East Sussex Local Safeguarding Children Board

Annual Report 2018/19

EAST SUSSEX
Local Safeguarding Children Board

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Foreword by Reg Hooke, East Sussex LSCB Independent Chair

Due to changes in legislation, this is the last annual report of the East Sussex Local Safeguarding Children Board (LSCB). It covers the year April 2018 to March 2019. In September 2019 East Sussex will move to new multi-agency safeguarding arrangements under the Children and Social Work Act 2017.

It is testament to the effectiveness and development of the LSCB over the years, and the high standard of multi-agency working and scrutiny across the county that, in practical terms, the new arrangements will be essentially the same as we currently have. Recent inspections of Children's Social Care, Sussex Police, Health and other partners have all commented positively on the value and contribution the LSCB has made to effective working and improving practices to keep children safe.

Through this year of change our primary concern has continued to be the safety of children who are the most vulnerable, and who are most at risk of harm by:

- **Holding organisations to account** at regular Board meetings,
- **Providing vital multi-agency training** to professionals, and
- Improving practices by conducting **targeted reviews and audits**.

This year's priorities have necessarily required work for the transition to new arrangements but we have kept our focus, particularly on child exploitation and safeguarding in schools. Here are just two examples:

- Following a pilot in Hastings **Operation Encompass** is being adopted across the county. This enables, and requires, police to inform schools immediately where a child has been exposed to domestic abuse so that schools can give appropriate support.
- With the support of University of Sussex the LSCB has led a move to a culture and approach of '**contextual safeguarding**'. This is a multi-agency approach to understanding, and responding to, children's experience of significant harm beyond their families. It recognises how the different relationships that children and young people form in their schools, neighbourhoods, and the online world can feature abuse. The partnership will continue to support this valuable development in assessment of risk to children and identification of options to reduce it.

On behalf of the LSCB my thanks go to those practitioners, volunteers and leaders from all agencies in East Sussex who work so tirelessly, and effectively, to make East Sussex a safe place for children to live well and live safely and to the many children who have helped us all learn how best to do that.

1. Key Learning & Achievements 2018/19

- Five multi-agency Rapid Reviews conducted to respond to serious incidents.
- Three serious case reviews initiated.
- New practice guidance for conducting child safeguarding reviews embedded.

- Successful implementation of Operation Encompass pilot with Hastings schools.
- Exploration of 'Contextual Safeguarding' at LSCB Workshop.
- Pan Sussex conference on developing approaches to safeguarding adolescents.
- New record keeping guidance published for schools.
- Annual School Safeguarding conference.

- 1,132 multi-agency staff attended 68 LSCB training courses

- 20 performances of County Lines theatre production shown in Schools, funded by ESCC and supported by Sussex Police and WiSE.
- Continued LSCB support for wider focus on all forms of criminal exploitation.

- Working Together 2018: Planning for new safeguarding arrangements
- Child T Serious Case Review
- Contextual Safeguarding

- Over two-thirds of cases audited rated good or above.
- Need for increased collaboration between different teams when safeguarding electively home educated children.
- Consideration of Support for adolescent males when in refuge.
- Use of fire safety home inspections as way of engaging families

2. Governance Arrangements

2.1 Overview of Board

The East Sussex Local Safeguarding Children Board (LSCB) is made up of senior representatives from organisations in East Sussex involved in protecting or promoting the welfare of children. The key aims of the Board are to: ensure children in East Sussex are protected from harm; coordinate agencies' activity to safeguard and promote the welfare of children; and ensure the effectiveness of agencies' activity to safeguard and promote the welfare of children through monitoring and review.

Further functions of the LSCB are set out in the box below, and a full list of Board members can be found in Appendix 4A.

The LSCB was established in compliance with the Children Act 2004. The work of the LSCB is governed by the statutory guidance Working Together to Safeguard Children. During 2018/19 there has been significant change to the legislation that defines our work. The Children and Social Work Act 2017 created new duties for three key agencies, police, health and the local authority, to lead arrangements locally to safeguard and promote the welfare of children in their area.

In July 2018 the Government published the revised statutory Guidance Working Together to Safeguard Children 2018. The changes include: the replacement of LSCBs with local safeguarding partnerships; a number of changes to conducting serious case reviews; and significant changes to the child death review process.

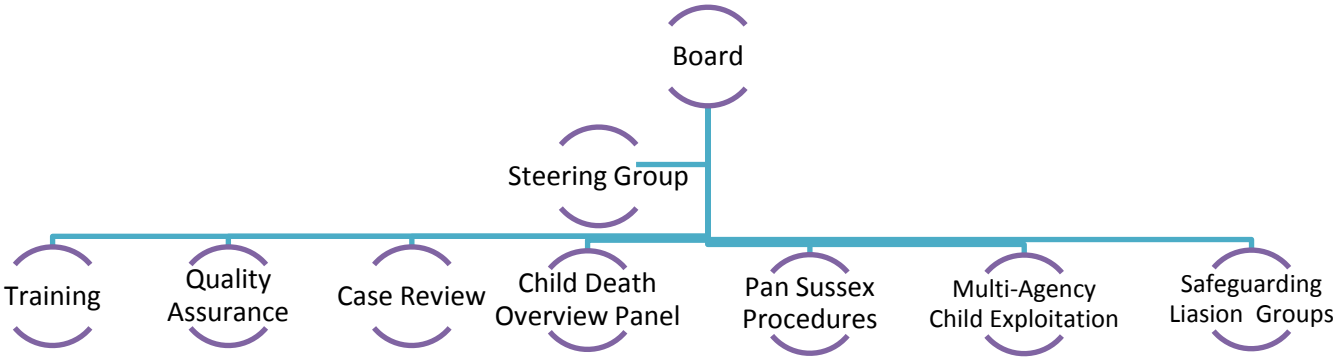
During 2018/19 the LSCB has been working on the transitional arrangements, whilst ensuring that the major functions of the LSCB continue. The Department for Education requires the three key agencies to publish their new arrangement by 29th June 2019, and for it to be implemented by 29th September 2019. The new arrangement is named the **East Sussex Safeguarding Children Partnership (ESSCP)**. Details can be found here: Safeguarding children in East Sussex – East Sussex County Council

Key functions:

- Ensure the coordination of child protection activity in East Sussex
- Evaluate safeguarding activity
- Develop robust policies and procedures
- Coordinate multi-agency training on safeguarding which meets local needs
- Conduct audits and monitor performance of safeguarding activity
- Raise public and professional awareness of safeguarding issues
- Participate in the planning of services for children in East Sussex
- Carry out serious case reviews where abuse or neglect is known or suspected, and there is concern about the way in which agencies worked together
- Ensure that the wishes and feelings of children and young people, and their families, are considered in the delivery of safeguarding services.

