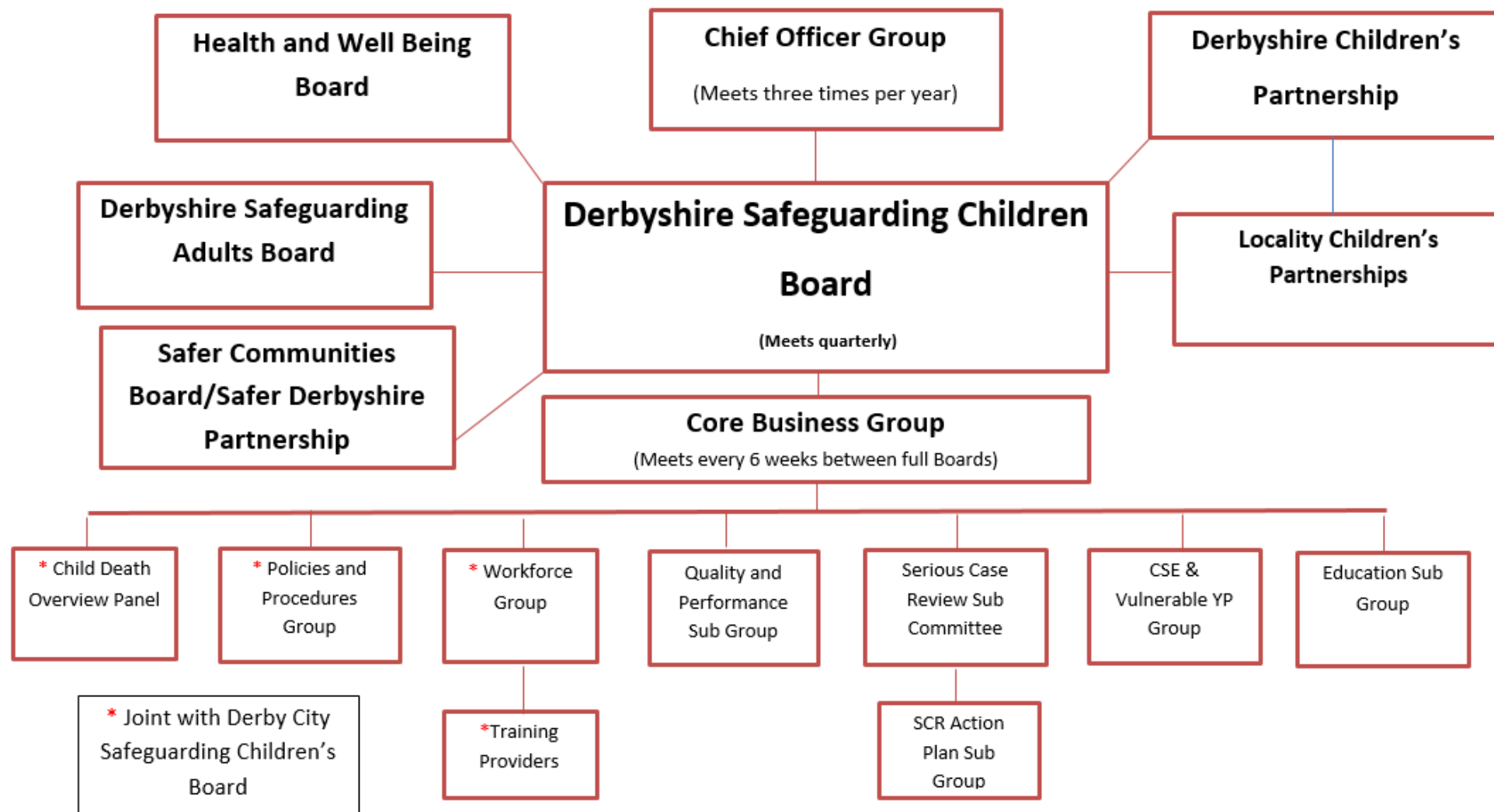
In light of the Wood Review and pending changes within Working Together 2018, during 2017/18, the DSCB and its partners began to develop a plan for the new local multi-agency safeguarding arrangements. A significant priority will be to align more closely with Derby City Safeguarding Board, to develop a robust and effective partnership for the whole geographical area. Work will continue during 2018/19 to ensure that partner agencies are engaged and involved in the development of the new arrangements, with a view to full implementation by September 2019.

## DSCB Membership 2017/18 - Appendix 1

Member	Role
Chris Cook	Independent Chair Derbyshire (April –December 2017)
Steve Atkinson	Independent Chair Derbyshire (March 2018)
Jane Lakin	Interim Board Manager – DSCB
DS Mark Knibbs	Head of Public Protection, Derbyshire Constabulary
Heather Summers	Head of Housing Services - Rykneld Homes
Karen Barden	Acting DCC Children's Services Head of Child Protection
Kathryn Boulton	Service Director, Schools and Learning, Derbyshire County Council
Lynne Greenhough	Headteacher (Secondary Education representative)
Carolyn White	Director of Quality/Chief Nurse, Derbyshire Community Health Services
Jane Parfremment	Strategic Director of Derbyshire Children's Services, Derbyshire County Council
Janice Ward	Service Manager - CAFCASS
Jayne Stringfellow	Chief Nurse and Quality Officer NHS North Derbyshire CCG
Jim Connolly	Chief Nurse, Hardwick CCG
Charlotte Dunkley	Head of National Probation Service Derbyshire LDUs
Grace Strong	Regional Manager, DLNR CRC
Kathy Webster ( Vice Chair of the DSCB)	Consultant/Designated Nurse Safeguarding Children
Natalie Amey	Principal Solicitor, Derbyshire County Council Legal Services
Lynn Woods	Chief Nurse, Southern Derbyshire CCG
Alison Noble	Service Director for Early Help and Safeguarding, Derbyshire Children's Services.
Linda Dale	Acting Service Director, Performance, Quality and Partnerships, Derbyshire County Council
Hazel Chamberlain	Lead Designated Nurse Safeguarding, Tameside and Glossop CCG
Munera Khan	Designated Doctor, Tameside and Glossop CCG
Patricia Field	Designated Doctor for Safeguarding Children Derbyshire

Peter Bainbridge	Derbyshire Representative EMAS
DSCB Membership 2017/18 - Appendix 1 (cont)	
Member	Role
Dave Bond	Head of Youth Offending Service, Derbyshire County Council
Carolyn Green	Director of Nursing and Patient Experience, Derbyshire Healthcare NHS FT
Alex Johnson/ Davinder Johal	Head of Prevention & Inclusion, Derbyshire Fire and Rescue Service
Councillor Alex Dale	Cabinet Member for Young People, Derbyshire County Council
Cathy Winfield	Executive Director of Patient Experience and Chief Nurse, Derby Teaching Hospitals NHS Foundation Trust
Lynn Andrews	Director of Nursing & Patient Care, Chesterfield Royal NHS Foundation Trust
David Peet	Chief Executive, Office of the Derbyshire Police and Crime Commissioner
James Drury	Executive Director of Chesterfield Borough Council
Alison Pritchard	Public Health Consultant, Derbyshire County Council
Jenny Tilson	Executive Director Of Nursing & Quality, Derbyshire Health United
Lay Members	
Miry Gosling	Lay Member
Stephanie Marbrow	Lay Member

**DSCB structure - August 2017**



Derbyshire Safeguarding Children Board  
County Hall  
Matlock  
Derbyshire  
01629 535716

