Coventry Safeguarding Children Board

Annual Report 2012 - 2013

Business Plan 2013 – 2015

Contents

1. Introduction from the Independent Chair

LSCB Annual Report on the Effectiveness of Safeguarding Children in Coventry

Nationally, there has been considerable public interest in child protection this year. For most of us, it is hard to understand or believe how anyone can inflict pain and suffering on defenceless children so this interest is to be expected. The child sexual exploitation cases in several parts of the country raised serious concerns about whether safeguarding systems in those areas had been effective.

NSPCC data shows that the rate of child homicide has reduced by 30% since 1981 and since 1980 63% fewer children have died as a result of assault. However, the rate of child maltreatment and levels of abuse being identified and acted upon is increasing. There are increasing numbers of court proceedings being initiated to protect children which shows that effective action is being taken across the country to protect more children who have been abused or neglected. Locally in Coventry, there is a rising rate of child maltreatment being identified in line with this national trend.

The Government issued new guidance on child protection this year. The Department for Education published *Working Together to Safeguard Children 2013,* which replaces the previous edition and acts as revised statutory guidance on safeguarding and promoting the welfare of children and young people. It covers the legislative requirements and expectations for all agencies and professionals. The NHS Commissioning Board also published *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework* which builds on Working Together and provides more detailed advice on how NHS organisations can fulfil their responsibilities. This should be read by all health professionals in conjunction with the statutory guidance.

Our Board has recognised and has continued to develop new strategies to meet our growing understanding of potential and new risks to children and young people. In particular, we have carried out local research and identified additional services required to improve the local response to child sexual exploitation.

The last year has been a very challenging one for the Safeguarding Children Board in Coventry. There has been a great deal of positive work to protect children and young people in the City following the national trend of increased activity. However, there have also been several serious case reviews undertaken following child deaths. The murder of 4 year old Daniel Pelka has, in particular, drawn considerable local and national media attention. The LSCB is leading the work to ensure that local agencies and professionals learn from these cases. We have successfully piloted new ways of undertaking SCRs with the support of DfE.

A Peer Review took place in March 2013 and the LSCB was given a positive rating. It was said to be providing "purposeful leadership" for safeguarding in Coventry and Board members were described as showing a strong positive commitment to the work of the LSCB. SCRs were said to be well managed with key learning being disseminated and progress on plans being effectively tracked.

We have agreed the LSCB priorities for next year. We are committed to continue to focus on challenging and supporting all the local agencies to ensure that the most vulnerable children in the City receive the protection and services that they need. Where there are

identified areas for improvement through our regular reviews and case audits, the LSCB is committed to challenge and require improvement.

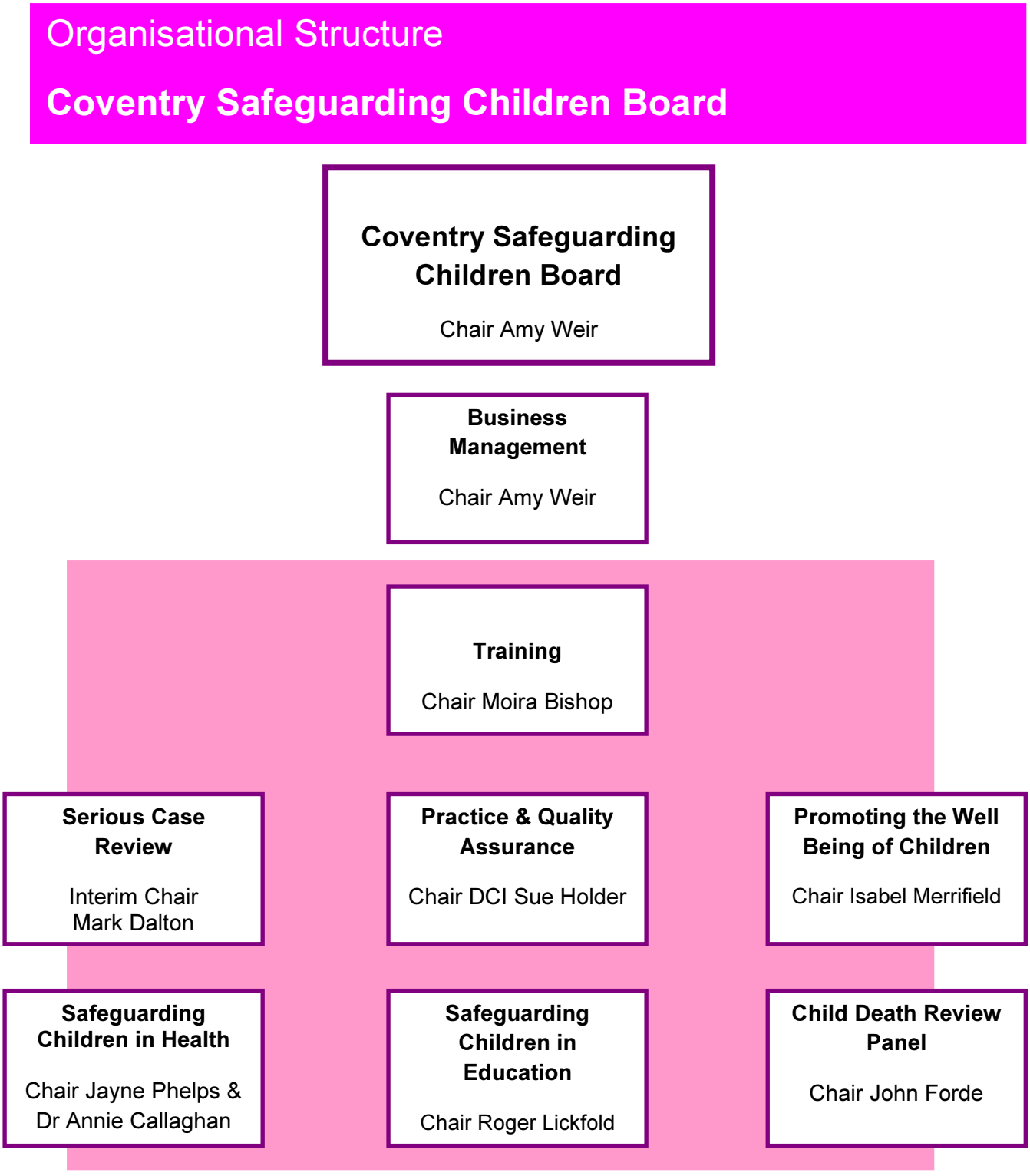
I want to thank all those in the City who are working hard to keep children safe and all the members of the LSCB for their commitment to improving safeguarding in Coventry.

Amy Weir

Independent Chair

Coventry LSCB

2. Structure chart



3. Membership of Coventry Safeguarding Children Board (at March 2013)

Amy Weir
Independent Chair

Jacqueline Barnes
Vice Chair, Executive Nurse, Coventry & Rugby Clinical Commissioning Group

Colin Green*
Director of Children, Learning & Young People (CLYP) Directorate

CS Andrew Nicholson
Chief Superintendent, West Midlands Police

Carmel McCalmont
Associate Director of Nursing, Children Safeguarding, University Hospital Coventry & Warwickshire, NHS Trust

Tracey Wrench
Director of Quality, Safety & Training, Coventry and Warwickshire Partnership Trust

Jayne Phelps
Designated Nurse, Child Protection, Coventry & Rugby Clinical Commissioning Group

Dr. Ann Callaghan
Designated Doctor, Child Protection Coventry and Rugby Clinical Commissioning Group

Moira Bishop
Named Nurse, Child Protection, Coventry and Warwickshire Partnership Trust

DCI Susan Holder*
Public Protection Unit. West Midlands Police

Kobina Hall
Head of Probation Service, Coventry, Staffordshire & West Midlands Probation Service

Cllr. George Duggins
Cabinet Member, Children & Young People

Cllr. David Kershaw
Cabinet Member, Education

Cllr. Faye Abbott
Member Services, Coventry City Council/Scrutiny Board 2

Mark Dalton
Interim Chair of Serious Case Reviews Subgroup, Independent

Julie Newman
Legal Advisor to the Board, Legal and Democratic Services, Coventry City Council

Andy Pepper
Assistant Director Children's Neighbourhood Services, CLYP Directorate

Isabel Merrifield
Assistant Director, Strategy, Commissioning & Policy, CLYP, Coventry City Council

Roger Lickfold
Strategic Lead, Inclusion Special Education Needs and Participation

Jivan Sembi*
Head of Safeguarding Children Service, CLYP Directorate, Coventry City Council

Hardeep Walker
Business Manager, Coventry Safeguarding Children Board

Mandie Watson
Community Safety Manager, Community Safety Partnership

Andrea Simmonds
Local Area Liaison Officer, West Midlands Fire Service

Kam Sidhu
Head of Tenancy Support, Whitefriars Housing Group

Rama Ramakrishnan*
Service Manager, NSPCC Coventry

Sue Doheny
Interim Director of Nursing, Area Team – Arden, Herefordshire and Worcestershire, NHS England

Liz Elgar
Head of Service, CAFCASS

Helen Hipkiss
Assistant Director of Patient Experience Area Team – Arden, Herefordshire and Worcestershire, NHS England

Steve Stewart
Executive Director, Connexions

Mandeep Bassi
Lay Member

John Forde
Consultant, Public Health

Susan Harrison
Head of Safeguarding Adults Service, Coventry City Council

* indicates members who have left the Board subsequent to March 2013

4. Progress on Key Priorities for the Board in 2012/13

The identified priorities for the 12/13 year were:

- Monitor the development of Early Help Services for children, young people and their families
- Getting out of and combating child sexual exploitation
- To monitor the further development of multi-agency services to prevent domestic abuse and support children and their families
- Develop an engagement policy and programme with young people
- Review the Coventry Safeguarding Children Board's performance framework to enable the Board to monitor the effectiveness of current services with a view to shaping priorities for the future.

  Progress has been made on these as outlined in the Business Plan 2012-15. Progress is summarised below.

Monitor the development of Early Help Services

The LSCB agreed revised CAF procedures (including details of step up and step down processes) in the autumn of 2012. These have been communicated across agencies and with the increase in the numbers of CAF coordinators there is potential for improvements in this area. The challenge is the monitoring of the impact of early help and and early intervention.
This work has fallen to the Promoting Children and Young People's Well-Being Board (a subgroup report can be found on page 20). The Board has heard about the setting up of an Early Help Hub bringing together CAF coordinators and Social Workers from the Referral and Assessment service to ensure new referrals and contacts are past to the right team for support. The Board will continue to monitor the impact of this service and are currently working to develop a CAF dashboard and CAF case studies to assist in understanding activity levels and also cases where CAF intervention can be effective.

Members of the PCYWB Board also contributed to the development of a multi-agency Prevention & Early Intervention Strategy for the City. This strategy will be signed off during the 13/14 year. This strategy includes an outcomes framework and performance indicators which will support the effective monitoring of early help services over the coming years.

Getting out of and combating child sexual exploitation

A focus group of the LSCB was set up in February 2012. Membership is made up of statutory and third sector agencies. The group has met regularly and progressed a number of key areas of work. There has been considerable success in raising the profile and general awareness of CSE amongst professionals and young people.

There has been an increase in identified cases of CSE across the City by agencies and this is seen as evidence that the message is getting across and thus young people are being better safeguarded.

The full detail of activities carried out by the CSE focus group is included in the subgroup section of this report. (page 22)

Monitor the further development of multi-agency services to prevent domestic abuse and support children and their families

A pilot commenced in December 2011 to send domestic abuse notifications to schools for their awareness and action in relation to the child attending their school. This has proven to be successful and the following information was reported to the LSCB:

- The case studies show that as a result of school acknowledgement of domestic violence pupils achieve positive outcomes in academic performance in the short term as well as attendance due to support for their well-being and school performance.
- The case studies show a high level of support given by the school whether through direct support or through contact via other agencies (e.g. through CAF).
- The pilot allows for further contact and communication with the relevant agencies as well as allowing a full picture of the child from a range of professional perspectives.
- The process of acknowledging domestic violence incidents allows for a more strategic overview by schools of families, drawing relevant agencies together to minimise risk and ensuring areas of concern are recognised through pastoral support as well as learning support.
- There is scope for the CAF process to grow and be capitalised on to help support schools and advising families on a range of issues that would not have otherwise been picked up.
- CAF coordinators are now involved with the process to help identify with schools those families that would benefit through support from the CAF process through initial data analysis.
- With the involvement of key agencies, the pilot has shown that overall risk can be reduced resulting in a more stable home environment which translates into better emotional well-being at school.

In November 2012 funding was successfully secured for this work to be rolled out across all schools in Coventry.

As a response to the Serious Case Review of Daniel Pelka, a review of the joint screening process and notifications of domestic violence incidents between partner agencies commenced towards the end of this year, the focus of this work is to review the following aspects:

- the timeliness of notifications,
- distribution to the information
- the degree of focus on the needs and safety of the children, and
- the holistic response to repeat domestic abuse incidents

This work identified a number of areas requiring further work and activity to be undertake, this is an area of ongoing work to ensure there is a robust joint screening process and response by agencies.

Develop an engagement policy and programme with young people

This work is scheduled in our Business Plan to be achieved during the 13-14 year and a full report will be provided in next year's Annual Report.

Engagement activity has commenced in relation to Child Sexual Exploitation where lesson plans have been developed with young people to support their awareness of this issue. Further plans are in place to consult with young people about their preparation and involvement in Child protection conferences and how this can be enhanced.