2.2 Board Structure and Subgroups

The Board is chaired by an Independent Chair and meets four times a year. The Independent Chair also chairs the LSCB Steering Group which meets four times a year. The main Board is supported by a range of subgroups that are crucial in ensuring that the Board's priorities are delivered. These groups ensure that the Board really makes a difference to local practice and to the outcomes for children. Each subgroup has a clear remit and a transparent mechanism for reporting to the LSCB, and each subgroup's terms of reference and membership are reviewed annually.



2.3 Links to Other Partnerships

The Board has formal links with other strategic partnerships in East Sussex, namely the Health and Wellbeing Board; Adult Safeguarding Board; Safer Communities Partnership; East Sussex County Council's People Scrutiny Committee; Children and Young People's Trust, and the Clinical Commissioning Groups. The commitment to these important links is set out in the Joint Protocol – Partnership Working which was written in 2016/17. This protocol will be reviewed and updated in light of the forthcoming changes to the LSCB, and to reflect changes in partner agencies.

The LSCB Chair also maintains regular liaison with other key strategic leaders, for example, the Police and Crime Commissioner, neighbouring LSCB Chairs and Government inspection bodies.

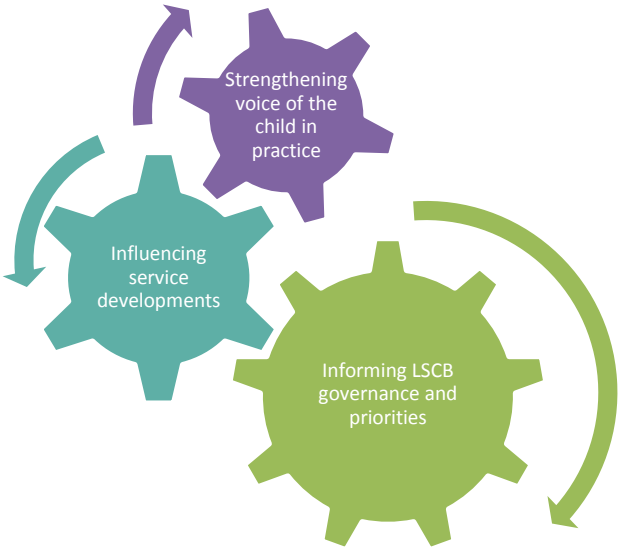
This Annual Report will be received by the East Sussex Health and Wellbeing Board; East Sussex County Council People Scrutiny Committee; the Children and Young People's Trust; the Safeguarding Adults Board, the Safer Communities Board, and other LSCB member organisations' senior management boards. It will also be presented to the Clinical Commissioning Groups, and to the Police and Crime Commissioner.

2.4 Safeguarding Context

The information below is a snapshot summary of the safeguarding context in East Sussex at the end of the performance year in March 2019. A full analysis of multi-agency safeguarding activity and the number of vulnerable children can be found in the accompanying East Sussex LSCB Local Safeguarding Context 2018/19 document.

3. Impact of Board Activity during 2018/19

3.1 Voice of the Child



East Sussex Local Safeguarding Children Board strongly believes that children and young people should have a say when decisions are made which may affect them. We also believe that children and young people should have the means and opportunities to be able to raise issues which are important to them, and ensure they are listened to. By doing so, we believe that this will create a stronger child protection system that is more responsive to the needs of our most vulnerable children.

East Sussex LSCB endeavours to ensure that children and young people are appropriately involved in the governance and decision making of the board. The LSCB also challenges and holds Board members to account on their engagement and involvement of children and young people within their own agencies.

The LSCB has continued to request that all reports presented at the Steering Group or main Board meetings contain a section on the 'voice of the child'. Agencies are required to consider how the voice of the child has impacted on the area of work. These contributions have provided a rich evidence base of how services are responding to children's voices in the day to day delivery of services and in longer term strategic work. For example, the annual MACE update to Board (January 2019) highlighted:

> *"Effective safeguarding for children who go missing and/or are vulnerable to or experiencing criminal exploitation needs to be underpinned by an understanding of the day to day experience for the child at home, in their family, in their school or education setting and in their community. Understanding the barriers to engagement for individual children and ensuring the best chance for the child to be heard, relies on each child having a trusted adult and professionals developing good relationships with children. This is fundamental to our approach."*

Specifically, young people have been involved:

- **In selecting the new LSCB Lay Members** (July 2018). A young person from the Children in Care Council was part of the selection panel and asked a range of questions to the prospective candidates.
- **In the Challenge Panels for both the East Sussex and Pan Sussex Section 11 Challenge Events** Standard 4 of the Section 11 toolkit asks agencies to demonstrate how they listen to children, how services are accessed equally and how information is shared in a 'child friendly' way. Young people were invited to provide additional challenge to agencies around their responses to this standard by asking them questions about how they do this. For example, at the Pan Sussex Challenge Event young people asked "how do you encourage participation?

"we need to break away from the past – because of risks we don't work directly with children; we need to rethink this and engage with wider family."

Sussex Partnership Foundation Trust (SPFT): we have changed clinic opening times acting on YP feedback. "You said, we did" and YP involved in design of services and YP on Board of Governors.

Sussex Community Foundation Trust – we invite YP to sit on interview panel (as YP is a service user). Need to improve work in A&E units and not treat YP as "children" – talk to YP and involve them in their care package. Feedback from YP services users used to change services

Brighton and Sussex University Hospital – regularly seek feedback from young people e.g. into design of new building – windows at different heights and offering appointments to YP in the afternoons.

"How do you encourage participation?"

