DANIEL PELKA REVIEW PROGRESS REPORT ON IMPLEMENTATION OF RECOMMENDATIONS

14th March 2014

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1. Introduction

1.1 This report updates the Coventry Safeguarding Children Board (CSCB) and the Education and Children's Services Scrutiny Board of Coventry City Council on further progress made by partners on the implementation of recommendations arising from the Daniel Pelka Serious Case Review conducted by Ron Lock and published on 17th September 2013.

2. Methodology

2.1 Further to previous reports in November 2013 and January 2014, this report summarises additional evidence supplied by key CSCB partners following an update request detailing progress against the fifteen key recommendations laid out in the original Serious Case Review report.

2.2 At the Full CSCB meeting on 24th January 2014, a Daniel Pelka Priority Action Plan was discussed and agreed by Board members. This specified in more detail the actions required to reassure the Board and other interested parties of actions taken, and the commencement of measuring the impact of such actions on local safeguarding practice.

2.3 The Priority Action Plan comprises of 35 priority actions arising from the original Serious Case Review recommendations. The actions as they relate to the recommendations from the published Serious Case Review report are reproduced at Appendix 1 in this report, but for expediency, the work to achieve successful implementation and measurement of these actions has been subdivided into seven categories within the body of this report.

2.4 The seven sub categories are:

1. Work to improve sharing of information on domestic violence and abuse incidents, including a review of the effectiveness of the Joint Screening Process, and how this can be measured and audited.
2. Efforts to implement an effective Early Help strategy across the City.
3. The effectiveness of the Social Care referral and assessment process, including consultation, strategy discussions and feedback to referrers.
4. Safeguarding issues in schools, including the recording of safeguarding concerns and the extent of child protection training and expertise across the workforce.
5. Wider multi agency training on child protection themes such as emotional abuse and neglect and the lessons arising from this review.
6. Specific health issues including health visiting provision
7. The use of interpreters to capture more effectively the voice of the child.

3. Information sharing of Domestic Violence reports

3.1 The Serious Case Review report required the CSCB to undertake a review of the existing notification process and improve the effectiveness and timeliness of domestic violence and abuse reports. This has been completed and the joint screening process has been revised and refined. There has been a marked improvement in the timeliness of information being passed by the Police in recent months. Additionally there has been a change to the process which has resulted in all cases not open to Social Care (or recently closed) now being jointly screened. A flow chart of this process is provided (Appendix 2).

3.2 Where a Domestic Violence and Abuse incident is identified as requiring an urgent child protection response, practice has not changed and will be responded to in line with statutory requirements to protect the child from immediate harm.

3.3 It must be remembered that the joint screening process for reviewing Domestic Violence and Abuse incidents in Coventry is an interim measure. The proposal for developing a Multi-Agency Safeguarding Hub (MASH) which would jointly screen all referrals including Domestic Violence and Abuse incidents has been agreed in principle by key partners represented on the recently convened MASH Board.

3.4 The Board first met in February 2014 and will continue to meet monthly to ensure that the various elements required to establish a MASH are prioritised and taken forward. This will involve key work streams around information governance, Information and Communications Technology, workforce, property etc. At the meeting held on 17th March 2014 the Board agreed the Terms of Reference and Project Mandate. The MASH will be developed over the next eight months.

3.5 In relation to information updating the CSCB Priority Action Plan, an analysis of incidents provided to the Board for the period from November 2013 to February 2014 has shown an improvement in the average number of days taken from being reported to the police to the incident being screened. In November for example the average was **18 days**. Statistics for February 2014 show this had reduced to **five days**.