Review the Coventry Safeguarding Children Board's performance framework to enable the Board to monitor the effectiveness of current services with a view to shaping priorities for the future.

The Performance Framework was reviewed in the autumn of 2012. The number of indicators was reduced and a schedule of regular reporting to LSCB meetings was created. The revised Performance Framework can be seen on our website. Indicators have been reported to the Board in line with the schedule during the year

5. Overview of Subgroups

A range of subgroups sit under the LSCB, undertaking and overseeing work streams of the Board with members representing the breadth of agencies working with children and young people.

Business Management

Chaired by the Independent Chair of the Safeguarding Children Board and involving chairs of subgroups, the LSCB Business Manager and the Interagency Training Officer. Its main purpose is to ensure that the progress against the business plan is monitored and achieved, the meetings assist the Chairs of the subgroups to identify cross cutting issues and themes across the activity, identifying the key issues for consideration by the Board as well as to making decisions and reporting these to the Board.

Practice and Quality Assurance

Chaired by the Detective Chief Inspector, Public Protection Unit, West Midlands Police. This subgroup is responsible for receiving and acting on comments or complaints from families or LSCB agency staff, arising from child protection enquires/conferences. It undertakes and commissions' audits in respect of inter-agency child protection services, by agency request and LSCB agreement, evaluating how well agencies work together to protect children. Audits are undertaken with the aim of enhancing, and where necessary seeking to improve interagency working to safeguard children. The subgroup also advises on and agrees local policies and procedures for interagency work to protect children within the framework provided by 'Working Together to Safeguard Children' (2010).

Training Strategy

Chaired by the Lead Professional for Safeguarding Children in University Hospital Coventry and Warwickshire up to December 2012, and after this by the Named Nurse Child Protection, Coventry and Warwickshire Partnership Trust. The subgroup is responsible for providing a comprehensive interagency training programme covering child protection and safeguarding and promoting the welfare of children and young people in response to local training needs. This group is responsible for monitoring the quality of safeguarding training delivered to member agencies and ensuring that all staff requiring access to training are being reached. Objectives also include providing multi-agency training in response to recommendations following serious case reviews.

Serious Case Review

Chaired by an independent consultant social worker, the subgroup has the responsibility for considering cases and recommending to the chair of the LSCB when the criteria for a serious case review is met. It also manages the process of conducting the review, ensuring that the review is of good quality and that it is concluded within agreed deadlines. Following the publication of the latest version of Working Together 2013 the subgroup will also take the lead in recommending the methodology and type of review to be undertaken. On the completion of a review the subgroup, on behalf of the LSCB, monitors the action plan and ensures that agencies produce evidence that they are responding to the findings and changing practice where necessary. Members of the subgroup and are also involved in training and dissemination events following the completion of a review.

Promoting Children and Young People's Wellbeing (CAF)

Chaired by the Assistant Director of Strategy, Commissioning and Policy, this group focuses on the Early Help offer and the use of the Common Assessment Framework (CAF)

across Coventry. Its aim is to promote effective multi agency working and information sharing, in relation to identifying earlier and more effective multi agency support to families, thereby reducing the need for child protection intervention. It is responsible for training professionals to use an agreed early intervention model across agencies.

Safeguarding in Education

Chaired by the Head of the Special Education Needs Service, it is responsible for overseeing how safeguarding issues impact on schools and educational establishments within the City ensuring that that there is the widest possible dissemination of information and communication. This group ensures that education services in the widest sense are aware of their responsibilities in respect of safeguarding and child protection. This group ensures that open and clear communication is maintained between the Safeguarding Children Board and the whole of the Education Service.

Safeguarding Children in Health

Co-chaired by the Designated nurse and Designated doctor for Child Protection of Coventry and Rugby Clinical commissioning group (CRCCG), the subgroup includes core members from all health providers. Membership is also open to all health services that are commissioned from outside the CCG and other professional groups. It is accepted that there will be further transient membership in relation to specific pieces of work as commissioning arrangements within health change.

The function of the health subgroup is to ensure that all health providers across Coventry engage in supporting the health elements of the LSCB priorities and to assure the LSCB of the appropriate and timely delivery of the safeguarding agenda across health services within Coventry. The health subgroup has a specific remit to ensure effective arrangements are in place to effect multi agency working between health and other agencies and to escalate issues to the board for action. The focus of the health subgroup has been widened to include safeguarding and looked after children's elements relating to health in recognition of the continuum of involvement through a child's journey within the health services and the variety of safeguarding issues that arise within health.

Child Death Review Panel

Chaired by a Consultant in Public Health; members are responsible for ensuring effective communication and coordination in the event of an unexpected child death in Coventry in line with the agreed Rapid Response procedure. Members are also required to analyse and review all Coventry resident child deaths (0 to 18 years) to identify learning and disseminate findings. An Annual Report of activity is provided to the LSCB.

6. Progress made by Subgroups

Practice and Quality Assurance Subgroup
Chair DCI Sue Holder, Public Protection Unit, West Midlands Police

Procedures

Interagency procedure and guidance for safeguarding children are continually being updated. This year's activity includes:-

- Consultation and feedback to Government into the new Working Together 2013. Review of current procedures against new WT 2013

- Child Sexual Exploitation Procedures
- Children Missing from Education
- Gang Activity Procedure
- Serious Case Review procedure and toolkit
- Common Assessment Framework
- Children's social care threshold and practice standards
- Working with resistant and non-compliant families
- Safeguarding concerns for unborn children

Audits

The sub-group has commissioned a number of audits on behalf of the LSCB to check that children are being effectively safeguarded. Much of the audit activity has been driven by the Serious Case Review Action Plan in respect of the learning from the death of Daniel Pelka:-

- An Audit was undertaken by Community Health Services and Children's Social Care separately to examine the response to domestic abuse notifications and risk assessments undertaken in respect of children living within domestic abuse households. This was undertaken to determine that the protection needs of the children are being fully addressed by such responses. This was in response to the Joint Screening Process and ensuring that the processes that are employed now are effective. Each agency carried out an audit. 80% of health visitors of school nursing service received the notification. All children that were assessed as Level 4(most serious), the school nursing were involved in contributing to the initial or core assessments. Limitation to the health audit was the notifications to general practitioners. At the time of the audit the GPs did not receive them but this is currently being addressed. In respect of managing data, school nursing suggested that electronic information transfer would be beneficial. This would release professionals for clinical time. In respect of the audit conducted by social care, all level 4 notifications had proceeded to a social care referral, strategy meetings were held and MARAC processes considered. For lower level notifications, there was evidence that initial assessments were not completed within timescales.

- An audit was undertaken in response to actions in the Daniel Pelka action plan. The reviewers used a cohort of 10 cases from a larger cohort that had required a child protection medical and looked at each action separately.
  a) An audit into Initial and Core Assessments was undertaken by children's social care in order to determine to what extent other agencies are being fully involved and consulted as part of the completion of such assessments. 90% of cases (9/10) the initial and cores assessment undertaken included assessments from partner agencies.
  b) The purpose of this audit was to find test out whether strategy meetings/discussions are being efficiently recorded with actions clearly identified for individual agencies or professionals to undertake. It was also to check that the record of listed actions was distributed to the relevant agencies as soon as possible after the meeting. In 2 of the 8 cases there was no evidence that the strategy meeting/discussions minutes were distributed. There were 2 cases where strategy meetings had not happened. Reviewers determined that one was appropriate that a meeting had not taken place, but that the other should have had a strategy meeting. These findings were followed up by the Head of Safeguarding and appropriate actions were taken. Further audit activity will be undertaken during 2013-14 to ensure progress in this area.

c) This audit looked at cases where a strategy meeting/discussion took place when medical opinion was unclear regarding whether injury was accidental or non-accidentally caused. The requirement is that follow up actions with the family must continue to include the child protection concerns as factors and these must continue to be addressed until any new information discounts them. It was evident in 90% of all cases there was on going consideration of the child that the follow up interventions with the family continued to include child protection concerns as factors and addressed these rigorously until any new information or assessments discounted them. It was also considered that the inclusion of a body map from the medical professional should in future enhance social workers understanding of the impact and severity of the injuries.

- Audit into cases of neglect. This focused on 31 cases (15 pre-birth and16 pre-school) on those cases where children who are subject to Child Protection plans under the category of neglect to understand the how effective processes were. The action plan arising from the audit will inform services who work with cases of neglect and enhance practice for the future. There was consistent evidence across the cohort that the threshold for a child protection plan was met at conference. These decisions all appear to be unanimous from the records. However, there was a consistent delay in appending Initial Child Protection conference minutes to the case files, sometimes over many months. There was a practice of repeat strategy meetings which may delay in convening Initial Child Protection conferences. This is being looked at and action is planned to address this. The audit found that the majority of child protection plans were robust and changed to meet developing circumstances, but there was evidence of slow implementation in a minority of cases. Most cases files had evidence of management oversight although only a few had supervision records appended to the record. The LSCB will be looking again in the coming year at the recording of supervision.

- Thematic audit that looked at the effectiveness of Common Assessment Framework process. This audit was carried out before the re-writing of the CAF procedures and recruitment of 6 CAF Co-ordinators. This audit looked at the information recorded and found that in the 6 cases audited this was good. There was evidence also of previous involvement and history having been recorded. Relevant agencies were involved in the CAF process. Only in one case was there a delay in allocation. This was because of a difference of opinion between the CAF leader who thought that the case should be stepped up and social care who did not agree it met the threshold. This led to a recommendation and action about an improved escalation policy. The assessments undertaken were found to be thorough. There was good evidence in 6 cases of the child being involved in the assessments and their wishes and feelings being listened to. There was also evidence of separate child files when siblings were present in the family, considering each child's individual needs. In respect of safeguarding, protection and life chances, there was evidence that complex needs were identified and responded to. Needs and risks were assessed appropriately. 6 cases had evidence of effective management oversight.

- Multi-agency audit of a Primary School. The audit was carried out in two parts. The school's processes and procedures were scrutinised and then also a case study model was undertaken. The school carried out its own safeguarding audit in March 2012 and this was reviewed as part of the multi-agency audit in April 2012. This to ensure that the schools safeguarding processes are embedded into all aspects of the running of the

school. The audit found that the school spent a lot of money on safeguarding and safeguarding has a high priority. Temporary staff are made aware of safeguarding issues. In respect of the two case studies, the schools recording systems were extremely robust.

Serious Case Review Subgroup
Independent Chair: Mark Dalton NSPCC

The statutory basis for Serious Case Reviews is fully explained in Working Together 2013; it describes the criteria for undertaking a review and guidance on the process. This is an important document for the sub-group and clearly states:

"Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCB's and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children." (WT. 2013 p66)

During the last 12 months the workload of the serious case review subgroup has been dominated by the demands of managing three new serious case reviews and overseeing and monitoring the action plan for one which reported the previous year. In terms of our responsibility it is important that we focus on thematic and systemic lessons as well as ensuring there has been an objective analysis of the practice in any particular case.

A re-occurring issue for a number of years has been the number of babies and infants who have died as a result of bed sharing or sleeping with their parents. We know that there are effective systems in place for warning new parents of the dangers of this practice yet the number of avoidable deaths remains stubbornly high. During the last year another co-sleeping death was the subject of a serious case review. The case very closely reflected some of the issues that had come to light in one of the reviews undertaken in the previous year. Clearly this is a concern not just for professional agencies, but for a wider public health debate and the need to raise awareness amongst schoolchildren, grandparents and the community at large as well as targeting parents.

We have also overseen the high profile case involving extensive deliberate cruelty and the eventual murder of four year old Daniel Pelka. The case has attracted national interest The review has been complex and both intellectually and emotionally demanding for the review team. During the trial of the child's mother and partner further details relevant to the analysis of practice came to light through the evidence presented to the court. The need to analyse and incorporate this information into the review delayed final publication for a short period. However it was clearly of paramount importance that the report dealt with all the known facts. This type of case inevitably leads to an upsurge in referrals and increasing demands for training and support for front-line professionals. The serious case review sub-group will work with the training and quality assurance sub-groups to disseminate the learning from this case.

A noticeable trend in the findings and recommendations of serious case reviews has been a shift in emphasis from recommending more rule and procedures actions (which often have the unintended consequence of making cooperation across agencies more difficult) to more systemic recommendations which focus on the blocks to good practice i.e. what prevents well intentioned and committed people from working effectively together to protect children.

Managing the LSCB's response to serious case reviews is the primary purpose of this subgroup. We have considered the circumstances surrounding the deaths or serious injuries of nine individual children during this 12 month period. Members of the subgroup have contributed to the domestic homicide review undertaken on a young woman from Coventry who was killed in Kent by her ex-partner. Again our involvement across a number of cases has highlighted the significance of recognising and assessing domestic violence is a key issue in keeping children safe.

With all this activity, it is important that the subgroup does not lose sight of its overarching responsibility to ensure that clear findings are identified and that practice is improved as a direct result of the reviews which are undertaken. It is clear that training opportunities and other recognised methods of improving the quality of service - such as mentoring and case sharing - are being increasingly constrained in the current climate of high demand and no additional resources. This is in the context of increasing workloads across the agencies represented on the LSCB. We include the learning from serious case reviews in on-going training and thus raise the awareness of managers and supervisors as well as providing stand-alone briefings**.**

Training Strategy Subgroup

Chair: Jayne Phelps, Lead Professional for Safeguarding Children, University Hospital Coventry & Warwickshire NHS Trust / Moira Bishop Named Nurse Child Protection, Coventry and Warwickshire Partnership Trust

The training strategy sub-group continues to function effectively in achieving its aims and objectives. The team has met on six occasions throughout the year and completed a significant number of key tasks.