The LSCB Manager **attended the annual 'Takeover Day'**, in November 2018, involving young people from the CiCC (Children in Care Council), Youth Cabinet, ABLE Group (for children with disabilities), and locality based youth forums, to engage with young people on their views about local services. Young people were particular concerned about support for mental health, specifically in schools. Following the event the LSCB manager wrote to the young people to say their concerns had been raised with the LSCB Chair, to highlight current support to schools, and to ask pupils to challenge their schools on how they are developing their mental health and wellbeing support for pupils, as set out in the East Sussex 'schools mental health guide'

3.2 Lay Members

Lay Members are a critical part of the Board. They act as ambassadors for the community and for the LSCB by building stronger ties between the two, making the work of the LSCB more transparent. The Lay Members also act as a further independent insight on behalf of the public into the work of agencies and of the Board. Lay Members support the work of the Board by:

- Encouraging people living in East Sussex to become involved in child safety issues
- Helping people living in East Sussex to understand the work of the LSCB
- Ensuring that plans and procedures put in place by the LSCB are available to the public
- Assisting the development of links between the LSCB and community groups in East Sussex

In June 2018, the LSCB recruited two new Lay Members to the Board – Graham Cook and Harriet Martin. As well as acting as a critical friend at Board meetings, providing additional

challenge and scrutiny, during 2018/19 the Lay Members have:

- ✓ **Met with young people** from the Eastbourne Youth Forum to consider their priorities (around mental health and emotional wellbeing) for the next Eastbourne Youth Strategy
- ✓ **Attended the Annual Safeguarding in Schools Conference** to hear how schools are strengthening safeguarding practice.
- ✓ **Taken part in practitioner workshops for serious case reviews (SCRs)** to champion the voice of the child and provide independent challenge and scrutiny of agencies.
- ✓ Acted as members of a **challenge panel** at the East Sussex and Pan Sussex Section 11 challenge events, to provide independent challenge and scrutiny.
- ✓ **Taken part in the LSCB's 'deep dive' audit** on fabricated and induced illness and perplexing cases, to champion the voice of the child and provide independent challenge and scrutiny of agencies.
- ✓ **Met with Lay Members from the Adult Safeguarding Board** to share best practice and learning.

Graham Cook:

I became a Lay Member in September 2018 after a senior management career in local government and consultancy. I was excited by the opportunity to make a contribution to the life of my local community…

It has become clear to me that the Board and it working groups are genuinely focused on improving services and acting on the needs of young people. Not an easy task given the pressures of growing demand and diminishing budgets seen across the public sector.

I have witnessed the work of a number of SCR panels and have been impressed by the effort that is made to learn and implement lessons from what are often sad and depressing life stories.

I am looking forward to being able to make a growing contribution to the work of the Board as it moves into a new structure and starts to deliver a new Business Plan.

Harriet Graham:

I have now been a lay member for a year. I have been impressed by everyone's commitment and their very collaborative approach. The LSCB meetings are large and could be daunting but I feel that everyone's views are appreciated. People have been very welcoming to me and the other new lay member and I have had plenty of opportunity to learn about how the services in East Sussex work and to attend different working groups in addition to the main board meetings.

As a lay member I see myself as being someone who is independent and can act as a critical, though often also complimentary, friend, as I do not work for any of the agencies involved in safeguarding. In this sense I think the lay members can act as support for the Chair of the Board who is also independent. I also see myself as a champion for the perspective of the child and a link between the board and the community. These are both things that I would like to continue to develop in the future. As a lay member on the LSCB I hope I am able to contribute to safeguarding children and young people in East Sussex. From a personal perspective the role is interesting and rewarding. My intention is to remain as a lay member for some time yet.

3.3 Quality Assurance

The Quality Assurance (QA) Subgroup is responsible for monitoring and evaluating the effectiveness of the work carried out by Board partners to safeguard and promote the welfare of children, and to give advice on the ways this can be improved. It does this through regular scrutiny of multi-agency performance data and inspection reports, and through an annual programme of thematic and regular case file audits. The group meets six times per year and is made up of representatives from NHS organisations, Sussex Police and East Sussex Children's Services.

What has been achieved during 2018/19:

- ✓ Strengthened the LSCB's Performance Dashboard to include a wider range of multi-agency data and make the impact of multi-agency work and outcomes for vulnerable children clearer to monitor.
- ✓ Ensured that learning from audit work is regularly shared with the Training Subgroup so that learning is reflected in the LSCB's training programme.
- ✓ Increased the number of 'deep dive' audits to provide greater opportunity to identify good practice and barriers/challenges to effective multi-agency working.
- ✓ Continued to produce learning summaries for managers and practitioners on the findings from the subgroup's case file audits. The summaries include key findings, areas of good practice, recommendations made, links to further information, and 'learning for practice' discussion points to take forward in team meetings or group supervision.
- ✓ Successfully collated and analysed 40 agency/team responses to the Section 11 audit on the arrangements agencies have in place to safeguard and promote the welfare of children.

During 2018/19 the QA subgroup held four audits: one regular case file audit, one thematic audit on electively home educated children and two deep dive audits: domestic abuse and fabricated and induced illness and perplexing cases. Of the 13 cases audited, six were graded Good and another two cases were identified as meeting the standard of Good by auditors, but were not graded at the audit meeting; four cases were graded Requires Improvement, and a further case was identified as meeting the standard of Requires Improvement by auditors but was not graded at the audit meeting.

The percentage of cases audited in 2018/19 that were graded 'Good' was 69%. Auditors noted that two of the cases graded Good had 'Outstanding' features. However, the small number of cases audited does not necessarily reflect the overall picture of safeguarding practice in East Sussex, especially as the audits require complex cases to be chosen to enable better learning.

Where cases were graded 'Requires Improvement' there was evidence of very good practice in many of the cases but, there were specific individual gaps in practice. For example: in once case there should have been more work with the family prior to initiation of Child Protection proceedings; in one case auditors found a lack of evidence of engagement by a family to justify a letter of support which one professional provided as part of a child protection process; and in once case there should have been a

S47 enquiry, and later a strategy discussion, when professionals received information regarding incidents involving the child.

In the majority of cases auditors found: improved outcomes for the child; good management oversight; good initial response and an effective response to safeguard the child; professionals looked beyond the immediate situation to identify the wider safeguarding context and risks; good decision making and direct work with the child and family; the voice of the child was carefully considered and reflected in child focused work; good collaboration between different teams working with a child in children's services; and excellent multi-agency working and record keeping.

Spotlight on deep dive audits: Domestic Abuse and FII & Perplexing Cases

The deep dive audits held in November 2018 and March 2019 involved front line practitioners working with the child, and their siblings, coming together and discussing a case. The domestic abuse deep dive audit was held over a whole day with one case discussed in the morning and another case discussed in the afternoon. The fabricated and induced illness & perplexing case audit was held in March and looked at one case.

The cases were not graded using the usual Ofsted based audit tool as the focus of the meeting was to explore the cases in depth with the front line practitioners. However, the approach used here enabled auditors to capture a good understanding of the systemic and environmental challenges to achieving good outcomes for the child. The audits identified substantial evidence of excellent relationship-based practice and improved outcomes for the children. Auditors agreed that on the information available to auditors two of these three cases would have been graded Good, if they had been graded as per the usual audit.