Table 1

Detail	Nov 2013	Dec 2013	Jan 2014	Feb 2014
Notifications received	206	279	250	222
Number of children noted	380	466	449	417
% open to Social Care (or contact already received)	29.1%	25.1%	34.2%	34.7%
% subject to Screening	70.9%	74.9%	66.8%	65.3%
% of notifications sent to Screening process that were joint screened	28.1%	26.3%	32.3%	95.2%
Ave number of days between report and returned	18.2	10.2	6.6	5

3.6 The above table also shows a significant increase in the number of incidents which are being jointly screened by the Joint Screening process. This figure was 28% in November (when Police were deciding which cases should be jointly discussed), but has risen to over 95% of all incidents not open to Social Care by February 2014. It has been reported that all cases not open to Children's Social Care are now jointly screened.

3.7 Police, Children's Social Care, Probation and health representatives from CWPT and the CCG attend the joint screening meetings. Incidents are shared with those attending the meeting for onward transmission and action as agreed at the joint screening meeting. Representation and attendance at Joint Screening meetings from Education Services will be in place by the end of March 2014.

3.8 CWPT also routinely receives a list of reported Domestic Violence and Abuse incidents on a daily basis which are input to the Trust Domestic Violence data system. The notifications are subjected to lateral checks within the CWPT and

reviewed by the named professional for domestic abuse and the information is then passed on to the relevant health professionals working closely with children and families within CWPT

3.9 Schools routinely receive Domestic Violence and Abuse notifications as agreed by local agencies and reported previously. This innovative practice enables schools to be notified of all Domestic Violence and Abuse incidents so that they are aware of this aspect of pupils' lives and can monitor and support accordingly.

3.10 All schools were put on the notification system by December 2013. The People Directorate undertake the secure transfer of Domestic Violence and Abuse information and are monitoring the number of days it takes from date of incident to onward transfer to schools. In January 2014 the average time taken was 12 days. This reduced to six days in February 2014.

Outstanding Issues

3.11 The People Directorate are also monitoring the response that schools provide in terms of the action they intend to take. Analysis shows that there are issues with some schools and delays in confirming the routine response they have decided upon (the "electronic handshake"). Council representatives have held meetings with Headteachers to agree how this can be further improved and will monitor and challenge schools where needed.

3.12 The author has been made aware of the plans in place to extend the routine notification of Domestic Violence and Abuse incidents to children centres in Coventry. There are some data transfer security issues which are being addressed and children centre staff will receive advance training from the police regarding content, but it is intended that this system will be able to be implemented by Easter 2014.

3.13 In the responses received so far there has been much mention of the engagement of schools with the Domestic Violence and Abuse process, but little information relating to the Early Years providers. Whilst it is acknowledged that there may be significant complexities in engaging with this large and diverse group, the author would be interested in understanding the extent to which senior CSCB partners have considered extending the information processes with them.

3.14 One issue which requires further attention relates to when a case is already open to Children's Social Care and there are multiple reports of Domestic Violence and Abuse incidents. In these cases further work and audit analysis is required from the Local Authority to assure the CSCB that these additional incidents are informing the work being undertaken by the Department, in particular how they influence any reassessment of risk that may exist. The author is aware that this is due to be

addressed through the monthly case file audit process and recommends that the resulting data be shared with the CSCB once it is available.

3.15 A gap has been identified with regard to notification of Domestic Violence and Abuse incidents to GPs. If a decision is made at joint screening meetings to notify the GP then this action is followed up. However, the current process does not allow for GP information to be added to the discussions held at joint screening, which might be useful in deciding what action should be taken.

3.16 Discussions with commissioners identified the need to develop a consistent method of checking Domestic Violence and Abuse information with GP practices prior to joint screening meetings.NHS England are currently looking at possible solutions to this issue.

Audit processes

3.17 The CSCB Practice and Quality Sub Group has reviewed its work plan and revised the multi agency audit tools that it employs to scrutinise the notification process.

3.18 In addition, partners have reported that they have included questions about the effectiveness of specific actions arising from the screening process within their own audits and information will be provided to the CSCB for scrutiny during 2014-15.

3.19 NHS England advise that they are undertaking GP audits during March and April 2014, including information about Domestic Violence and Abuse. Results from the audit are expected by the end of May.