All partner agencies are represented within the current membership as are other key agencies eg. voluntary and faith sector. This continues to ensure that the safeguarding training needs of all practitioners who work with children and young people and/or their parents and carers are represented. A bi-monthly report, identifying significant issues, is provided to the Board.
The key priorities for 2012-13 are addressed below and are reflected in the sub-group's business plan.

- Objectives linked to Serious Case Reviews: a reminder to all trainers, including those who deliver on single agency courses, to include the use of appropriate interpreters where English is not the first language, commissioning of training around severe emotional abuse and neglect including an evaluation of the impact of this training, also a review of the use of the signs of safety risk assessment model including an extra training session for all practitioners and a training session with targeted practitioners.
- The development of half-day awareness raising sessions on child sexual exploitation to increase recognition and make appropaite referral to the relevant agencies
- An on-going review of LSCB training provision, including ensuring that learning from serious case reviews, audits, procedural and legislative changes and local developments are incorporated. Key areas have included a change in the case studies used in the domestic abuse and safeguarding children training and the parental mental ill-health and safeguarding children training, and new information for the forced marriage and so called honour based violence training. An action tracker is maintained by the Interagency Training Officer and is reviewed at each meeting.

- Single agency training is also reviewed by the sub-group for quality assurance. During this period serious case review training for Education has been reviewed.
- During this period there was a link with the COMBAT Trafficking Project which was raising awareness around trafficking of children and young women across Coventry, Warwickshire and Solihull. 876 professionals across a range of statutory and voluntary agencies in Coventry attended awareness raising training.
- A charging policy review has been held which included an analysis of the costs of providing training. There is now guidance in place on which agencies will be charged to attend training in addition to an increase in charges for attendance, cancellation and non-attendance.
- The Annual Conference 2013 "Learning from Serious Case Reviews, Research and Audits" was planned with the support of training sub-group, but was held after the time period for this report – May 2013.
- The Interagency Training Officer provides a process of support and development to trainers through regular meetings, dissemination of information, including messages from serious case reviews, and contact around each training delivery.
- The Faith Forum – a joint working project between Coventry and Warwickshire Safeguarding Children Boards supports Faith organisations and communities through meetings and events. The latest event took place 2012, which also included voluntary organisations, involved training around signs of abuse and how to respond, safeguarding policies and procedures and safer recruitment. Speakers included representatives from the Churches Child Protection Agency and Safe Network.
- The training subgroup membership has included a representative from Voluntary Action Coventry. This has enabled the needs of voluntary organisations to be considered and has included training sessions for faith and voluntary organisations around signs of abuse and how to respond and safer recruitment.

Challenges and priorities ahead:

- The interagency training programme has been streamlined to ensure it is good value for money and continues to meet the joint priorities for organisations this will be an on-going challenge for the Board.

- Child Sexual Exploitation is a key priority in Coventry. A more in-depth training course will be added to the programme and there will be monitoring around training attendance with a view to providing more sessions if required.

- There will be an on-going review of training to ensure that it continues to meet the changing and diverse needs of Coventry practitioners and contains up to date information and messages. Evaluating training will continue so that quality and impact on practice can be assessed. Quality assurance of single agency training will continue.

- It remains a challenge to ensure that the pool of trainers remains sufficient in numbers to deliver the interagency training programme. Board members are must ensure that staff continue to engage as trainers, particularly when faced with budgetary and staffing challenges. This is crucial to building expertise and quality in training and promoting interagency working.

- There will be a bi-annual review of training attendance to ensure that all staff requiring access to training are being reached and to establish any difficulties due to agency budgets and financial pressures. Agencies identified who don't attend will be contacted for discussion.

Safeguarding Children in Health Subgroup

Chair: Jayne Phelps, Designated Nurse, Coventry & Rugby Clinical Commissioning Group

Between April 2012 and March 2013 the health subgroup has undertaken a number of pieces of work some standalone work and some in conjunction with other subgroups. Members of the health subgroup all form part of other subgroups and the work streams overlap ensuring that there is health involvement throughout the work of the board.

A considerable amount of health subgroup activity has been in relation to ensuring learning from serious case reviews is embedded in health engagement with clients and families. This includes work around emotional abuse and neglect, domestic violence and abuse and sudden infant death. An evolving function of the health subgroup is to receive and manage all evidence provided by health agencies in response to serious case review or local reviews to assure the LSCB that the safeguarding issues are addressed. This runs alongside other arrangements for performance management of providers within health.

The procedures for safeguarding and protecting unborn babies have been developed and updated and a programme of training for staff involved has been jointly delivered between health and social care. This reflects the recognition of the health and social impact on babies of preventing disordered attachment in line with research findings.

The subgroup has undertaken specific work around emerging health issues relating to safeguarding and child protection to inform the LSCB. Ensuring that there is an effective response from health in relation to recognising young people at risk and supporting them to escape from child sexual exploitation has been a feature of the work.

Work is on-going to ensure that within health provider's child protection work is of high quality and that health staff are trained and supervised in relation to activity to safeguard and protect children, this has incorporated reviews of policies and procedures, addressing challenges and providing development opportunities for named professionals including level 3 and level 4 training. This has also led to the development of a safeguarding network across Coventry and Warwickshire which includes leads in child protection, domestic violence and abuse and looked after children.

Safeguarding in Education Subgroup

Chair: Roger Lickfold Strategic Leader for Inclusion, Education and Learning, Coventry City Council

In 2012/13 key areas of progress in promoting the quality and consistency of safeguarding practice in schools were:

- A safeguarding in education training strategy has been agreed and circulated to all schools and academies.
- 'Emergency' safeguarding training has been designed to deliver to link teachers in occasional cases where a newly appointed link teacher has an Ofsted notification before he/she can access scheduled training, so that all schools have an appropriately trained designated member of staff for safeguarding at the time of Ofsted inspection.

- The safeguarding training for governing bodies has been rolled out to all schools and academies, so that all governors with responsibility for safeguarding have the opportunity for safeguarding training tailored for governors.
- Learning from SCRs has been fed back to the Safeguarding Children in Education Subgroup and incorporated into safeguarding training programmes.
- The Local Authority has facilitated safeguarding audits in one secondary school and a number of primary schools. Through the safeguarding training schools have been introduced to the Safeguarding Audit Tool so they can audit their own safeguarding arrangements.
- Briefings have been provided to the Safeguarding Children in Education Subgroup and to all schools and academies on sexual exploitation and child trafficking, so that awareness is raised in schools of the signs and the action that should be taken.
- E-safety has been incorporated into the work of the sub-group, and a full briefing provided to subgroup members, so that awareness is raised in schools of the signs and actions that should be taken in relation to this area of risk.
- An audit of private fostering was completed with pupils of a second secondary school, providing further evidence of a significant under-recording of private fostering. No new actions arose from this audit as its findings were very similar to the initial audit of secondary school pupils. The number of children and young people formally recorded as being privately fostered has risen significantly in 2013 (year ending 31.03.13) compared to 2012, although it remains below the level indicated by the sample of 11-16 year olds audited. Further awareness raising work is underway.
- A domestic violence pilot, involving the City Council working in partnership with the Police and 41 schools, concluded successfully. Funding was agreed for the pilot to be rolled out to all schools and academies.

Membership and attendance

Attendance at the subgroup has generally been very good, but a small number of members have either not attended in the last the year or have attended infrequently. These members have been contacted to check whether they continue to be the representative of their particular stakeholder group and the situation is being monitored.

Priorities for 2013/14

Priorities for 2013/14 have been identified as:

- To consider any new national or local guidance or information in relation to education and safeguarding children and update Local Authority guidance and disseminate to schools as appropriate.
- To ensure that all Headteachers and chairs of governors have undergone safer recruitment training, either face to face or online.
- To ensure that all link teachers of schools and services undergo training on safeguarding children in education (on at least a two yearly basis).
- To consider all SCRs undertaken by the LSCB, to learn from these cases and strengthen safeguarding processes.
- To further develop safeguarding policy and guidance for schools/education services and the associated training programme.
- To provide safeguarding audits for all schools where safeguarding issues have been raised or where section 5 Ofsted inspection is due.
- To disseminate to Headteachers and education services the recently revised Children Missing from Education protocol.

Promoting the Well-being of Children and Young People

Chair: Isabel Merrifield, Assistant Director, Strategy, Commissioning & Policy, CLYP, Coventry City Council

The subgroup has refocused its activity on the implementation of the Common Assessment Framework this year to ensure that early intervention is being properly progressed across all agencies in the City. As part of this refocusing, the terms of reference were refreshed as was the membership in late 2012. A revised workplan was created, picking up issues arising from Serious Case reviews.

In accordance with the workplan, revised and updated CAF procedures were developed including step up and step down. These were agreed by LSCB in September 2012. Since then, the subgroup has reviewed CAF training and discussed blockers to implementation of CAF.

The group is currently working on the development of a CAF dashboard, this will develop as the new eCAF system is rolled out and data becomes available. In the interim, the subgroup is monitoring training take up. CAF statistics are reported to the LSCB via the subgroup. This dashboard development will enable the subgroup to monitor CAF activity and highlight evident gaps in terms of agency participation.
The subgroup has also considered the development of the Early Help Hub and will continue to monitor this as it develops. Members also gave input into the developing Prevention and Early Intervention strategy during 2013.

Priorities for next year are to complete the development of a meaningful and robust CAF dashboard to enable effective monitoring and challenge of CAF performance within and between agencies. This needs to include the monitoring of step up / step down procedures and a developing understanding of the impact and effectiveness of CAF processes. The group also needs to support wider communication of CAF messages and act as a critical friend to those who lead for CAF so that training and engagement are successful across all agencies.

Child Death Overview Panel (CDOP)
Chair John Forde, Consultant, Public Health NHS Coventry

The focus for 2012-2013 continued very much on the same theme as previous years by aiming to review cases in a timely manner, finalise outstanding areas of work, progressing actions arising from reviews and continually reviewing and improving the process as a whole.

Coventry Child Death Overview Panel (CDOP) conducts reviews of all deaths, irrespective of circumstances. Following a review of the process it was apparent that not all deaths required an in-depth review and in view of this ‘Fast Track’ CDOPs were introduced during 2012-2013. Fast Track CDOPs have a streamlined membership and are convened as and when required. The principles remain the same and any actions arising from ‘Fast Track’ reviews are recorded on the CDOP Action Plan and progressed. The implementation of Fast Track CDOPs has enabled more timely reviews of early neonatal deaths and allows more time to discuss the more complex cases at the full CDOP. In 2012-2013 the CDOP met 7 times (5 full CDOPs and 2 Fast Track CDOPs) and reviewed 39 deaths, a slight increase from 2011-2012.

During 2012-2013 the following work was completed from the reviews conducted:

In the case of an accidental asphyxiation, a design fault in the bed was identified. Both Trading Standards and the manufacturers were alerted and the manufacturer subsequently altered the design of this bed. A recommendation was also made to LSCB for all Early Years practitioners to be made aware of the potential hazards of high level/multi-level beds used by young children, in order to advise families. The Child Accident Prevention Trust charity (CAPT) was also notified to include a warning in their monthly newsletter.

Following the review of a death from Sudden Infant Death Syndrome (SIDS) where parents acknowledged that they did not follow 'safe sleeping' advice given, a recommendation was made to LSCB to: 'Maximise the impact of contact with families by a range of agencies to influence and motivate changes in parents' behaviour whereby safe sleeping messages could be strengthened if these are reinforced by a range of Early Years practitioners. Methodologies of brief intervention and brief advice could be consistently delivered to 'make every contact count (MECC) across a range of positive lifestyle messages to families, particularly in relation to safe sleeping practices, alcohol, substance misuse and smoking cessation. The board was also requested to consider implementing the SIDS risk assessment tool developed by Derbyshire NHS.

Following the review of a neonate born at home, a recommendation was made for the West Midlands Ambulance Service to review their Obstetric Care Procedures to clarify factors when expectant mothers in labour should be conveyed immediately to hospital and when a Midwife should be called to the address, to clear any ambiguity and also for a local NHS Foundation Trust to include a review of its 'Born Before Arrival' policy as part of the Root Cause Analysis investigation.

We also promoted the 'HeadSmart' project to GPs to help raise their awareness of symptoms of brain tumours in children and young people and to include CDOP learning in GP 'Protected Learning Time'.

A separate annual report has been completed for the child death review process which outlines further detail on the activity of Coventry CDOP and outcomes. This can be viewed at www.coventrylscb.org.uk.

Licensing and Safeguarding Children

The Safeguarding Licencing Officer was in post on from August to December 2012.

Whilst in post the Licencing Officer undertook an induction and training to support the development of her knowledge of local Safeguarding arrangements and associated processes and systems. The Licensing Officer produced a briefing note for a LSCB Newsletter. She also began to develop links and relationships with partner agencies.

The statutory role of reviewing routine licencing applications and variations were undertaken. The Safeguarding License Application database was reviewed to ensure it was current and complete.

The Licensing Officer undertook a number of site visits to varied venues in response to applications and variations. This was to ensure Licensees have robust risk assessments in place and that appropriate safeguarding policies are in place. The Licensing Officer also

contributed to Key partnership working focusing on a joint initiative. This included concerns regarding possible Child Sexual Exploitation.