Recommendations made in 2018/19 included:

- ✓ There should be increased collaboration between the different teams involved with a child who is being educated at home, and those helping the child to secure a school place, and a greater clarity for these teams on their distinct roles.
- ✓ The Clinical Commissioning Groups should encourage GPs to attend training covering the issues affecting children who are educated at home. The training for GPs has now been updated to included electively home educated children
- ✓ The LSCB to remind agencies that they can refer in to the East Sussex Fire & Rescue Service for a fire safety home inspection. Professionals working in different agencies were reminded (via team meetings, briefings and QA learning briefing) that they can refer to the East Sussex Fire and Rescue Service for a fire safety home inspection if they are struggling to gain entry to a home and there are safeguarding concerns.
- ✓ Head of Specialist Services to discuss with Sussex Refuge the rationale for refusing entry to any male professional and what steps they can implement to support a child or parent's relationship with male professionals while the family are in the refuge. Sussex Refuge will consider further how to support a child entering the refuge, especially teenage boys, to maintain a stable and continued working relationship with any male professional.
- ✓ Head of Specialist Services to ensure that when commissioning refuge services there is consideration for how adolescent males will be supported at the refuge.
- ✓ Social workers should deliver domestic abuse intervention work. Social workers are delivering domestic abuse interventions informed by the most up to date evidence.

- ✓ Social workers should attend up to date domestic abuse training which addresses different domestic abuse orders and safety planning.

Spotlight on Section 11

Section 11 of the Children Act 2004 places a statutory duty on organisations to make arrangements to safeguard and promote the welfare of children. The Section 11 Audit is a key source of evidence, for agencies and the LSCB, of how well organisations are working to keep children safe.

The Section 11 audit tool was sent out to agencies at the start of April 2018. A total of 22 agencies (40 including individual ESCC teams) returned the Section 11 audit tool. Of the 1830 responses to the 81 standards included in the Section 11 audit tool, 85% were rated Green 'standard met'.

The standards with the most amber/red responses included standards relating to online safety, domestic abuse, consideration of fathers and other males, and safer recruitment.

Since the previous Section 11 audit there had been improvement in 22 measures; mostly in the standards relating to private fostering, Prevent, and harmful traditional practices.

The Local Peer and Pan Sussex Challenge Events – which involved young people and LSCB Lay Members - provided additional scrutiny, identified areas of best practice, and identified areas for LSCB support.

3.4 Serious Case Reviews

The LSCB Case Review Subgroup meets every month and is a well-established multi-agency group which reviews cases and, using the guidance set out in Working Together, makes recommendations to the Independent Chair and Board, about whether a SCR or another type of review is required. Cases considered by the group are referred in by group members, professionals from partner agencies, or are identified by the Child Death Overview Panel.

Working Together to Safeguard Children 2018 (WT2018) made changes to the SCR process. Chapter 4 of WT2018 states that:

"The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy-makers...Reviews should seek to prevent or reduce the risk of recurrence of similar incidents".

From 29 June 2018 local authorities were required to notify the Child Safeguarding Practice Review Panel ("the Panel") of incidents where they know or suspect that a child has been abused or neglected

and the child has died or been seriously harmed. Local authorities will be expected to notify the Panel of any serious incident within five working days of the incident, and safeguarding partners should undertake a rapid review of the case within fifteen working days. The local authority must also notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

The Case Review Subgroup successfully implemented these changes during 2018/19. A total of five rapid reviews were undertaken, following cases being referred to the group. Three SCRs were initiated in 2018/19. Although all three SCRs were ongoing at the end of March 2019, one review, Child T, will be published in June 2019 and will be available on the LSCB website - Child T - Serious Case Review Report.

Rapid Reviews: the aim of the rapid review is to enable safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps they should take next, including whether or not to undertake a child safeguarding practice review
- as soon as the rapid review is complete, the safeguarding partners should send a copy to the Panel [to include] their decision about whether a local child safeguarding practice review is appropriate, or whether they think the case may raise issues which are complex or of national importance such that a national review may be appropriate

During 2018/19 the Case Review Subgroup started to use a new model of conducting SCRs known as SILP – Significant Incident Learning Process - which is provided by Review Consulting.

The SILP model involves the front-line practitioner group - the professional who knew the child and family and worked with them. It explores significant events and focuses on why things happened, rather than reporting on the detail of what happened – this is still covered during the process but is not the focus of the SCR report which means the SCR reports are shorter and more effective at communicating key learning and recommendations.

3.5 Training

East Sussex LSCB provides a thriving and well attended training programme. During 2018/19 the training programme continued to offer a diverse range of courses. All of the forthcoming LSCB training courses can be accessed via the ES Learning Portal - LSCB.

The LSCB Training Subgroup meets quarterly to:

- review and update the training programme
- analyse key data such as the number of courses run, numbers of attendees, and attendees by agency
- analyse data on the course evaluation/feedback from attendees
- plan for LSCB communication including: learning briefings for SCRs and themed audits

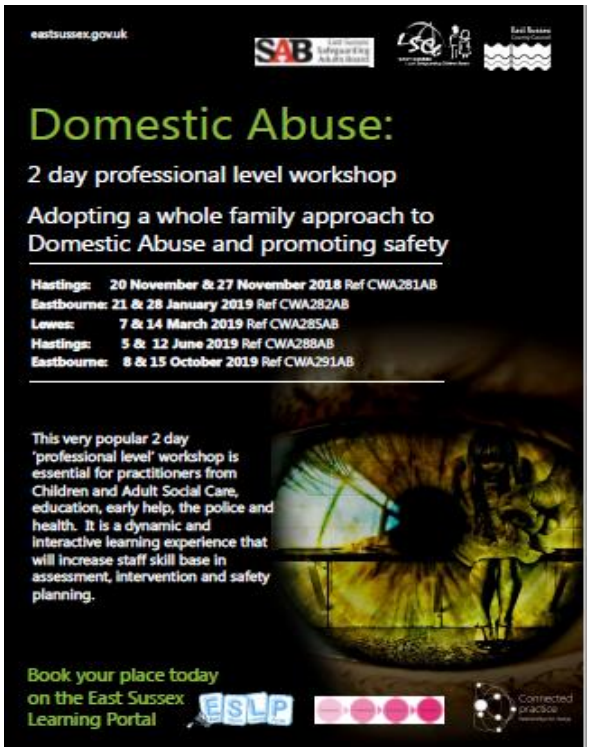
The LSCB training offer is planned and delivered by the LSCB Training Consultant alongside a 'pool' of experienced local practitioners. Only a very small number of external expert trainers are commissioned to provide courses. The training pool, which delivers the majority of LSCB courses, is a valuable resource and mutually beneficial to the training programme and to the practitioners who deliver training as they are able to gain new skills alongside their day to day practice.