4. The Early Help Process in Coventry

4.1 The original Serious Case Review report noted that there was a requirement to accelerate the progress of a coherent early help strategy in Coventry. This would assist not only families experiencing domestic abuse but also respond to the additional needs of families in respect of a range of issues.

4.2 The Prevention and Early Help Sub Group is leading on addressing this deficit. The Group has developed a draft strategy and action plan to implement this across Coventry which is due for ratification by partners at their next meeting in March 2014.

4.3 A baseline report will be provided to the CSCB in May 2014 to advise partners of progress made at that time.

4.4 NHS England has specifically rewritten the specification and a set of standards are in place with regard to the health visiting service, including the requirement to lead on the Common Assessment Process where appropriate.

4.5 The CCG also reports that it has revised its own contract specifications with local health providers to take due regard of the recommendations arising from the Daniel Pelka case. They further report that within their monthly performance meetings with providers safeguarding is a standing agenda item for discussion.

5. The effectiveness of the Referral and Assessment Process

5.1 Ron Lock's Serious Case Review report identified four specific areas relating to the Local Authority's response to referral information. They were:
a) Assurance that when completing assessments they involve and consult with other agencies and do so in a timely manner
b) Strategy Meetings/Discussions are being efficiently and accurately recorded with actions clearly identified and that the record and listed actions are distributed to the relevant agencies in a timely fashion.
c) In instances within a Strategy Meeting/Discussion when medical opinion is inconclusive regarding whether an injury was accidentally or non-accidentally caused, then the follow up interventions with the family must continue to include the child protection concerns as factors and address them rigorously until any new information or assessment discounts them.
d) That effective processes are in place to ensure that there is appropriate and consistent feedback to professionals who make safeguarding referrals, of the work undertaken in response to those referrals.

5.2 Children's Social Care report that recent audits of case files commissioned by them show that appropriate consultation with agencies has been sought in 73% of cases.
More information is required for the CSCB to understand whether in the other 27% of cases there should have been other agency involvement and how this is being addressed.

5.3 It is further reported that timeliness of completion of assessments is occurring in 43% of cases. This is recognised by the Local Authority as being too low and the Council improvement plan has set a target of 85% compliance within the next nine months.

5.4 Following the Serious Case Review review delays in providing actions arising from strategy discussion were improved by the move to copying hand written notes from any discussions/meetings held (electronic notes to follow). Agency partners confirm that this practice is being maintained. There is however the issue of the receipt of notes after the meeting for those not in attendance. Currently the average

time taken from date of discussion to being entered onto the Integrated Children Service system for onward transmission is approximately 14 days. The Local Authority acknowledges this should be expedited much quicker and are looking at how this can be improved.

5.5 An issue which has been noted previously is that of police attendance at strategy discussions/meetings and this still remains a cause for concern. This is due to a current working practice between West Midlands Police and Coventry Council. Both partners are continuing to work together to review the effectiveness of this process and will update the CSCB of their deliberations.

5.6 Children's Social Care are currently working on ways to improve their Integrated Children System in order to capture their effectiveness in providing feedback to professionals who have made a safeguarding referral. In addition the Practice and Quality Assurance Sub-Group of the CSCB has included this parameter in their multi-agency audit process for S47 referrals and will be able to independently report back on compliance when they undertake their next scheduled S47 audit.

5.7 The Practice and Quality Assurance Sub-Group also asked partners to undertake a brief dip sample analysis of ten cases where they had made a CP referral. UHCW reported back that they had received feedback in only 50% of the cases. Where feedback had been given it ranged from 4-87 days. CWPT are currently undertaking a similar audit.

5.8 NHS England has advised that they are reviewing ways in which GPs can take a more active part in child protection processes, using good practice examples from other parts of the region. They will update the CSCB shortly.

6. Safeguarding Issues in Schools

6.1 The original Serious Case Review report identified the need for the CSCB to receive assurance that schools in the area undertook sufficiently adequate child protection training for their staff, as well as the need to ensure that robust recording systems are in place to note safeguarding concerns.