Child Sexual Exploitation Task and Finish Group (CSE)

The following areas of work were carried out by members in 2012/13:

- A scoping exercise was carried out to obtain a greater understanding the level and nature of CSE in the local area. This exercise produced a good response from organisations indicating staff are aware of CSE and the need to act together to combat it.

- An Inter-agency CSE procedure has been produced and is being finalised. The procedure outlines the indicators of CSE and how a professional should make a referral.

- The Multi-Agency Screening Panel (MASP) has taken responsibility for ensuring that all CSE referrals are discussed and action plans developed and monitored for individual victims. The MASP has also been working on developing a Triage system, where the level of risk determined will identify the support and involvement of agencies required.

- A data collection tool (University of Bedfordshire) is currently being embedded into the MASP process. This is a specific recommendation from 'Tackling Child Sexual Exploitation' Report produced by the DfE in November 2011. The data captured will enable the LSCB to have accurate information that reflects the volume and profile of victims of CSE as well as perpetrators.

- A programme of awareness training has been produced by the LSCB trainer officer and currently being delivered by a senior social care practitioner and the missing persons police officer.

- Specialist Training for workers who work directly with CSE victims is currently being developed this will be delivered jointly Solihull LSCB.

- "Say Something If You See Something" campaign - Awareness training has been delivered for hotel staff within the City. This campaign originated in Coventry and has now been taken up nationally. This is an ongong piece of work to engage hotels in recognising this is an issue they need to be aware of and take appropriate action on if taking place.

- The drama piece 'Chelsea's choice' has been showcased to schools in Coventry. This has been received well and recognised to be effective in raising awareness with young people and preventing CSE taking place. Plans are in place to deliver this drama piece in the autumn 2013 to all seconday schools in Coventry.

- Direct work has taken place with young people to raise awareness about the risks of CSE and the forms this can take with our most vulnerable young people including young people in Pupil Referral Units and Care Homes.

- Education Service of the Local Authority have also produced and supported the delivery of a CSE awareness raising package for young people in schools. This includes 'My Dangerous Lover Boy' DVD. A survey is currently underway to assess the take up of this material by schools.

- The intelligence picture is increasing around identifying CSE perpetrators, victims and hot spot locations. West Midlands Police are currently refreshing the problem profile for CSE. An intelligence pro-forma has been developed for completion by professionals to be given to the police representative on MASP. This form will be embedded into the Inter-agency procedures.

- West Midlands Police now have a dedicated CSE Team who support complex investigations and who also carry out awareness raising to front line staff. This is assisting in bringing offenders to justice and developing a consistent response across the Force.

- Work is being progressed to produce guidance leaflets for Parents and Carers. This is being done in consultation with parents.

- The LSCB is also an active member of the Regional CSE Group. This group has been working on the following areas :
    - Multi-agency Screening Tool for universal service providers,
    - Risk Assessment Tool for those professionals that work directly with the child,
    - Information Sharing linked to CSE cases
    - Induction packs for new staff which focuses upon runaways, human trafficking and CSE,
    - Having a generic performance framework
    - A generic audit tool for case of CSE.

Much of the work of the focus group identified above is on-going and is being reported on to the LSCB at regular intervals.

7. LSCB Budget 2012 -13

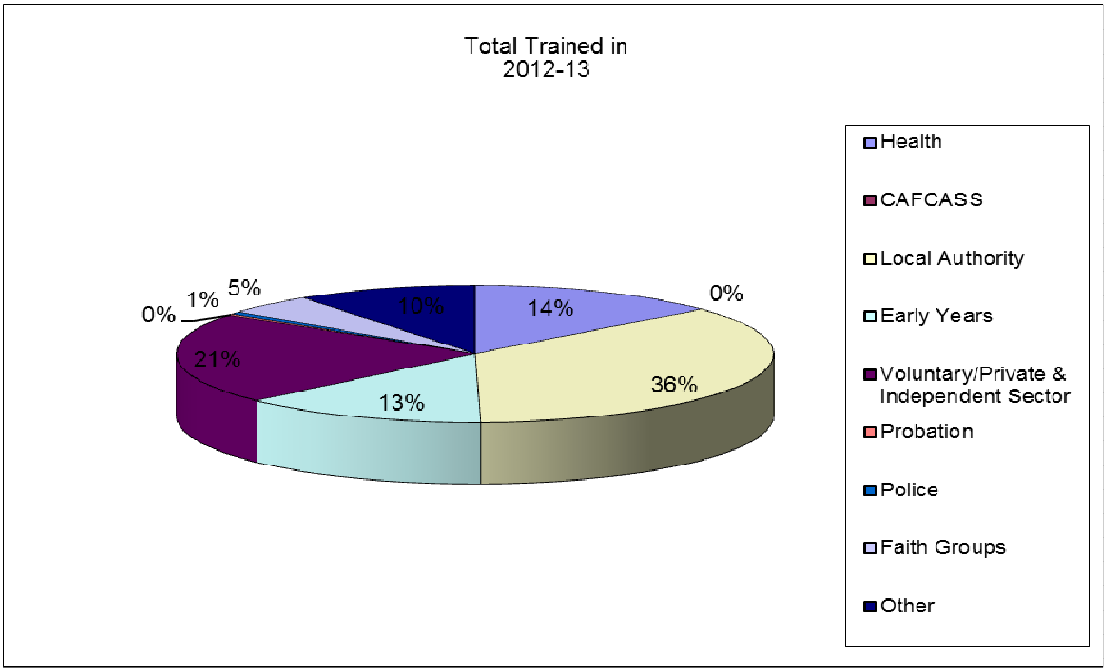
At the start of the financial year the LSCB had a base budget of £193,505 to fund the three dedicated LSCB staff and to deliver the core activities of the Board. A number of measures had been put in place in the previous year to find savings from the various core activities the LSCB undertakes to ensure the budget would balance at year end.

However during the course of the year it became clear that the budget would not cover all aspects of the LSCB activity namely the additional SCR function and the cost of a temporary officer who was drafted in to cover the maternity leave of the Business Manager. These increased expenditure. To address the significant overspend expected due to Serious Case Review activity, the three core agencies Coventry City Council, West Midlands Police, Coventry NHS PCT – as it was previously known, shared the costs of Serious Case Review activity. This enabled the Board to balance its budget.

8. Interagency Training Statistics from April 2012-March 2013

2012-13 Programme Year- Total numbers of attendees per sector

Category	Total Trained in 2012-13	%
Health	135	13.7%
CAFCASS	0	0.0%
Local Authority	354	29.7%
Early Years *	131	11.0%
Voluntary/Private & Independent Sector	212	17.8%
Probation	3	0.3%
Police	6	0.5%
Faith Groups	47	3.9%
Other	96	8.1%
TOTAL	**984**	



These figures are for multi-agency training, most of these organisations also provide single agency training and advise staff, depending on job role, on which training they should attend. In 2011–12, 1190 professionals attended interagency training courses, in 2012-13, **984** professionals attended training courses. Some of the factors which contributed to the lower figures this time around are:-

- There was no LSCB Annual Conference during this reporting period.
- Courses which run biannually e.g. training around Fabricated Illness and Child Abuse Images did not run during this reporting period.

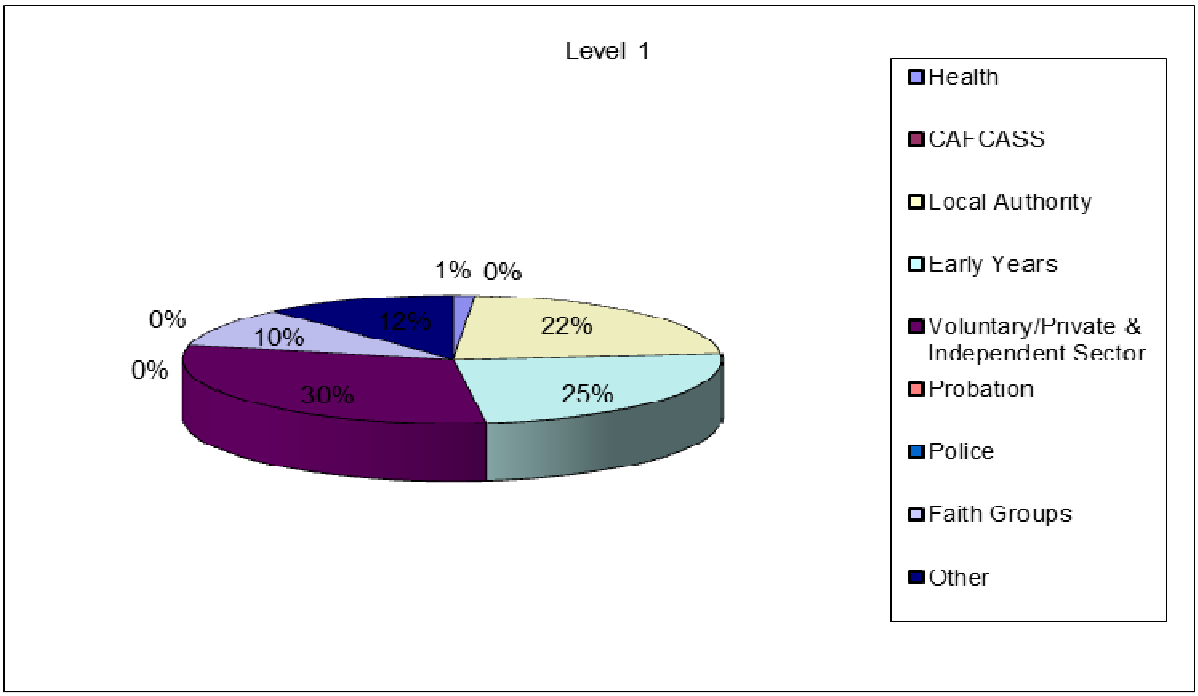
- Training around Safeguarding Children from Abroad is no longer being delivered as of April 2012.
- Training around Safeguarding Disabled Children did not run during this period, as an internal course was in the process of being developed.
- Training around the launch of new and/or refreshed procedures was not delivered in this reporting period unlike last year.

* *Some Early Years organisations come within the Local Authority but for these figures they are included in the separate category so that the whole range of Early Years organisations can be counted together. Those which are separate to the Local Authority include private and voluntary nurseries, childminders and crèches.*

2012-13 Programme Year- Number of attendees per level and sector

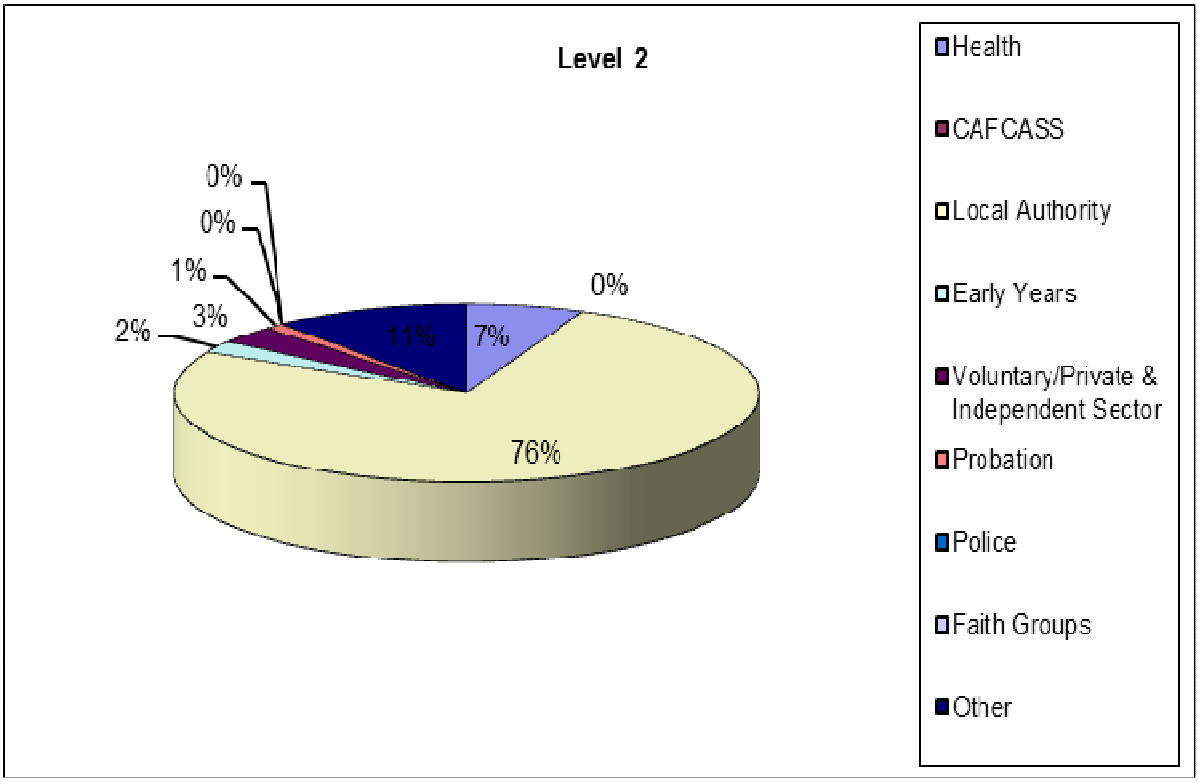
LEVEL 1

Category	Level 1	%
Health	6	1.3%
CAFCASS	0	0.0%
Local Authority	100	22.2%
Early Years	110	24.4%
Voluntary/Private & Independent Sector	137	30.4%
Probation	0	0.0%
Police	0	0.0%
Faith Groups	45	10.0%
Other	52	11.6%
TOTAL	**450**	