To support the training pool, regular development sessions were held during 2018/19; this provided an opportunity to share knowledge and information, look at local and national developments, and ensure that the training pool is thanked for its contributions.

In 2018/19 a total of 68 training courses were delivered; attended by 1,132 participants from a variety of statutory, private and voluntary agencies. During 2018/19 the LSCB ran 16 more courses than the previous year due to jointly commissioning courses with partner agencies such as the Children's Services Training Department, and the Safer East Sussex Team, meaning that more courses are offered on a multi-agency basis.

The courses offered in 2018/19 covered a wide range of subjects, some examples being:

- ✓ **Holding Difficult Conversations with Families - workshop**
- ✓ **Working with Resistance and Disguised Compliance in Child Care**
- ✓ **The Effective Communication of Safeguarding Concerns**
- ✓ **Young People and Substance Misuse – professional level**
- ✓ **Mental Health: impact of adult mental health on children and young people**
- ✓ **Child Criminal and Sexual Exploitation (updated course content to include all forms of exploitation including County Lines)**
- ✓ **Domestic Abuse – professional level**



Training participants are invited to evaluate, and give feedback about, the training they attend. On average around 48% of participants complete the evaluation which is sent to them electronically after the training has taken place. The evaluation returns tell us that training is very well received with the vast majority of participants rating their training as either good or excellent. The evaluation data is carefully considered by the subgroup at each meeting, paying particular attention to any feedback where courses have been rated less positively so that the group can use this information constructively.

Spotlight on Children and Young People Who Display Harmful Sexual Behaviour

During 2018/2019 there were two training courses held on working with children and young people who exhibit problematic and harmful sexual behaviours. 33 people attended this training designed and delivered by colleagues from SWIFT (Specialist Family Services).

The training course includes exploring the links to the growing challenge of children's access to online pornography depicting explicit and often violent sexual images. An article from Research in Practice 2017 states that:

'Currently, professionals are not always clear what is meant by 'online abuse'. They may not realise the full range of technologies that can be used to facilitate sexual abuse. They may also think there is a clear distinction between abuse that happens online and offline, without understanding that the two can be, and often are, entwined. This could mean they do not ask young people about the involvement of technology in abuse, nor offer them appropriate support after having experienced online abuse'

Following the training, 18 of the 33 attendees completed the evaluation/feedback questionnaire about the course and of those: 10 rated the course as 'Excellent', and 8 gave an overall rating as Good. All 18 attendees took time to write comments which gave a good level of feedback about the impact of this training course, including the following:

"Children will benefit from my educated and informed approach and will have better interventions that will more effectively protect them from re-offending"

"I believe I have taken with me, key understanding of what language to use when discussing behaviours and/or disclosures with children, which will best support them through what they are sharing"

" I am currently undertaking protective behaviours work with 3 siblings and this training has improved my knowledge around the behaviours that they have displayed and my interventions"

3.6 Child Death Overview Panel

The Child Death Overview Panel (CDOP) is a statutory function of the East Sussex LSCB. 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 actions could be taken through national or local interventions, the risk of future death could be reduced.

The work of the CDOP

Between April 2018 and March 2019, the CDOP was notified of 25 deaths of children living in East Sussex. The number of children who died has decreased from the previous year when there were 34 deaths notified. During this period, the CDOP met 10 times, reviewing a total of 31 deaths (including some deaths which occurred prior to April 2018). Of these deaths, 9 were deemed to have modifiable factors.

The CDOP is well attended. There is a strong commitment from the Independent Chair and multi-agency panel members to carefully consider the information presented about each child death, as this can make a real difference to keeping children safer by informing future practice. The work of the CDOP continued to be strengthened during 2018/19 by a CDOP coordinator that worked across the three local authority areas of Sussex. This has enabled greater sharing of learning and best practice.

It should be noted that from 29 September 2019 the responsibility for reviewing child deaths will no longer be a function of the LSCB, but of local child death review partners: the local Clinical Commissioning Groups and local authority.

What has been achieved during 2018/19:

- ✓ The work of the **Pan Sussex Suicide Prevention Group** was escalated to the LSCB Steering Group for oversight and action. The LSCB has subsequently requested that it provides multi-agency input in to the CCG re-commissioning of services, and redesign of pathways of support, for vulnerable children following presentation at A&E due to self-harm.
- ✓ Achieved better working relations with the **Learning Disabilities Mortality Review** (LeDeR) Programme. The LeDeR programme was set up to learn from the deaths of all children and adults with a learning disability. By finding out more about why people died, lessons can be learned about what can be changed to make a difference to people's lives.
- ✓ During the last year the East Sussex CDOP, along with members of the West Sussex and Brighton & Hove CDOPs, have worked together to respond to the national changes to review child death as set out in Working Together 2018 and Child Death Review: Statutory and Operational Guidance 2018. As part of this:
    - An agreement was made to purchase a **new Child Death Case Management System (eCDOP**). This is a cloud based system that will streamline the previous management of sensitive information. eCDOP went live in April 2019.
    - Child Death Review (CDR) partners agreed to **establish a pan Sussex CDOP** from October 2019 and developed operational guidance for joint working. It was also agreed to recruit a single Independent Chair for the panel.
    - The CDOPs helped support the design of the child death review process in local hospital settings.

CDOP Recommendations to East Sussex LSCB 2018/19

If, during the process of reviewing a child death, the CDOP identifies an issue that could require a SCR; a matter of concern affecting the safety and welfare of children in the area; or any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area, a specific recommendation is made to the LSCB.

During 2018/2019 the East Sussex CDOP made no recommendations to the LSCBs regarding the need for a SCR, but did make five recommendations to the LSCB regarding matters of concern about the safety and welfare of children, and wider public health concerns. These included:

- **That the LSCB should discuss with the Department for Transport how best to promote better understanding by drivers of their obligations to discuss with health professionals, and disclose to DVLA, when they have health conditions that might preclude them from driving.**

  The LSCB wrote to the Department for Transport, and the ESCC Director Communities, Economy & Transport, to request how best to respond to the issues raised by CDOP. Jesse Norman MP (Minister responsible for the DVLA) responded that the DVLA accepts notifications from third parties and also runs regular campaigns, focusing on a variety of medical conditions, and has developed processes to investigate driver's health.
- **The LSCB should raise with the relevant agencies how best to improve the messages being shared with young people about risk minimisation when drinking alcohol.**

  The East Sussex Alcohol Partnership coordinates the multi-agency alcohol harm reduction strategy for East Sussex. The strategy has three priorities, including: develop individual and collective knowledge, skills and awareness towards alcohol; provide early help, intervention and support for people affected by harmful drinking and; create better and safer socialising. There are a number of work streams that target young people's safe use of alcohol. This information will be shared with the CDOP.