6.2 The CSCB circulated a Schools Safeguarding Audit in late 2013. The template is provided at Appendix 3 of this report. At the time of writing this report 95% of schools have responded and the Local Authority is currently chasing the few outstanding schools for their returns.

6.3 Each of the audits returned have been analysed by CSCB and Council staff to identify areas that require immediate or medium term follow up. The Local Authority reports that letters are being sent to all schools in response to their submission. If

safeguarding deficits have been identified these have been referred back to the school for action.

6.4 Where the audit identifies any safeguarding risks the Local Authority reports that these are followed up immediately. All advice on improving and strengthening practice will be monitored through further audit work in the Summer Term 2014 and further action is expected.

6.5 The Local Authority has also advised the Board that 10% of schools are in the process of being visited by Council staff for closer scrutiny of their safeguarding and child protection arrangements, particularly where concerns have been identified as a result of the audit.

6.6 In addition, the Local Authority has asked an independent Education specialist, Dr. Lynn Perry (who was involved in the Daniel Pelka Deeper Analysis Project) to provide a view of the robustness of the audit undertaken.

6.7 A full report on the audit findings will be presented to the CSCB in May 2014. A summary report of findings will be published at this time, further demonstrating the commitment of the CSCB and schools to improving safeguarding and child protection in the City.

6.8 With regard to schools training, the Local Authority reported a number of developments, including:

- Additional safeguarding training has been arranged for school staff, particularly at Level Two, to address and prevent waiting lists.
- A two hour training update session on safeguarding and child protection is planned for all Headteachers during the summer term.
- A similar session for all Governors is planned for April 2014 and has been arranged through the Coventry Governors Association.
- The Local Authority reports that over 150 Governors have received safeguarding training since September 2013 and that there is currently no waiting list for this specific training. A further course is planned for the summer term.
- A new specialist course for senior designated staff in education settings, which will include coverage of recording systems, has been developed and will be offered during the summer term.
- An updated refresher training package, appropriate for delivery at whole school safeguarding training, is due to be issued to all schools in the summer term in readiness for dissemination for the new Academic year.

6.9 In addition to those developments detailed above, the half termly meetings between designated school safeguarding leads and senior officers of Education, Social Care, Health and Police continue.