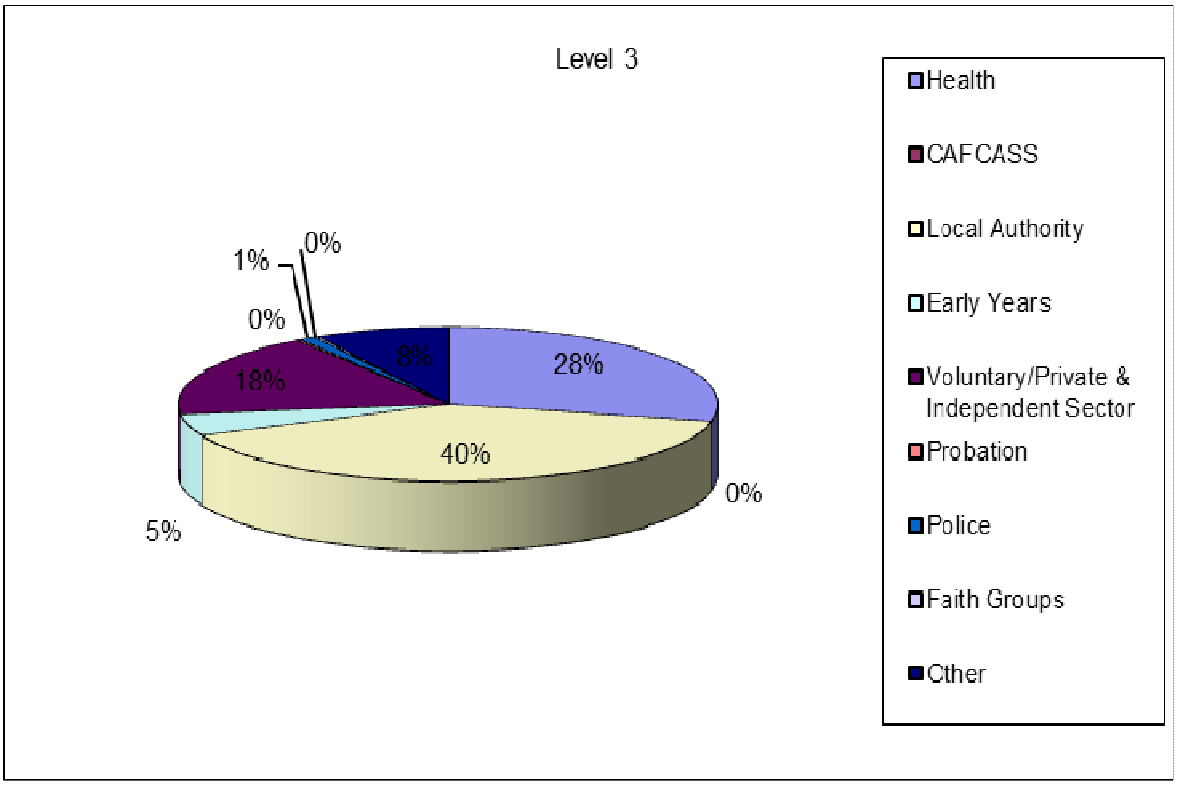
LEVEL 2

Category	Level 2	%
Health	6	6.5%
CAFCASS	0	0.0%
Local Authority	70	76.1%
Early Years	2	2.2%
Voluntary/Private & Independent Sector	3	3.3%
Probation	1	1.1%
Police	0	0.0%
Faith Groups	0	0.0%
Other	10	10.9%
TOTAL	**92**	



LEVEL 3

Category	Level 3	%
Health	117	28.5%
CAFCASS	0	0.0%
Local Authority	163	39.8%
Early Years	19	4.6%
Voluntary/Private & Independent Sector	72	17.6%
Probation	1	0.2%
Police	4	1.0%
Faith Groups	1	0.2%
Other	33	8.0%
TOTAL	**410**	



Evaluating the impact of training on practice

This process began in March 2012 examining the impact of training from a range of courses. The interagency training officer carryied out an analysis of end of course and post course feedback specifically linked to impact on practice. This was based on information provided by participants and line managers providing evidence of demonstrable changes in practice as a result of training.

Trainers both from partner organisations and external organisations are involved in the developing the analysis process, information is also shared with trainers and the LSCB training group including any amendments to courses as a result of feedback. Courses which have been evaluated during this period include:

- Level 2 -Working Together to Safeguard Children and
- Level 3 – Sexually Harmful Behaviour,
- Level 3 - Domestic Abuse, Self Harm,
- Level 3 - Supervision in Child Protection,
- Level 3 - Understanding Sex Abusers
- Level 3 - Spirit Possession and Witchcraft

Examples of how training has had an impact on practice and learning:

- University Hospital Trust (UHCW) amending their supervision policy
- A Voluntary Nursery writing a supervision policy,
- A manager in UHCW reporting that a midwife had learned a great deal about child sexual exploitation and her awareness level when dealing with young mothers had been greatly increased,
- A Mosque representative making a referral to Social Care after learning about Private Fostering on Level 1 training.

Impact has also been identified from courses delivered linked to Serious Case Reviews:

- Emotional Abuse and Neglect training resulted in GPs increased awareness and interaction with children and observation of the parent/child interaction,
- Another GP now holds weekly meetings with the Health Visitor to discuss families where there are concerns,
- A Family Nurse Partnership Manager who has observed an increased awareness that has translated into her practice with children and families
- A CAF Team Manager who shared a practice tool with peers and team to use within their work.

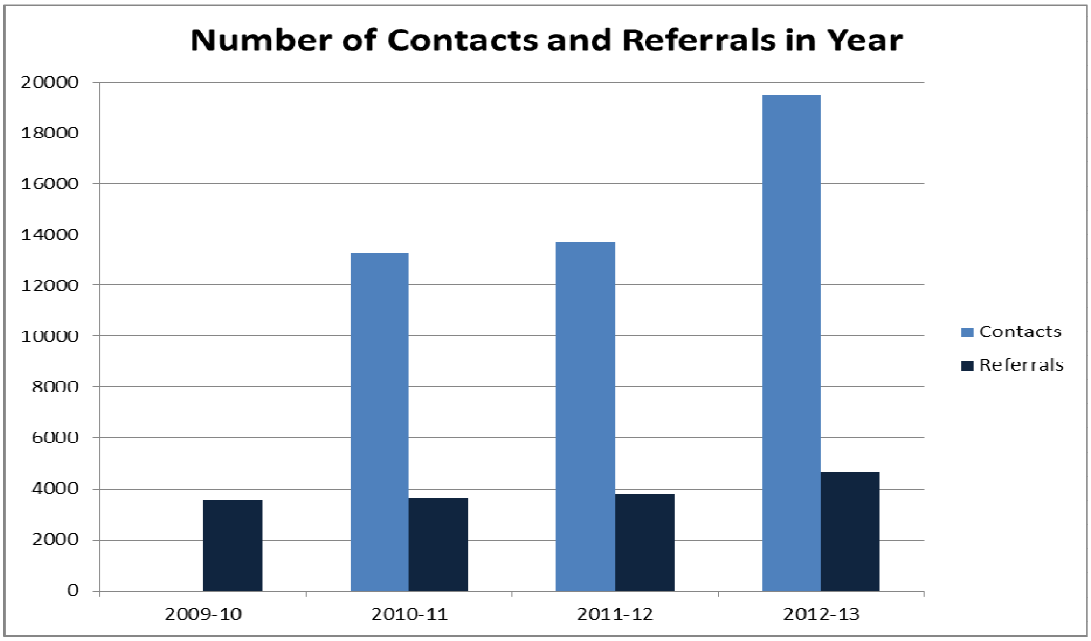
9. Performance Reporting 2012-2013

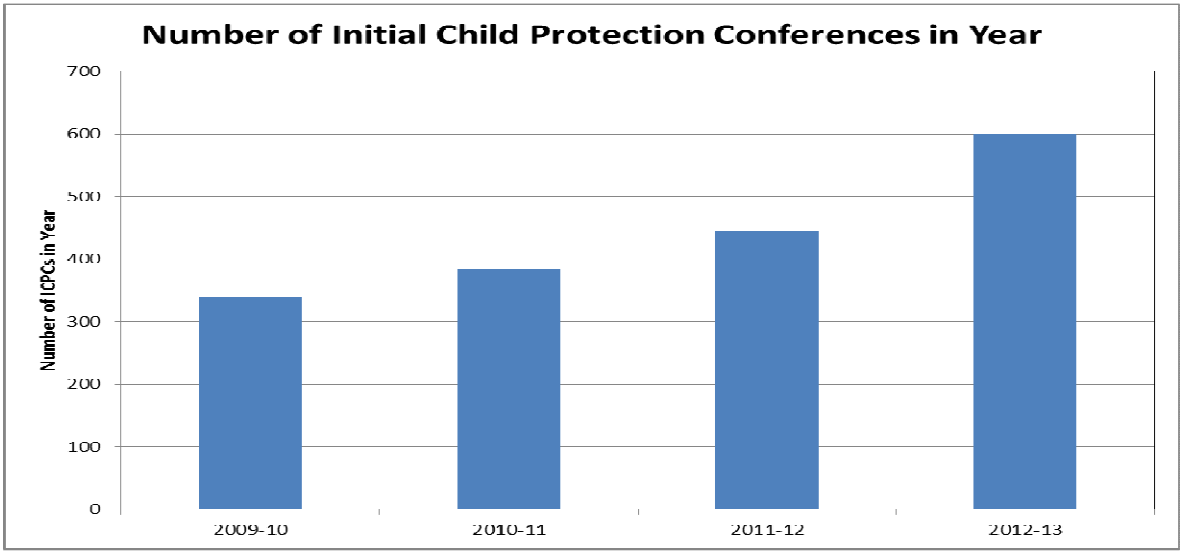
Introduction

In accordance with our priorities for 2012/13 the performance framework was refreshed and reduced in the autumn of 2012. There have been a succession of reports on performance issues to the Board during the year and performance information is routinely shared through the Board. What follows is a summary of key performance information showing safeguarding performance across the City during 2012/13. The Board remains committed to reviewing this regularly to see how performance can be better monitored and the actions which need to be taken to deliver improvement in key areas.

Child Protection Activity

There has been an increase in activity this year in social care



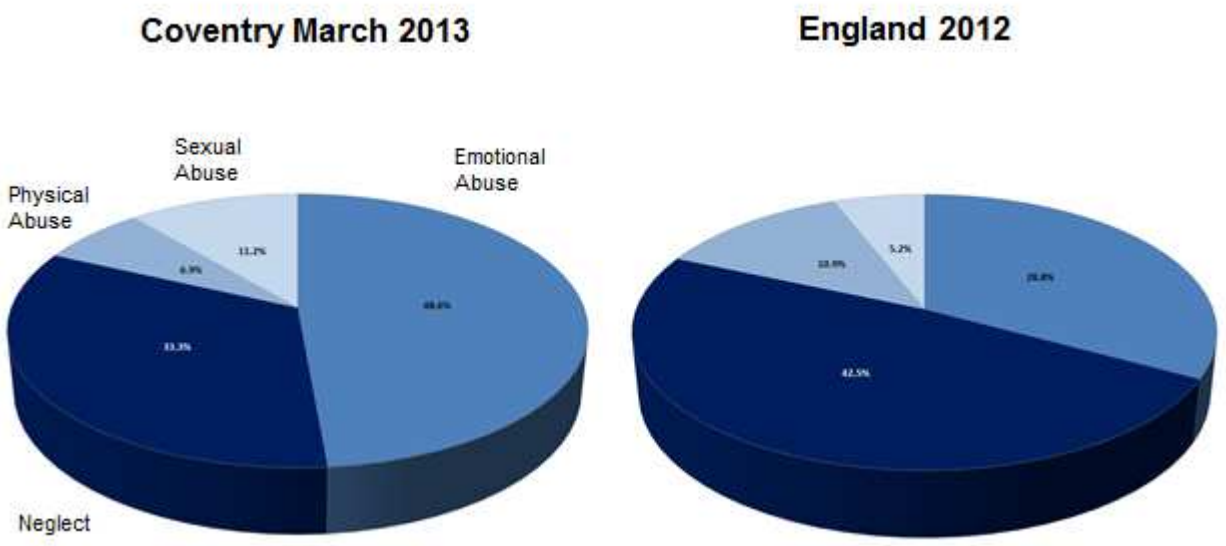


Where comparative data is available, it shows our activity levels are higher than national averages (Statistical neighbour averages are not available at the time of writing)

	Coventry as at 31st March		England
	2012	2013	2012
Referrals leading to IA's	88.50%	90.6%	74.60%
Timeliness of IAs - IAs carried out within timescales(10 working days)	73%	73.6%	77.40%
Number of Strategy Discussions	1221	NA	NA
Number of Section 47 enquiries		908	NA
Number of Section 47 enquiries per 10,000	101.8	128.7	109.9
Number of CP Plans	423	519	NA
Number of CP Plans per 10,000	64.5	73.6	37.8
2nd or subsequent plans	14.6%	14.1%	13.8%
CP cases reviewed within required timescales	99.7%	98.5%	NA
Number of ICPCs held within 15 days of Section 47 start	80.4%	57.7%	NA