- **That the Board consider what reasons there may be for parents failing to take on board safe sleep advice and Sudden Infant Death Syndrome (SIDS) risk reduction guidance and to take action as appropriate.**
- **The LSCB should request that the agencies commissioning and providing the HV and Midwifery services require Midwives/HVs to see where babies are sleeping as part of their mandated home visits and where unsafe sleeping practices are identified the parents are advised of the risks and provide support.**

  The LSCB has requested assurance from East Sussex Healthcare Trust (ESHT) and ESCC Health Visiting Service that staff see where the baby is sleeping as part of the their home visits.

  ESHT have advised that safe sleeping is discussed with parents on discharge, which is documented in the maternity postnatal notes. Subsequently, all new mothers and new-borns are visited by the community midwife in their own home, on the first day home following discharge from the hospital. The community midwife discusses safe sleep at this visit and asks to see where the baby is sleeping. This is documented in the postnatal hand held notes.

  In the last six months, the **Health Visiting and Children's Centre Service** has delivered safer sleep training to Health Visitors, Community Nursery Nurses and Key Workers. The recording of safer

sleep information has been strengthened to record that HV's have seen day and night time sleeping arrangements, with targeted follow up depending on outcome.

3.7 Pan Sussex Procedures

Child Protection and Safeguarding Procedures Manual

The Pan Sussex Procedures Group reviews, updates and develops safeguarding policies and procedures in response to local and national issues, changes in legislation, practice developments, and learning from serious case reviews and audits. The procedures are a tool for professionals working with children and families across Sussex. The group meets four times a year and has a membership drawn from key agencies across the LSCBs in East Sussex, West Sussex and Brighton & Hove.

Spotlight on Pan Sussex Procedures Conference on Safeguarding Adolescents

Each year the Pan Sussex Procedures Group hosts a conference based on an important area of practice development, local learning arising from serious case reviews, and/or related to reviewed or updated procedures. In 2018 the theme of safeguarding adolescents was chosen, and a conference was held with over 100 delegates attending from a wider range of agencies.

The key themes of this conference included:

- Contextual safeguarding approach to safeguarding adolescents
- Understanding adolescent neglect
- Suicide prevention for young people – equipping our workforce
- Transition from child to adult services

Speakers at the event included: Action for Children, the Children's Society, the National Centre for Suicide Prevention, and the National Working Group for Sexually Exploitation Children and Young People.

3.8 Local Safeguarding Children Liaison Groups

The LSCB facilitates two 'Local Safeguarding Children Liaison Groups' (LSCLG) which cover the East and the West of the county. The group provides a dynamic forum for sharing information (e.g. about thematic service developments or referral pathways), strengthens multi-agency working, disseminates learning, escalates practice issues, and promotes LSCB training courses relevant to topics discussed and group membership.

The group is very popular and is attended by a range of frontline practitioners and managers across partner agencies. In 2018/19 a total of 11 meetings were held.

The group's aims include:

➢ To promote positive working relationships, effective communication, and information sharing between agencies.

➢ To ensure the LSCB priorities and related action plans are implemented and learning from audits and SCRs is disseminated across partner agencies.

➢ To allow a safe forum for professional challenge and case discussion in order to learn, develop and improve practice.

The group invites guest speakers, or speakers from within the group membership, and covers a diverse range of topics. Some of the highlights of the 2018/19 meetings were:

- ✓ Presentation from MYTrust "preparing young people for their future" a charity who work with 15-19 year olds and specialise in employment support, careers guidance and supporting vulnerable young people in the community, particularly if they are not in education or employment.
- ✓ Presentation from East Sussex Young Carers Service who provide support and advice for 5-18 year olds who are young carers e.g. having a role in caring for a parent with physical or mental health problems. This generated a useful discussion about the balance between supporting and safeguarding. An action agreed from the meeting was to circulate the details of the service to schools via the Designated Safeguarding Leads network.
- ✓ Presentation from WiSE (what is sexual exploitation) Boys and Men Campaign, the group heard about the awareness campaign to tackle the exploitation of boys and men, and the support that is available, either on a one to one or group work basis. The service also offers advice to professionals, or to parents and carers.
- ✓ Presentation from a Practice Manager in the Children's Disability Service to update the group on the restructure of the service, and to provide an overview on how the Education, Health and Care Plan (EHCP) system works for children with special educational needs and disabilities.
- ✓ Learning summaries presented from the Pan Sussex Procedures annual conference on adolescent mental health, and from the annual School Safeguarding conference.

Each year the Chair of the LSCLGs invites feedback from group members to ensure the groups remains purposeful and relevant. The feedback received indicated how valued the groups are, and included the following comments:

> *"The LSCLG Subgroup is very helpful for information sharing, networking and in particular learning from SCRs."* **Manager, Education Support, Behaviour & Attendance Service**

> "For me the LSCLG subgroup is invaluable. It provides the only regular opportunity to meet with other agencies and to update on service changes and new ways of working. It is a relaxed meeting where professionals feel able to share their views and experiences. It is, for me a really important networking event". **Named Nurse, East Sussex Healthcare Trust**

> "As an academy we gain a lot by sharing up to date information regarding the support and practices in place with other agencies. This is particularly valuable with regards to Health professionals as it is often hard to ascertain key points of contact otherwise". **Assistant Principal and Designated Safeguarding Lead, Academy School**

> "The LSCLG is particularly valuable to us in that it supports us in promoting our service to partner professionals, enables us to have an overview of what is new in relation to safeguarding across a range of teams and disciplines, and supports our CPD through presentations and visiting speakers, learning which is then cascaded through the Speak Out! Team". **Service Manager, Speak Out! Advocacy, Change, Grow, Live**

3.9 Multi-Agency Child Exploitation Group

The Multi-Agency Child Exploitation (MACE) Group is the strategic planning group for partnership activity to address the sexual and/or criminal exploitation of children, including 'County Lines' and missing children.

The priorities in 2018/19 were:

- Deliver a holistic and effective response to children and young people referred to MACE.
- Raise awareness within the community and deliver preventative education to equip children and young people with the skills they need to make safe and healthy choices and avoid situations which put them at risk of Child Exploitation.
- Develop a 'disruption toolkit' to divert children and young people from being exploited and disrupt those engaging in child exploitation.
- Strengthen and support safeguarding arrangements for transitional 18-25 year olds (with a particular focus on care leavers).
- Oversee the statutory delivery and performance of services to Missing Children.