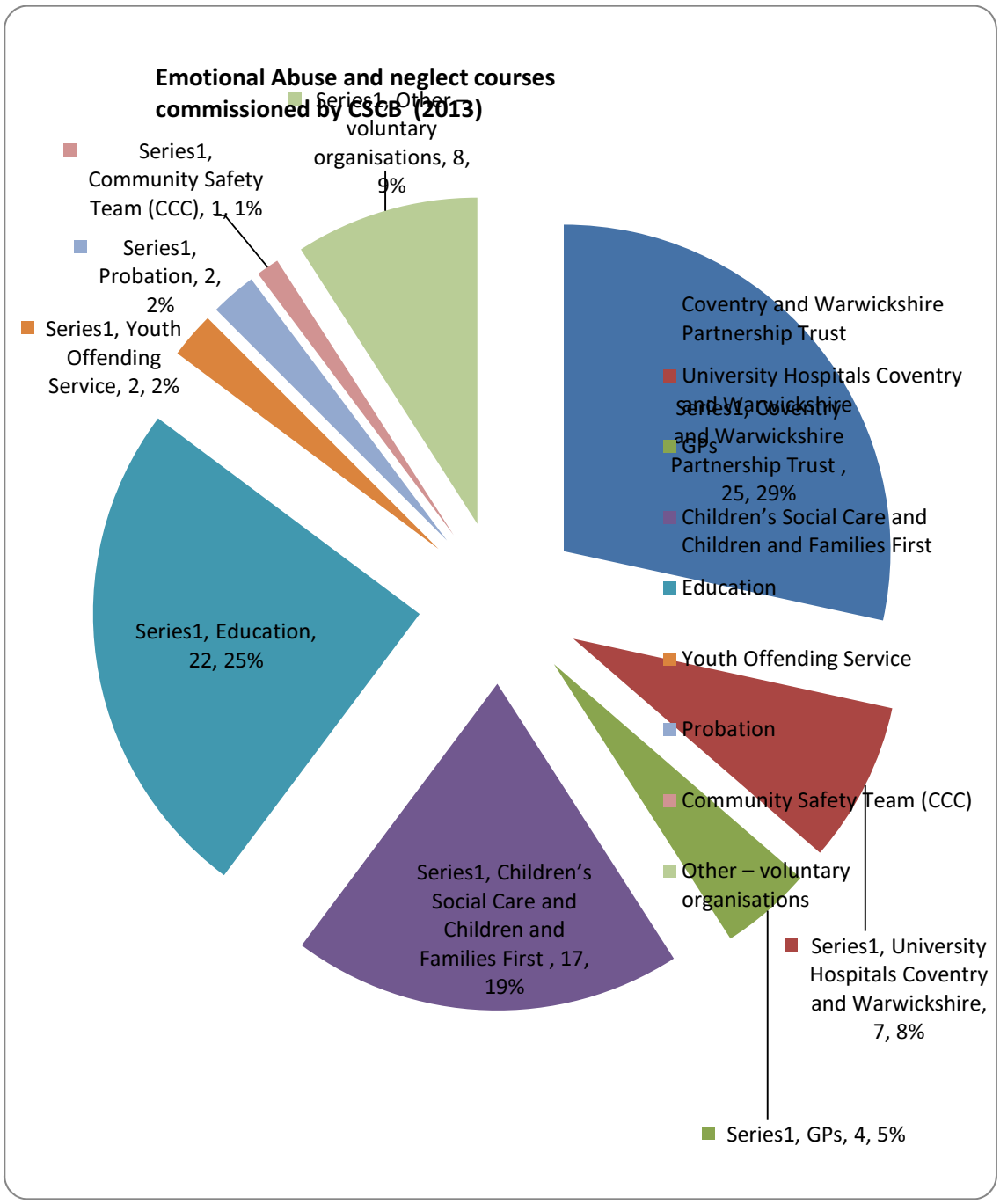
6.10 With regard to child protection policies, the Local Authority circulated a model policy and recording proforma to schools in December 2013. They report that they are currently in the process of following up with schools to confirm that all policies have been updated to reflect the Local Authority's guidance to better understand the current practice in Coventry.