Characteristics of CYP subject to CP plans

a) Reasons for being subject to a CP plan

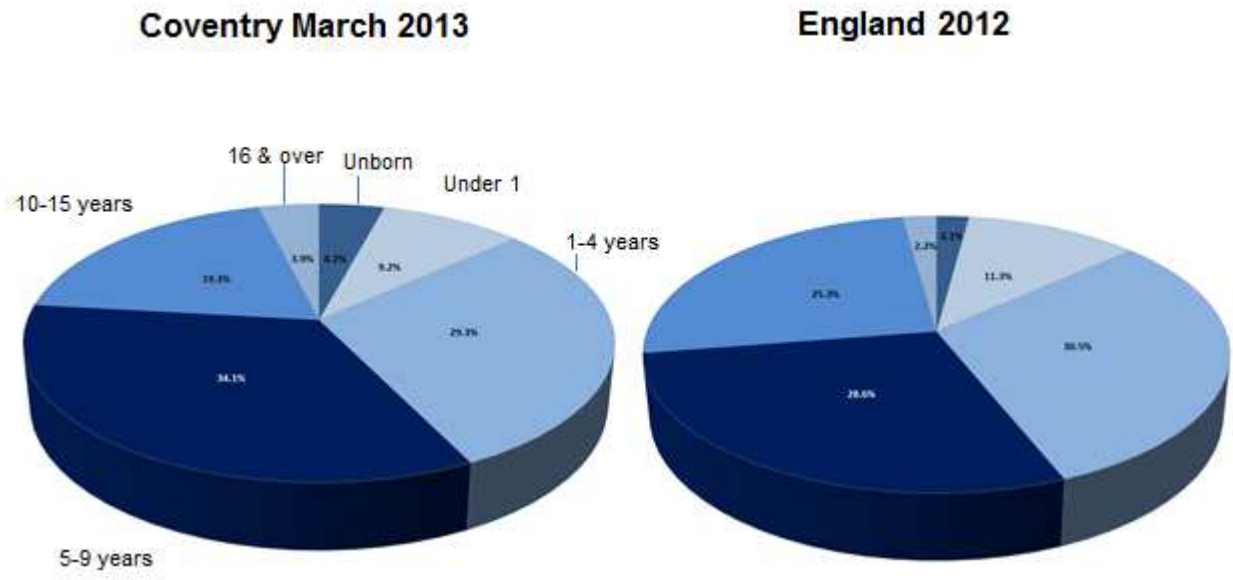


Coventry's proportion of emotional abuse is significantly higher than in England in 2012. Emotional abuse can often be related to domestic violence in the household. This indicates we have a greater problem in Coventry with this than nationally. Coventry has double the national percentage of children categorised under sexual abuse.

b) Gender

Gender	Coventry as at 31st March 2013		England 2012
	No.	%	%
Male	257	49.5%	49.9%
Female	261	50.3%	47.8%
Missing/Indeterminate	1	0.2%	2.3%
Total	**519**		

c) Age



Coventry's age profile is similar to the national profile. Coventry's proportion of unborns at 4.2% is double that of the England rate (2.1%) last year.

Children Missing from Care and Home

There were 211 children/young people recorded as having a total of 581 missing episodes in 2012 -13 this is a decrease on the 270 C&YP reported missing for 2011-12. This year's total included 21 young people who were reported missing from out of city residential homes resulting in 113 episodes. Therefore there were 190 C&YP reported missing who lived in the city on 469 occasions.

Of the 190 C&YP living in the city having missing episodes in 2012:

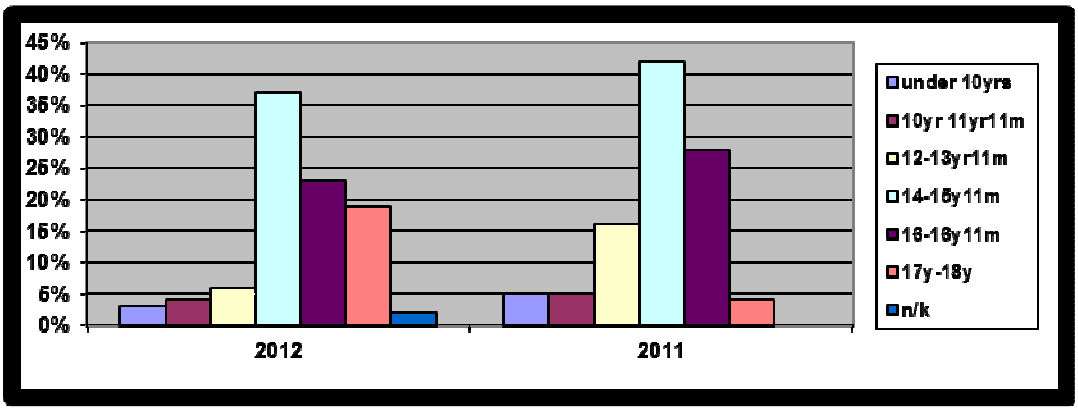
- 120 of them had only 1 episode
- 51 had 2-4 episodes
- 9 had 5-9 episodes
- 6 had 10-15 episodes
- 4 had 20+ episodes

Of the 21 C&Yp reported missing who lived out of city:

- 10 yp had1 episode
- 7 yp had 2-4 episodes
- 2 yp had 5-9 episodes
- 1 had 28 missing episodes
- I had 38 missing episodes.

It is likely that the rates of children and young people going missing are under estimated both nationally and locally as there are a proportion of children and young people who go missing from home that go unreported by their family and as a result their episodes will not be captured.

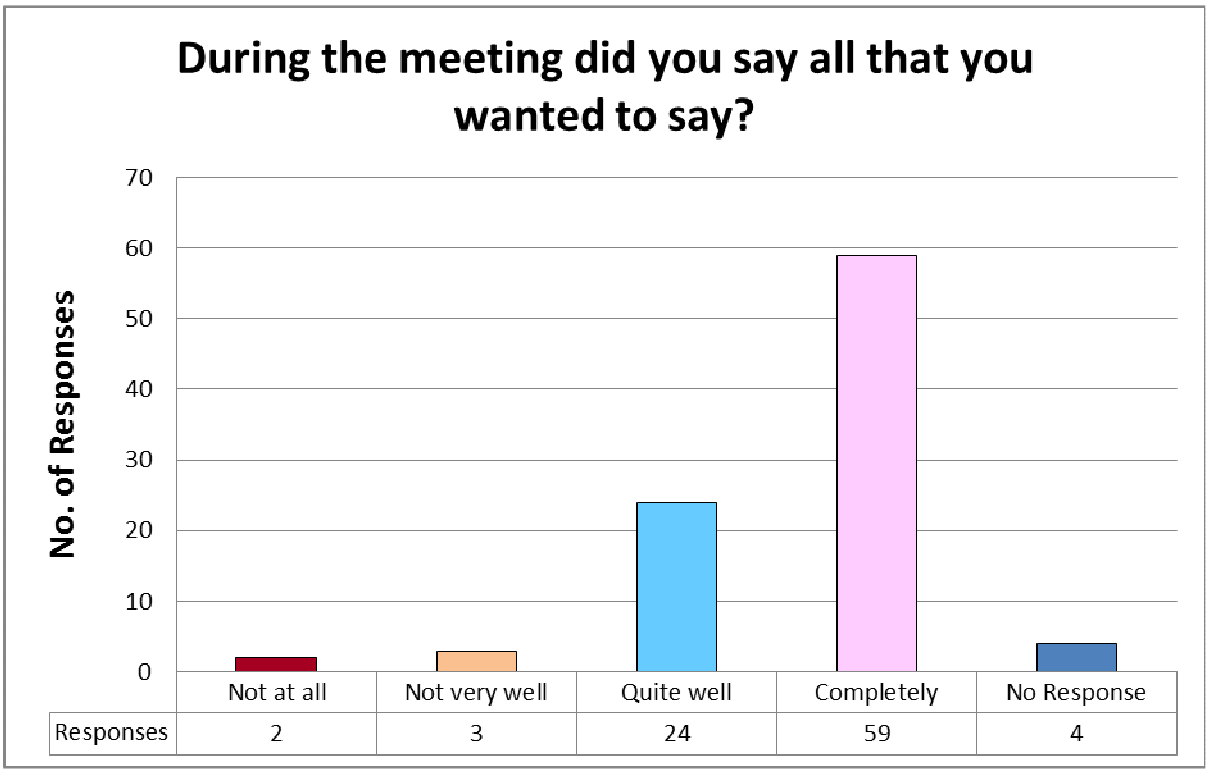
Chart 1 – the age range of those going missing



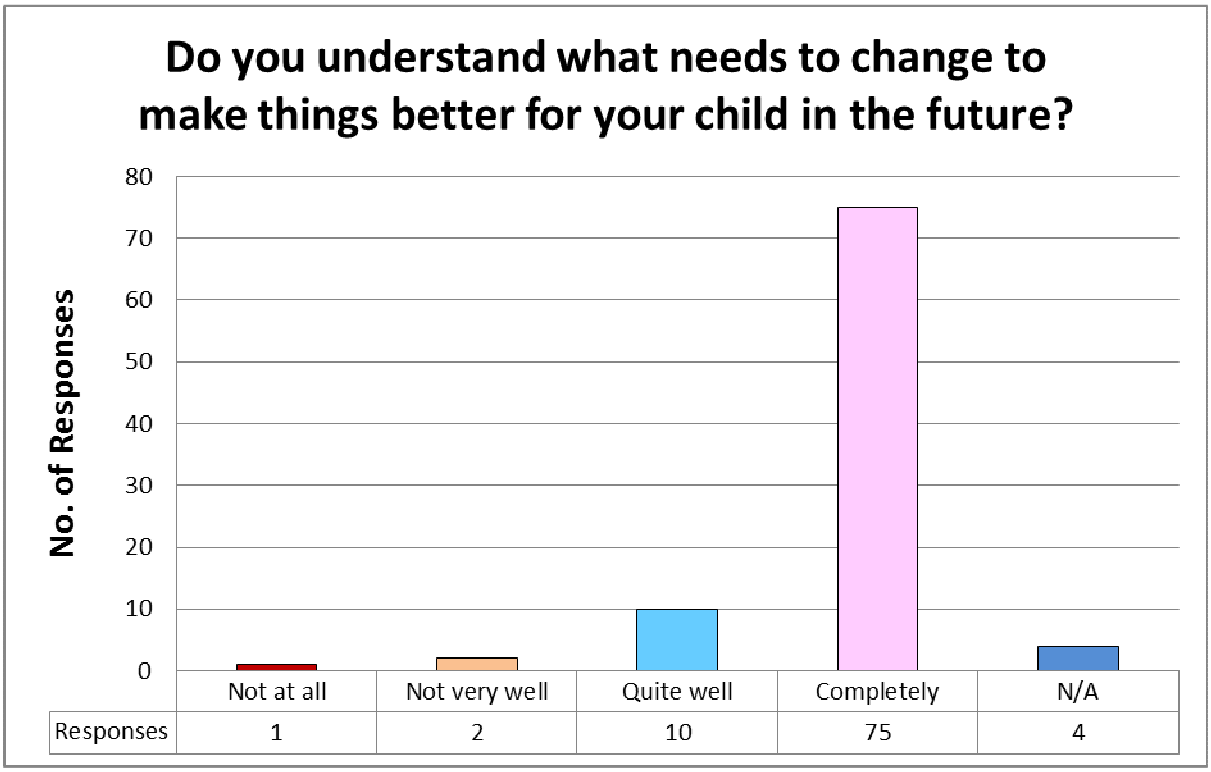
Work continues through the Multi Agency Screening Panel to identify, monitor and address incidents of children and young people who go missing.

Parental Feedback from child protection conferences

The Safeguarding Service regularly collects feedback from parents and children on their experience of child protection conferences. These forms are completed anonymously after the child protection meeting. Over this reporting period, 92 forms have been completed in all. Some of the key outcomes about parents experience of child protection conferences have been highlighted below.



This indicates that over 90% of respondents felt they were able to say most or all of what they needed to in the conference and indicates that the process is effectively promoting the voice of parents and families in the child protection conference meeting.



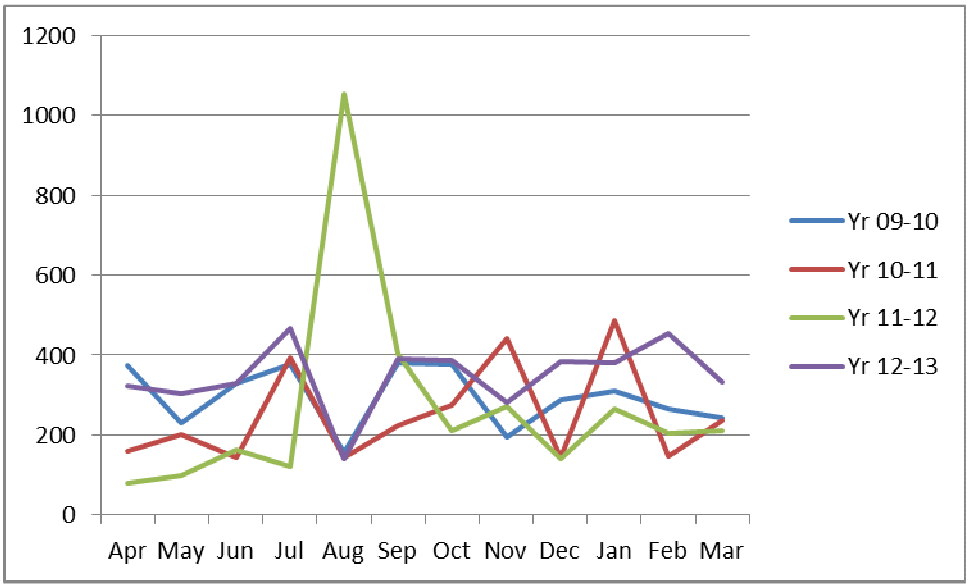
Most encouraging is the response from 81% of respondents that they completely understand what needs to change in order for the situation to be safe for their children. When the 10 who responded that they understood quite well is added to this, the percentage rises to over 92%. This is a key outcome for a Child Protection meeting where it is essential for parents to have a clear understanding of what professionals are concerned is harming their children and of how they need to change.