Key areas of work in 2018/19:

- ✓ The MACE Bronze Operational Group, which reports to the strategic group, delivered a multi-agency response to 66 children; 44 of this number were discharged with risks reduced.

- ✓ The Council's Standards and Learning Effectiveness Service (SLES) have incorporated child sexual exploitation, and criminal exploitation, within the Designated Safeguarding Leads training.

- ✓ Between January and March 2019, SLES commissioned 20 theatre productions from AlterEgo Creative Solutions on 'County Lines' the term used to described how criminal gangs exploit children to sell drugs. The theatre productions were shown to secondary school children to raise awareness around the County Lines model of drug trafficking and child criminal exploitation. The performances were supported by the YMCA WiSE Project.

- ✓ In partnership with Sussex Police, the Safer East Sussex Team held a County Lines awareness event for 50 front line professionals. A speaker from St Giles' Trust gave a presentation to professionals who are directly involved in supervising or spending time with children, so that the warning signs of criminal exploitation could be identified effectively.

- ✓ In September 2018 the SpeakUp Forum, a countywide network for the voluntary and community sector in East Sussex, hosted a one-day conference event focusing on "Safeguarding & Community Safety: The Roles of the Voluntary Sector". This was an opportunity for 137 community organisations to hear a presentation from the Safer East Sussex team about child criminal exploitation.

- ✓ Work started to look at transitional arrangements for 18 – 25 year olds across East Sussex. The MACE Group engaged with the Child Sexual Exploitation National Working Group, using their benchmarking framework to disseminate information to partner agencies with the intention of ascertaining what more each organisation can do to support and safeguard this group of young people. Further work is expected in 2019/20.

- ✓ To promote the voice of the child, the MACE worked with the Principal Social Worker to interview 8 young people who had been subjected to exploitation and received services via the MACE process. The interviews identified many common struggles in the backgrounds and life experiences of the young people, as well as common themes in the feedback about the help and support they received. This led to good suggestions about what agencies can improve to ensure young people take up the support offered.

- ✓ The MACE group provided oversight of children who are reported missing. The responsibility for the completion of the return home interviews, which are an important part of understanding, and intervening with children who go missing, returned to Children's Services in July 2018.

Spotlight on Appropriate Language Toolkit

The LSCB and the MACE group disseminated the child exploitation appropriate language toolkit during 2018/19. The toolkit was produced by The Children's Society, Victim Support, and the NSPCC:

Appropriate Language: Child Sexual and/or Criminal Exploitation – guidance for professionals

"***It is imperative that appropriate terminology is used when discussing children and young people who have been exploited, or are at risk of exploitation. Language implying that the child or young person is complicit in any way, or responsible for the crimes that have happened or may happen to them, must be avoided.***

Language should reflect the presence of coercion and the lack of control young people have in abusive or exploitative situations, and must recognise the severity of the impact exploitation has on the child or young person. Victim-blaming language may reinforce messages from perpetrators around shame and guilt. This in turn may prevent the child or young person from disclosing their abuse, through fear of being blamed by professionals. When victim-blaming language is used amongst professionals, there is a risk of normalising and minimising the child's experience, resulting in a lack of appropriate response".

3.10 Local Authority Designated Officer (LADO)

The LADO responds to allegations made about people who work with children. The statutory guidance Working Together 2018 sets out the requirements for all agencies providing services for children to have procedures in place for reporting and managing allegations against staff and volunteers. The criteria for LADO involvement applies when an individual working or volunteering with children has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates he or she would pose a risk of harm if they work regularly or closely with children.

The work of the LADO and their team is set out in an Annual Report received by the Board annually. The information below is the Executive Summary.

Activity and Demands on the LADO Service 2018-19

Activity and demands on the service have remained high with 1,781 new enquiries received. This includes all contacts classified as non-LADO, where advice was provided and signposted elsewhere. A total of 1,108 were classed as consultations, including 252 potential allegations which had already been dealt with, but were referred to the LADO for a review of the decision making at the end of the process, and those which did not meet threshold. Of the additional 253 contacts received, 205 came from social care teams. There were 673 referrals, requiring additional support and monitoring. In addition to these cases, there were 9 carried over from 2015-2016, and 3 of these remain open because of ongoing police/regulatory body investigations. A further 93 cases from 2017-2018 were unresolved and of these 31 remain open.

What Went Well?

As a result of increasing contact with the LADO over the last three years, a full-time Assistant LADO post was created during 2018. There is also part-time administrative support, which has also had a positive impact on being able to complete tasks and manage workloads more effectively. Positive feedback has been received internally and from other agencies regarding this change. This has been complemented with the development of a bespoke database for recording.

All consultations and referrals were reviewed by a LADO within 24 hours and referred to Single Point Of Advice (SPOA), Multi-agency Safeguarding Hub (MASH), police or other agencies where appropriate. When threshold was not met for LADO involvement, advice, support and guidance was provided to a setting.

Allegations management procedures have been promoted through training, liaison with colleagues in the school safeguarding and Early Years settings. When opportunities arise visits to other agencies have been undertaken to explain the role and the process for consultations and referrals.

What Difference Has It Made?

Each referral is allocated to one of the LADO team who will oversee the case, giving advice and chasing updates until the matter has been concluded. The administrator undertakes the fostering and adoption checks for new applicants in consultation with the LADO, which frees up further capacity for ongoing casework.

The LADO team have worked well with partner agencies including police, education, health, transport and Ofsted, in addition other teams in the organisation and continuing to work on improving links with language schools.

4. Appendices

(4.A) Board Membership 2018/19

NAME	TITLE, ORGANISATION
Reg Hooke (Chair)	Independent East Sussex LSCB Chair
Sally Williams	Manager, East Sussex LSCB
Victoria Jones	Manager, East Sussex LSCB
Graham Cook	Lay Member, East Sussex LSCB
Harriet Martin	Lay Member, East Sussex LSCB
Maxine Nankervis	LSCB Administrator

Allison Cannon	Chief Nurse, NHS Hastings & Rother Clinical Commissioning Group (CCG)
Bethan Haskins	SECAmb
Catherine Scott	Deputy Director for Safeguarding and Transforming Care East Surrey & Sussex CCGs
Debbie Barnes	Designated Nurse Safeguarding Children, East Sussex
Dee Harris	Designated Nurse Safeguarding Children, East Sussex
Domenica Basini	Assistant Director for Safeguarding and Quality, Nursing and Quality Directorate NHS England
Jayne Bruce	Deputy Chief Nurse, Sussex Partnership Foundation Trust (SPFT)
Jeanette Waite	Named Nurse for Safeguarding Children East Sussex
Jessica Britton	Chief Operating Officer, Sussex and East Surrey STP Commissioners
Martin McAngus	Acute Service Manager Coastal / AMHP Sussex Partnership
Naomi Ellis	Head of Safeguarding and Looked After Children, Sussex CCGs
Sue Curties	Head of Safeguarding, (Adults and Children) ESHT
Tracey Ward (Deputy Chair)	Designated Doctor Safeguarding Children, East Sussex
Vikki Carruth	Director of Nursing, ESHT