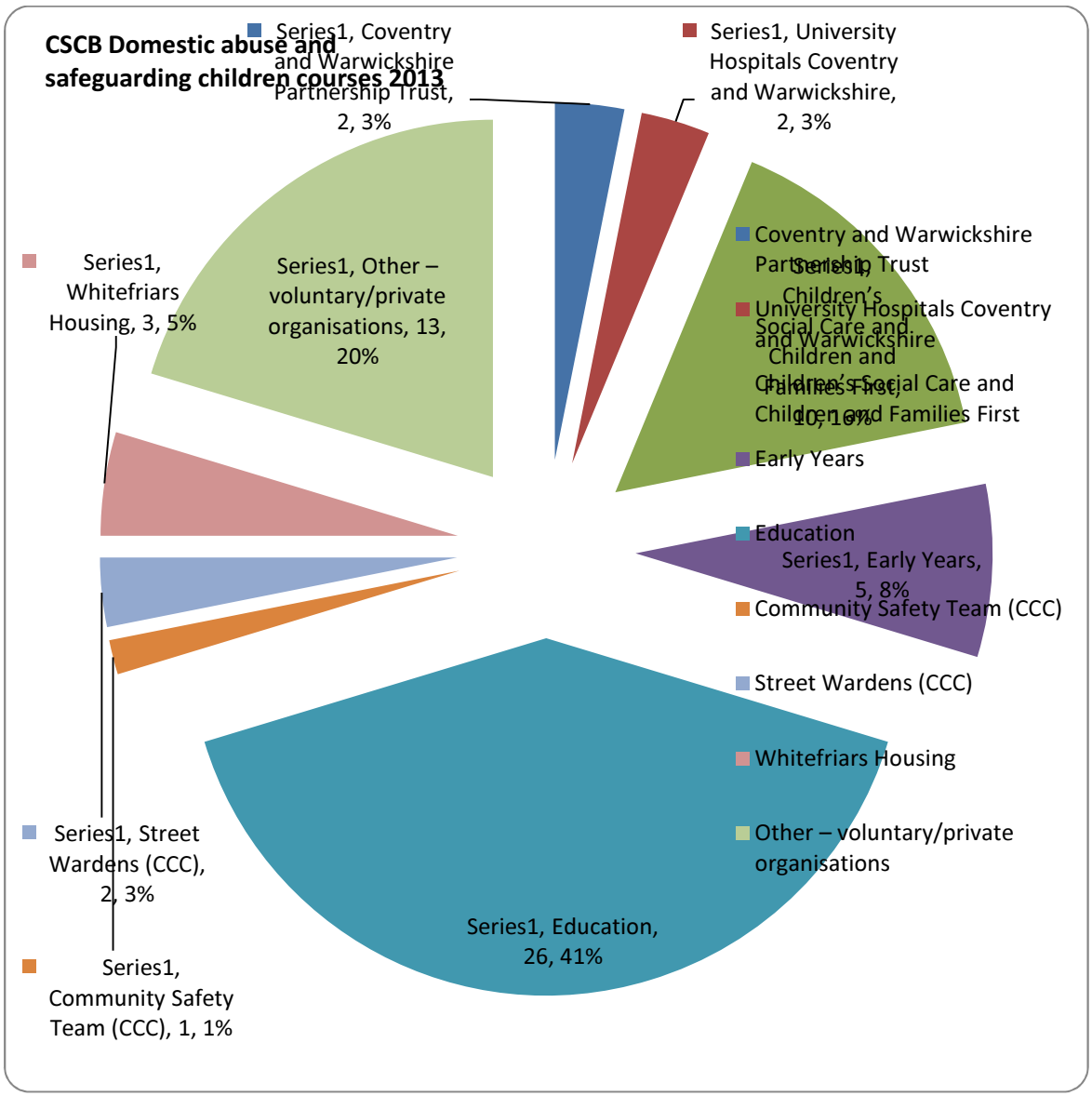
7. Wider multi-agency child protection training issues

7.1 The Serious Case Review report highlighted the need for the CSCB to review, and where necessary initiate, training and development opportunities in Domestic Violence and Abuse, emotional abuse and neglect. It further determined that the lessons from the review should be disseminated widely across the children's workforce in Coventry.

7.2 Partners have already provided information to the author outlining how they have embedded the messages in their communications with staff. The Training Sub Group of the CSCB has also explained to the author how multi agency training commissioned by the Board has included these messages and information about the working of the joint screening process.

7.3 In responding to the Serious Case Review recommendations, the CSCB has commissioned four Emotional Abuse and Neglect courses, with 88 attendees, and three Domestic Violence and Abuse courses (64 attendees), attended by a range of agencies. Breakdowns are as follows:


Emotional Abuse and neglect courses commissioned by CSCB (2013)
Series1, Other – voluntary organisations, 8, 9%
Series1, Community Safety Team (CCC), 1, 1%
Series1, Probation, 2, 2%
Series1, Youth Offending Service, 2, 2%
Series1, Education, 22, 25%
Series1, Children's Social Care and Children and Families First , 17, 19%
Series1, GPs, 4, 5%
Series1, University Hospitals Coventry and Warwickshire, 7, 8%
Series1, Coventry and Warwickshire Partnership Trust , 25, 29%
Coventry and Warwickshire Partnership Trust
University Hospitals Coventry and Warwickshire
GPs
Children's Social Care and Children and Families First
Education
Youth Offending Service
Probation
Community Safety Team (CCC)
Other – voluntary organisations



7.4 In addition, 230 primary care practitioners and other agencies attended a session held in late February 2014 that focused specifically on the messages from Daniel Pelka's case, including messages on Domestic Violence and Abuse and early intervention particularly the Common Assessment Process

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7.5 Two sessions at UHCW have been held for staff during the last six months specifically around the case and learning has also been transferred to Warwickshire GPs.