Police Protection Powers

- Between April 2010 and March 2011, 22 families became looked after under Police Protection (37 children)
- Between April 2011 and March 2012, 27 families became looked after under Police Protection (45 children)
- Between April 2012 and March 2013 43 families became looked after under Police Protection Powers (70 children)

Domestic Violence Incident Screenings

Levels of domestic violence incidents screened have continued at a relatively consistent level for the past 4 years as shown in the graph below. Overall, 12-13 has seen a higher level of monthly screenings. The spike in 2011 was due to a delay in screening during the riots in August.



The DV screening process has been reviewed and audited during the 12/13 year. This led to improved multi-agency engagement.

Hospital admissions caused by injuries to children

The statistics for hospital admissions are shown by ward. This is the first year data at this level has been established and shows some interesting variations. These figures are based on hospital figures and so do not give the whole picture of injury to children and young people, for example figures of attendances at GP surgeries or the walk in centre are not included.

Chart 1 – Hospital in-patient admissions

Wards	AGES	Rates per 1,000	Rates per 1,000	Rates per 1,000	
	0-17 mid 2010	Accidents	Assault	Intentional Self Harm	Grand Total
Bablake	3189	9.72	0.63	0.94	11.60
Binley and Willenhall	3924	14.78	0.00	1.53	17.84
Cheylesmore	2925	11.96	0.00	0.68	14.36
Earlsdon	2836	11.28	0.00	1.76	15.16
Foleshill	6094	11.65	0.66	0.98	15.10
Henley	4825	17.20	0.41	1.24	20.31
Holbrook	4244	10.13	0.71	1.18	13.67
Longford	2783	**18.68**	0.00	2.87	**22.27**
Lower Stoke	4402	13.86	0.45	2.04	18.63
Radford	4310	6.96	**1.39**	1.16	9.98
Sherbourne	3389	17.12	0.00	1.77	21.84
St. Michael's	4986	12.64	0.20	1.40	16.25
Upper Stoke	4147	10.13	0.96	2.65	14.95
Wainbody	3421	**4.09**	0.00	1.17	**5.55**
Westwood	4098	10.01	0.00	**3.66**	14.15
Whoberley	2747	8.74	0.73	**0.36**	9.83
Woodlands	3096	14.86	0.32	1.29	17.44
Wyken	3725	12.62	0.54	1.07	15.57
total	69142	12.02	0.42	1.55	15.33

Chart 2 – Attendances at Accident & Emergency which did not result in admission

Ward	Sum of Attendances not resulting in an admission	Average of Mid 2010 0-17	Rate per 1000
Bablake	132	3188.8	41.39
Binley and Willenhall	178	3924.2	45.36
Cheylesmore	117	2925.2	40.00
Earlsdon	105	2836.2	37.02
Foleshill	201	6094.2	32.98
Henley	301	4824.6	62.39
Holbrook	166	4244	39.11
Longford	181	2783.4	**65.03**
Lower Stoke	159	4402.4	36.12
Radford	128	4310.4	29.70
Sherbourne	125	3388.6	36.89
St. Michael's	162	4986	32.49
Upper Stoke	164	4146.6	39.55
Wainbody	56	3421.2	**16.37**
Westwood	119	4097.8	29.04
Whoberley	71	2747.2	25.84
Woodlands	159	3096.4	51.35
Wyken	148	3725.2	39.73
Grand Total	2491	69142.4	36.03
A&E Attendances 2012/13 not resulting in admission			
A&E Attendance Code 20 (Assault), 30 (Deliberate Self Harm), 60 (Other Accidents)			

Effectiveness of Multi-Agency Risk Assessment Conference

Number of cases discussed: 285 cases 114 of these cases were repeat victims.

The Coventry MARAC is a meeting where information is shared on high risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the Coventry MARAC is to safeguard the adult victim. The MARAC will also make links with other forums to safeguard children and manage the behaviour of the perpetrator. At the heart of the Coventry MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA (Independant Domestic Abuse Advocate) who speaks on their behalf.

Multi Agency working is key to tackling the complex issues associated with domestic abuse, and in particular, cases that are assessed as "high risk".

Coventry MARAC meetings combine up-to-date risk assessment information, together with a comprehensive assessment of the victims needs, and would link this information directly

to the provision of appropriate support services for all those directly involved in a domestic abuse case i.e. victim, children and other immediate family members, and the perpetrator.

The sharing of information gained through the Domestic Abuse MARAC meetings can only be used for MARAC purposes, and cannot be used for any other purposes without prior and authorised approval from the MARAC, and the appropriate Lead Agency providing the specific information. The sharing of personal information will be managed under the guidelines of the Crime and Disorder Act, the Children Act, the Data Protection Act and the Human Rights Act.

The Effectiveness of Multi-Agency Public Protection Arrangements

Number of cases where there is a risk to children

The total MAPPA level 2 and 3 cases during the year (to 31.3.13) where risk to children was identified as being medium, high or very high was twelve. This was made up of seven sex offenders and five violent offenders. The risk was identified as medium in 2 cases, high in 5 cases and very high in 3 cases. There were also 2 cases not known to Probation and therefore not assessed using 'Oasys' (Probation's assessment tool).

There are currently no cases registered as Critical Public Protection Cases.

Comment on the quality of interagency work to manage risk

The quality of interagency work at panel continues to be very good. Despite reductions in resources across all partner agencies, attendance and participation in MAPPA has continued to be prioritised and this is crucial to the effectiveness of MAPPA in Coventry. Although participation by prisons is not always consistent, they bring enormous benefit when they attend and this has ensured a much smoother transition between custodial and community settings.

Number of cases where there was re-offending

One MAPPA Level 3 case has reoffended during the year. There was no risk to children from these offences. Another MAPPA Level 3 case was recalled to custody for not complying with the terms of their licence although this was related to reoffending. This was in accordance with the plan agreed by the partners to MAPPA. There was one Level 2 MAPPA case that re-offended and again adults, not children, were the victims.

10. LSCB Business Plan 2013- 15

Priorities

In establishing its priorities for the coming year, the Board has considered Serious Case Review findings, the effectiveness of local safeguarding arrangements, the recently published Working Together 2013, the developing national agenda, recent audits carried out on safeguarding and child protection processes and recommendations made by the Peer Review which took place in March 2013.

The Board has therefore compiled a business plan for 2013 -15 detailing the actions it will take primary responsibility for on the following pages.

The specific priorities of the board are summarised below:

1. Embed learning from recent serious cases
2. Challenge the effectiveness of early help
3. Work together to tackle Child Sexual Exploitation
4. Improve multi-agency responses to domestic abuse
5. Challenge practitioners to listen to / see the needs of the child

All members of the Board are responsible for progressing these priorities within their own organisations.

In addition the Board will continue to address other areas of work stated below. These will be progressed through sub groups which are held to account by the Board.

The LSCB has taken particular account of the Daniel Pelka case and the Serious Case Review:

The horrific death of Daniel Pelka rightly received national attention as the full details and extent of his suffering were revealed through the criminal trial of his mother and stepfather.

The Serious case review subcommittee commissioned a case review within weeks of his death. It was clear from early on in the review process that the case was one of the most serious child deaths that we have reviewed in recent years. The review process followed the guidance outlined in Working Together 2010.

During the trial of the child's mother and partner further details relevant to the analysis of practice came to light through the evidence presented to the court. This information was incorporated into the final version of the report, which was made public in September 2013.

Following publication of the report, the Minister for families from the Department for Education wrote to Coventry LSCB requesting further work is undertaken to analyse the actions taken by professionals. This work has already started and will be supported by specific training and awareness raising sessions for all those who work with Coventry's children.

Daniel's death has affected all those who work in Coventry who have the responsibility to safeguard children. Professionals will no doubt redouble their efforts to ensure that children do not slip through the net and become "invisible" as seems to be the case for Daniel. They

will also need greater access to training and confidence in the systems which support them in doing their work.

The original report in both Polish and English is available on the LSCB website (http://www.coventrylscb.org.uk/); these pages will be regularly updated with progress reports on how we have turned the recommendations in to actions.

Coventry Safeguarding Children Board –Business Plan Summary 2013 - 2015

Priority	**Measures and monitoring of success**
Embed learning from recent serious cases	Evidence provided by Board partners to show progress has been made and lessons learned. More robust processes in place to safeguard children
Challenge the effectiveness of early help	Monitoring through the LSCB performance framework, highlighting areas of concern and further challenge. Early help meets the needs of children and families and therefore prevents these children entering into the child protection process
Work together to tackle Child Sexual Exploitation	Professionals and young people are more aware of CSE. Initially an increase in reporting and recognition of cases of CSE, however over the long term. This will decrease where awareness raising reduces the risk of young people being brought into sexual exploitation.
Improve multi-agency responses to domestic abuse	An on-going review and strengthening of the process for screening notifications received and the follow on actions to safeguard children. Effective action is taken in line with the severity of domestic violence, impact on the child and the cumulative number and frequency of incidents taking place.
Challenge practitioners to listen to / see the needs of the child	Practitioners clearly evidence listening to/seeing the child's views and experience. Children are at the centre of decision making
Additional areas of work	
• Review LSCB arrangements including LSCB membership in line with Working Together 2013 • Review of agencies compliance with Section 11 'Children Act 2004 'promoting the safety and welfare of children' agencies • Review the LSCB governance arrangements • Review, agree and establish the roles and relationships with existing and emerging partnerships to ensure that it fulfils its responsibilities in ensuring that there are	

effective safeguarding arrangements in the city.

  - Joint Commissioning Board (Children's Trust)
  - Health & Wellbeing Board
  - Clinical Commissioning Group
  - Adult Safeguarding Board
  - Domestic Violence and Abuse Partnership
  - Community Safety Partnership
  - Review the costs of implementing the LSCB business plan for 2012-15. Specify from where the required resources/additional funding will be obtained and identify any shortfalls.

- Effective management of serious case reviews and compliant with Working Together 2013

- All child deaths are monitored, trends are identified and prevention planning is enhanced to prevent untimely deaths

Appendix 1

Subgroup work plan details for 2012/13

Subgroup: Training	
Objective	**Outcome/measure of success**
1.Daniel Pelka SCR Action Plan: Consider the need to initiate multi agency training in respect of the detection and identification of severe emotional abuse and neglect and provide clarity regarding the responses necessary to address such abuse. Evaluate the impact of learning.	Training provided. Course includes identification of emotional abuse and neglect and how to respond to concerns. Four courses evaluated through end and post course forms and line manager feedback. Participants have increased confidence and knowledge around identification and response which is reflected in their practice.
2a.Child Sexual Exploitation Awareness Raising Training. 2b.CSE one-day specialist training for people who work with vulnerable young people (co delivered with Solihull LSCB)	Half day training sessions provided. Participants have increased confidence and knowledge around vulnerabilities and risk factors and how to respond which is reflected in their practice. One course identified for evaluation through end and post course forms and line manager feedback. Training provided and adapted to include Coventry context. Participants gain understanding around the needs and sensitivity required when working with vulnerable young people. Participants have a greater knowledge about how to support young people who are victim's of CSE Learning reflected in practice.
3a. Domestic Violence and Abuse Risk Assessment Tool Training for Social Care (Barnardos tool) 3b. DVA DASH Risk Assessment Tool	Training provided for targeted social care staff. Train the trainer course provided, participants identified, support for trained trainers identified. Trained trainers provide further courses for social care staff. Staff Train the trainer course provided, participants identified, support for trained trainers identified. Trained trainers provide

Training for multi-agency delegates	further courses for multi-agency participants.
4. Child W SCR Action Plan: Use of risk assessment tools, including signs of safety model, may lead to ambiguous judgements and decision making. Consider implications of this to ensure a standardised implementation of the use of the tool. There should be sufficient knowledge of the tool to allow professionals to challenge decisions which flow from the use of the tool.	Training session to re-look at signs of safety, issues from SCR and new developments in signs of safety delivered to targeted participants. Extra 2 day solution focused/signs of safety training delivered including new developments. Signs of safety session, including new developments delivered to IROs. All professionals using the tool use the same application and have confidence to challenge decisions when necessary.
5. Charging policy: Identify which agencies will be charged for attending training. Identify process for managing financial transactions	Charging policy and process reviewed and amended and agreed by Safeguarding Board. Charging policy advertised. Agencies attending training have knowledge of charges. Financial transaction process efficient.
6. Safeguarding Board Annual Conference – Learning from scrs, audits and research 22nd May 2013	Conference provided key note speakers. Delegates have increased knowledge of latest learning and messages around safeguarding children, reflected on feedback forms and in practice. Information from conference available on website.
7. Core group training	Half day training sessions provided. Participants have increased knowledge of core group functions and increased confidence around their role as core group members. There is clear focus on and action taken in relation to the CP plan Reflected in course evaluation forms and practice.
8. Safeguarding Disabled Children Awareness Raising Training	Half day training sessions provided. Participants gain understanding and knowledge around the vulnerabilities of disabled children, indicators of abuse and how to respond. One course identified for evaluation through end and post course forms and line manager feedback.
9. Workshops to disseminate new developments and procedures in relation to unborn children	Deliver workshops to targeted audience to launch update of unborn procedures. Participants have knowledge of procedures. Knowledge reflected in practice.