Andrea Holtham	Service Manager, Sussex CAFCASS
Andrea Saunders	Head of the National Probation Service, Sussex
Carwyn Hughes	Det. Superintendent, Public Protection Command, Sussex Police
David Kemp	Head of Community Safety, East Sussex Fire & Rescue Service
David Satchell	Snr Probation Officer, National Probation Service, Sussex
Debbie Piggott	KSS, CRC – Head of Service, Assessment & Rehabilitation
Lee Whitmore	KSS, Assistant Chief Probation Officer
Till Sanderson	Acting D/Sup Sussex Police

Jerry Lewis	Principal Deputy Head Teacher, Bede's Senior School
Kate Bishop	Rotherfield Primary School
Richard Green	Deputy Head Teacher, Chailey Heritage School
Richard Preece	Executive Head teacher, Torfield & Saxon Mount Federation

Catherine Dooley	Senior Manager, Standards and Learning Effectiveness (5-19), Children's Services
Delyth Shaw	Interim Safeguarding Adults Board Development Manager

Douglas Sinclair	Head of Safeguarding and Quality Assurance, Children's Services
Fraser Cooper	Safeguarding Adult Board Manager
George Kouridis	Head of Service Adult Safeguarding
Justine Armstrong	Safer Communities Manager
Liz Rugg	Assistant Director (Early Help & Social Care), Children's Services
Richard Grout	Legal Services Manager
Stuart Gallimore	Director of Children's Services
Sylvia Tidy	Lead Member for Children and Families
Vicky Finnemore	Head of Specialist Services, Children's Services
Victoria Spencer-Hughes	Consultant in Public Health

Jeremy Leach	Principal Policy Adviser, Wealden District Council
Malcolm Johnston	Executive Director for Resources, Rother District Council
Oliver Jones	Lewes DC + Eastbourne BC, Strategy and Partnerships Lead
Pat Taylor	Strategy & Commissioning Lead for Community & Partnership Lewes DC & Eastbourne BC
Seanne Sweaney	Strategy and Corporate Projects Officer, Lewes DC and Eastbourne BC
Verna Connolly	Head of Personnel and Organisational Development, Hastings Borough Council

Kate Lawrence	Chief Executive Home-Start East Sussex
Micky Richards	Change Grow Live, Director Operations
Rebecca Luton	3VA

(4.B) LSCB Budget

Actual Income & Expenditure 2018/19

Actual Income 2018/19		Actual Expenditure 2018/19	
Sussex Police	£12,500	Independent Chair	£22,206
National Probation Service	£1,434	Business Manager(s) 1.4 FTE	£85,765
Kent, Surrey and Sussex (KSS) CRC	£2,500		
CAFCASS	£550	Administrator	£20,245
CCGs	£39,999	Administration	£1,370
Change Live Grow (CLG)	£750	Child Death Overview Panel (CDOP)	
East Sussex County Council (ESCC)	£165,500	Trainer	
Training Income	£14,750	Training Programme and Conferences	£10,474
		Projects	£15,285
		Pan Sussex Procedures	£2,030
Brighton & Hove CC contribution for CDOP	£12,500	IT Software & Hardware	£1,130
		Serious Case Reviews	£6,946
LSCB brought forward from 17/18	£45,278	Carry forward	£49,698
Total	**£295,761**		**£295,761**

Projected Income and Expenditure 2019/20* (for remainder of LSCB 01.04.19 to 30.09.19)

Projected Income 2019/2020		Projected Expenditure 2019/2020	
Sussex Police	£6,250	Independent Chair	£11,100
National Probation Service	£717	Business Manager(s) 1.4 FTE	£42,900
Kent, Surrey and Sussex (KSS) CRC	£1,250		
CAFCASS	£275	Administrator	£10,100
CCGs	£20,000	Administration	£700
Change Live Grow (CLG)	£375	Child Death Overview Panel	£13,900
East Sussex County Council (ESCC)	£79,200	Trainer	£26,400
Training Income	£7,375	Training Programme and Conferences	£5,000
Brighton & Hove CC contribution for CDOP	£6,250	Projects	£7,600
		Pan Sussex Procedures	£1,000
LSCB brought forward from 18/19	£49,698	IT Software & Hardware	£600
		Serious Case Reviews	£52,090
Total	**£171,390**		**£171,390**

(4.C) Links to other documents

East Sussex Health and Wellbeing Strategy (2016-19)

This strategy is a framework for the commissioning of health and wellbeing services in the County. The Health and Wellbeing Board will consider relevant commissioning strategies to ensure that they have taken into account the priorities and approaches set out in the Health and Wellbeing Strategy.

The main priority is to protect and improve health and wellbeing and reduce health inequalities in East Sussex, to enable us to do this over the next three years the strategy will focus on: Accountable care; Improving access to services; Bringing together health and social care; Improving emergency and urgent care; Improving health and wellbeing; Improving mental health care; Improving primary care; Better use of medicines; Better community services.

Sussex Police and Crime Commissioner – Police and Crime Plan 2017-21

The Commissioner has identified the following four policing and crime objectives:

- Strengthen local policing
- Work with local communities and partners to keep Sussex safe
- Protect our vulnerable and help victims cope and recover from crime and abuse
- Improve access to justice for victims and witnesses

East Sussex Safer Communities Partnerships' Business Plan (2017-2020)

The East Sussex Safer Communities Partnership undertakes a strategic assessment of community safety every three years with an annual refresh in order to select work streams and plan activity for the year ahead.

Colleagues from the LSCB and ESCC Children's Services work closely with the Safer Communities Partnership to respond to the broader threat of exploitation. Sustaining existing work within the partnership and developing new and existing relationships with partners is of particular importance to ensure that we are supporting vulnerable individuals within the community and helping them feel safe and confident in their everyday lives.

East Sussex Safeguarding Adult Board Strategy 2018-21

The LSCB works closely with the SAB on the overlapping themes of Modern Slavery, Domestic Abuse, and Cuckooing. The two boards are also collaborating on a needs analysis for the cohort of 18-25 year olds who may be at risk of exploitation to identify any current gaps in service provision