7.6 The CCG has ensured that all GP practices have received child protection training on issues that include emotional abuse and neglect. In addition messages from the Daniel Pelka review also informed training events.

7.7 The CSCB have been involved in and are aware of a number of events where recent Serious Case Reviews have been disseminated and newsletters have been circulated and made available on the website. Whilst numbers are not currently available key partners have made an assurance at Board level of the wide dissemination of the messages from Daniel Pelka's case.

7.8 The CSCB are currently delivering further Serious Case Review seminars to multiagency audiences. A session will also be delivered specifically for schools to further embed the learning in the City.

7.9 NHS England is planning to develop a GPs safety newsletter which includes messages from serious case reviews.

8. Health Issues

8.1 In addition to the requirement for Health partners to show how effectively they engage with the Domestic Violence and Abuse notification system, the assessment process and in the training of their staff as key partners to the CSCB, there were some specific questions raised within the original Serious Case Review report with regard to health matters.

8.2 The CSCB were asked to monitor developments within the Coventry health visiting provision to ensure the progressive delivery of the Healthy Child Programme in line with increased health visiting capacity. NHS England representatives have subsequently provided data to show to the Board that in this area the agency remains on track to deliver the necessary increase in health visitor provision in line with nationally set targets.

8.3 NHS England also advised that the health visitors recruited are all aware of their safeguarding and child protection responsibilities.

8.4 The report also highlighted the requirement that health partners assure the CSCB that their Paediatricians and other medical staff involved in assessing the welfare of children would consider child abuse as a differential diagnosis as part of an holistic assessment of the child. Assurances have been given that all identified staff have been made aware of this requirement. CWPT discuss this issue regularly at peer review meetings when appropriate. This has also been embedded within specialist training for health staff.

9. Use of Interpreters

9.1 The Serious Case Review report highlighted the need to have a consistent response for using interpreting services to ensure that the 'voice of the child' is heard in cases of concern.

9.2 All CSCB multi-agency audits have been revised to ensure that the question of the 'voice of the child', including use of interpreters, is asked and considered within the Board's own audit findings.

9.3 The revised Children's Social Care audit specifically asks this question and looks at the use of interpreters. The random audits undertaken by the Department will ensure that this important area of assessment is not overlooked.

9.4 CWPT has also advised the Board that they have revised their audit tool to look at how interpreting services are being utilised by their agency. Their first audit is planned for June 2014.

9.5 The CCG has implemented a service development in provider contracts by requiring providers to show the commissioner how they are implementing the 2011 Ofsted recommendations capturing 'the voice of the child'. This forms part of their performance review.

10. Conclusion and summary of progress made

10.1 Since the last report to the Board partners have begun to provide more detailed analysis of the impact of the work commenced as a result of Daniel Pelka's review, alongside the need to provide evidence of improvement in safeguarding from other processes.

10.2 The author can report that information provided recently supports the assertion by CSCB partners that progress has been made across the fifteen recommendations identified in the original report.

10.3 There was a delay in the CSCB's development of a more detailed action plan to measure progress against the fifteen recommendations. However this has been rectified and work has been completed on the identification of where within the CSCB organisational structure future evidence submissions from partners will be scrutinised and where necessary challenged. Sub group work plans are currently being revised to embed this scrutiny work for 2014-15.

10.4 There remains evidence of variability in practice however that is of concern. Six months on from publication of the original Serious Case Review report some of the improvements in practice required to be implemented are only now starting to be addressed.