10. Continuous review of training programme, incorporating learning from scrs, research, audits, policy and procedural changes, legislation and local and national developments Review of single agency training.	Content of courses updated where relevant. Specific courses identified for review. Trainers involved. Separate review plan maintained and reflects updates. Review schedule identified. Training sub-group Minutes reflect reviews completed. Also training give professionals the most current information/research findings/ learning from reviews to equip them with the skills to undertaken their work with children and families
11. Evaluation of impact on practice of LSCB training. Evaluation forms devised for each course to cover quality, relevance, short and long term outcomes and impact. (Working Together 2010). Post course forms to include section for line managers.	End of course and post course forms developed for each course. Courses identified each term for evaluation. Separate evaluation plan maintained and reflects impact on practice. Messages/changes communicated to relevant professionals. Further information received about impact of learning on practice collated. Knowledge obtained on how training is impacting on practice.
12. Ensure that all staff requiring access to training are being reached.	Attendance reviewed 6 monthly in training sub-group. Agencies not attending contacted to make sure that training needs are being met. Multi agency training is available to all agencies that require it.
13. Ensure trainers are supported for training role and kept up to date with local and national developments.	Trainers meeting once per term. Information shared and training role discussed. Liaison with trainers before each training session. Trainers are confident in their role and deliver training effectively.
14. Training around deeply held religious and cultural beliefs and safeguarding children	Half day training sessions provided. Participants have knowledge around cultural/religious beliefs and understanding of when these beliefs may be abusive. Participants are confident around challenging and responding to practices which are not appropriate. This will be reflected in practice. One course identified for evaluation through end and post course forms and line

	manager feedback.

Subgroup: Quality Assurance & Practice	
Objective	**Outcome/measure of success**
Review the quality assurance framework which enable the LSCB to monitor the effectiveness of current services, encompassing a dataset with qualitative and quantitive information that reflects local and national priorities.	The LSCB will have a clear understanding of areas of concern, hold agencies to account on these and monitor progress to address these. Success will be measured by these areas no longer being of concern.
Examine the volume of safeguarding/ child protection cases to understand whether effective interagency processes are in place and whether cases are being managed in the correct arena.	The LSCB has an understanding of the volume of cases across the spectrum of safeguarding and child protection. The LSCB has a view of how well these cases are being managed and areas requiring improvement to manage cases effectively. Those areas requiring improvement have been addressed resulting in a better delivery of service to children, young people and families.
monitor the effectiveness of single and multiagency safeguarding arrangements through thematic auditing of the following areas: • Section 47 Enquiries • Recording and quality of supervision • Field visit of primary/secondary schools to assess safeguarding arrangements • Unborn children in the child protection process • Field visit of local hospital including A&E to assess Safeguarding arrangements Field visit of referral and assessment service to assess arrangements	Through dip sampling cases a view can be formed of the work being carried out in the areas specified across. A clear action plan to address areas of weakness is produced and implemented. The areas highlighted are addressed and processes are more robust as a result.
Review the layout and content of interagency procedures in line with Working Together 2013	Staff have access to the procedures that reflect the most up to date information and processes to guide themselves and other partner agencies professionals in addressing safeguarding / child protection concerns. Staff are clear about the process they should be undertaking
Review and update the Children Missing	Ensure this reflects up to date processes in line with the most recent guidance and

from Education Procedure.	legislation. All those working to these procedures are aware of their role and carrying this out. Young people who fall into this category are bettered safeguarded.
Have in place a baseline level of supervision that all partner agencies should be carrying out with staff who are working with children and families where there are child protection concerns	All staff working with children and young people are receiving an appropriate level of supervision linked to the vulnerable children/ young people they are working with. This will enable staff at all levels to be supported to carry out their role effectively.
Obtain service user feedback to inform and shape child protection services.	The subgroup will have a view of how well service users feel they have been engaged in this process. Areas of improvement are identified and implemented to ensure service users receive an effective and supportive level of service from professionals
Review the Serious Case Review procedure in line with WT2013 and develop a toolkit covering all aspects of conduction a review	Clear processes in place to conduct an SCR. All agencies have a good understanding of how an SCR is conducted.
Produce a procedure to safeguard young people affected by gang activity	All agencies are aware of the process to follow and issues to consider in relation to this safeguarding issue
Produce a procedure to safeguard young people affected by violent extremism	All agencies are aware of the process to follow and issues to consider in relation to this safeguarding issue
Produce an interagency procedure in relation to cases of Sexual exploitation	All agencies are aware of the process to follow and issues to consider in relation to this safeguarding issue
Improve processes for engaging young people in the child protection process to develop appropriate information and increase participation	Children and young people have an increased understanding of the processes they are involved in. The voice of the young person is heard, taken into consideration and acted upon where safe for the young person. Children and young people feel more engaged in the process.
Review and update procedures related to strategy meetings and discussions to reflect learning from SCR's and changes in process.	Processes are in place that reflects learning from SCR's where professionals are clear about the actions they and others will be taking following a strategy.
Review processes for children displaying sexually harmful behaviour	All agencies have a clear understanding of the process to be taken and the role of each agency. Further risk of harmful behaviour is

	reduced.
Subgroup: Serious Case Review	
Objective	**Outcome/measure of success**
To consider cases which may meet the criteria for a serious case review and make recommendations to the chair of the LSCB accordingly	Cases to be considered against regulation 5(2)(a) and (b) Working Together 2013 p68
To scope reviews, which are proportionate to the seriousness of the case and recommend a suitable methodology. Also to identify suitably qualified lead reviewer(s)	Meaningful reviews take place within timescale and budget.
To audit recommendations/findings on behalf of the LSCB and report progress back to the main Board	Partner agencies are aware of progress against recommendations; they are clear about what needs to change and the reasons why.
To improve practice with regard to family involvement	Families are able to make meaningful contributions to serious case reviews
Alongside the LSCB training officer, to disseminate practice lessons and learning to a multiagency audience	Every review is followed by a clear process of dissemination and learning events. Lessons from reviews are collated thematically and incorporated in interagency training

Subgroup: Safeguarding Children in Education	
Objective	**Outcome/measure of success**
To consider any new national or local guidance or information in relation to education and safeguarding children and update Local Authority guidance and disseminate to schools as appropriate.	To take new national or local guidance to the SCiE Sub-Group and to disseminate to schools as agreed.
To ensure that all Headteachers and chairs of governors have undergone safer recruitment training, either face to face or online.	The LA to maintain a central record of safeguarding training undertaken by Headteachers and Chairs of Governors, and to prompt schools where refresher training is required.
To ensure that all link teachers of schools and services undergo training on safeguarding children in education (on at least a two yearly basis).	The LA to maintain a central record of safeguarding training undertaken by link teachers, and to prompt schools and services where refresher training is required.
To consider all SCRs undertaken by the LSCB, to learn from these cases and strengthen safeguarding processes.	All SCRs with implications for educational settings to be considered by the SCiE Sub-Group, and action taken where necessary.
To further develop safeguarding policy and guidance for schools/education services and the associated training programme.	Policy and guidance reviewed twice yearly.
To provide safeguarding audits for all schools where safeguarding issues have been raised or where section 5 Ofsted inspection is due.	Using city-wide date on safeguarding activity in schools to support schools in completing safeguarding policy and practice.
To disseminate to Headteachers and education services the recently revised Children Missing from Education protocol.	Updated protocol shared with all headteachers before 30.09.13.

Subgroup: Promoting Children and Young People's Well-Being Board	
Objective	**Outcome/measure of success**
Monitor the delivery of an effective early intervention offering to contribute to safeguarding	Early intervention demonstrably improving outcomes for children as shown by: Numbers of children & young people receiving an intervention Numbers / proportion of children & young people entering CP or LAC after an early intervention (aim for the proportion being referred "up" to reduce as an indication of early intervention having an preventative effect)
Specifically oversee the CAF system across all agencies and monitor its effectiveness	An effective CAF system is in place and used by all agencies. This will be measured by: Numbers of people trained in CAF and the numbers / proportion of CAFs held by which agencies. Confirmation of pathways and use of case studies to confirm the right children & young people are receiving support through a CAF. Feedback from CAF lead professionals on the effectiveness of CAF processes and support
Develop and deliver effective performance management arrangements for early intervention & CAF	Robust and regular performance monitoring in place to ensure that issues with the system are identified quickly and are resolved. Performance reports to be shared with the LSCB full Board to ensure all partners are aware.
Monitor step up and step down arrangements	Children are effectively supported and their cases stepped up and stepped down from / into CAF seamlessly. Demonstrated by: Performance focus on step up and step downs (numbers and identifying features of these cases) Review processes for specific cases. Report on any findings.

Subgroup: Safeguarding children in health	
Objective	**Outcome/measure of success**
Ensure that serious case review action plans are completed in relation to health and participate in the dissemination of learning,	Timely completion of serious case review actions and dissemination of learning to health professionals
Monitor the development of early help services for children , young people and their families	The health subgroup will monitor the engagement and participation of providers in the development of early help services and provide advice on health engagement to the board
Support young people to get out of situations of sexual exploitation and reduce the risk of such cases	Be assured that health services participate in identification, risk assessment, referral and support of young people at who are being or are at risk of sexual exploitation.
To monitor the further development of multi-agency services to prevent domestic violence and abuse and support children and their families	The health subgroup will be assured that there is a robust and proportionate response from health professionals working with families where there is domestic violence and abuse.
Review arrangements around child sexual abuse medicals	Both Warwickshire and Coventry health sub groups will have been assured that SARC and paediatric arrangements are robust in relation to child sexual abuse medicals
Review existing arrangements for health involvement in rapid response and child death process, benchmarking against Working Together (2013) to ensure compliance across Coventry and Warwickshire and report to and discuss with executive leads for safeguarding	Health commissioners and LSCB will be assured that arrangements for health involvement in rapid response for child death are robust and in line with Working Together (2013) guidance
Review capacity to meet demand for safeguarding , child protection, training, advice and supervision and assure the board and commissioners that providers have capacity to and are meeting their statutory safeguarding responsibilities in line with Working Together 2013 and other statutory guidance	Health providers will demonstrate to commissioners and the LSCB that there is sufficient capacity to undertake statutory safeguarding responsibilities in line with Working together 2013

Appendix 2

LSCB Contributions and expenditure 2012- 2013

a) LSCB Contributions

Agency		**Amount (£)**	**% of Budget**
Coventry City Council	Core Budget	120,061	
	Services to Schools	10,563	
	Early Years & Childcare	3,230	
	Youth Offending Service	1,077	
	Total	134,931	59.9%
Coventry NHS PCT		42,516	18.9%
West Midlands Police		15,000	6.7%
Probation		3,000	1.3%
Connexions		1,120	0.5%
CAFCASS		550	0.2%
Training Income		7,000	3.1%
Coventry NHS PCT – SCR Contribution		10,612	4.7%
West Midlands Police – SCR Contribution		10,612	4.7%
Total		**225,341**	

b) LSCB Expenditure 2012-13

Category	**Amount (£)**
Salaries	81,778
Support Service – Administration Officer	16,000
Business Manager Cover (during maternity leave)	25,370
Independent Chair of LSCB	12,699
Independent Chair of SCR group (from November)	1644
Travel Expenses - for staff	2,534
Support Service - ICT	2,600
Child Death Overview Panel costs	20,300
Procedures and Website	4,000
Support Service - Printing	2,845
Support Service - Stationery	819
Serious Case Review (x3)	28,789
Training and LSCB development	
Equipment Hire	166
Catering	3,609
Room Hire	3,727
Consultancy - scr author costs	11,339
LSCB development day	1413
Annual Conference	1497
Total Expenditure	**221,129**
Under Spend	**4,212**

Appendix 3

Acronyms

CAF	**Common Assessment Framework**
CAIU	**Child Abuse Investigation Unit**
CCG	**Clinical Commissioning Group**
CDOP	**Child Death Overview Panel**
CFFT	**Children & Families First Team**
CLYP	**Children Learning and Young People's Directorate**
CME	**Children Missing from Education**
CPC	**Child Protection Conference**
CSCB	**Coventry Safeguarding Children Board**
CSP	**Community Safety Partnership**
DVA	**Domestic Violence and Abuse**
FNP	**Family Nurse Partnership**
IRO	**Independent Reviewing Officer**
LARC	**Local Authority Research Consortium**
LSCB	**Local Safeguarding Children Board**
PCYW	**Promoting Children and Young People's Wellbeing**
PNMR	**Perinatal Mortality Rate**
PPU	**Public Protection Unit**
PRU	**Pupil Referral Unit**
PVI	**Private Voluntary and Independent Sector**
RAS	**Referral and Assessment Service**
SCIE	**Social Care Institute for Excellence**
SCR	**Serious Case Review**
SIDs	**Sudden Infant Death syndrome**
UHCW	**University Hospital Coventry & Warwickshire**