10.5 One area that requires particular attention over the next three months is the clear identification of pathways to understand how organisations across the diverse range of health partners receive information relating to Domestic Violence and Abuse and, more importantly, how the Board can be assured that they are able to participate in the information gathering and decision making of the joint screening process (particularly the work commenced with GPs in this regard).

10.5 Whilst it is acknowledged by the author that the work on the joint screening process is an interim measure until the full implementation of a Coventry MASH, it is important for the Board to be clear that progress on information gathering, sharing and decision making in cases of Domestic Violence and Abuse is made from as wide a range of information sources as possible.

10.6 Another area that the CSCB should receive assurance on is the method by which Children's Social Care ensures that further Domestic Violence and Abuse notifications on already open cases receive a greater level of attention and inform and influence the allocated worker's understanding and reassessment of risk factors that may or may not be present in the case.

10.7 A further area is outlined in 3.13 above. The CSCB would benefit from a discussion with key partners as to the viability of extending the Domestic Violence and Abuse notification system to organisations in the Early Years sector.

REPORT ENDS

Appendix 1 – Priority Action Plan

Rec no.	Recommendation	Priority Actions
16.1	There must be a review of the systems which currently exist for the notification and sharing of information in respect of domestic abuse incidents within families to ensure that they generate effective outcomes in relation to the safeguarding of children. The review should particularly focus on:•The timeliness of notifications•The agency to which they should be distributed, including schools•The importance of a focus on the needs and safety of the children•The efficiency and effectiveness of the joint screening processes and the responsibility for agreed outcomes, and•How repeat domestic abuse incidents need to be responded to more holistically	**Priority Action 1. Police to ensure appropriate agencies receive timely notifications** **Priority Action 2. Partner agencies to improve the timely dissemination of notification reports.** **Priority Action 3. Improve management of screening process** **Priority Action 4. Ensure higher priority for consideration of intervention is given to multiple incidents of DVA**
16.2	In order for the LSCB to understand and identify how to improve the multi-agency response to domestic abuse notifications, particularly in respect of the safeguarding of children, then an audit process must be developed to judge how individual agencies respond to notifications which they receive, and as a result, what changes are needed to improve the ways in which agencies individually and collectively ensure that the protection needs of the children involved are being addressed by such responses.	**Priority Action 5. Develop a multi agency audit framework to ensure improvements in DVA responses are made** **Priority Action 6. Develop or update existing single agency audit processes and provide periodic audit evidence to Board**
16.3	The LSCB needs to demonstrate a clear cohesive understanding of the scope of early help and prevention work to support children living with domestic abuse.	**Priority Action 7. LSCB to commission an independent review of the child's journey through care processes, including early help** **Priority Action 8. To ensure existing strategic work underway is progressed.** **Priority Action 9. To convene periodic strategic meetings to engage all partners and update progress.** **Priority Action 10. Plan and implement audit of effectiveness of early help**
16.4	The LSCB will need to be assured by the provision of evidence that assessments undertaken by Children's Social Care appropriately involve and consult with other agencies and professionals in the completion of such assessments and do so in a timely manner.	**Priority Action 11. Local authority to provide periodic audit data to evidence timeliness and quality of assessment**
16.5	The LSCB must be assured that Strategy Meetings/Discussions are being efficiently and accurately recorded with actions clearly identified for individual agencies or professionals to undertake, and that the record and listed actions are distributed to the relevant agencies in a timely fashion.	**Priority Action 12. Partner agencies to provide periodic audit evidence of their engagement with assessment process and assurance that they have been consulted**

Priority Action 13. Local Authority to provide the LSCB with quarterly updates in respect of strategy meetings/discussions, to include: > The number undertaken, > Which agencies were in attendance, > % of records of meetings provided within procedure timescales

16.6 In instances within a Strategy Meeting/Discussion when medical opinion is inconclusive regarding whether an injury was accidentally or non-accidentally caused, then the follow up interventions with the family must continue to include the child protection concerns as factors and address them rigorously until any new information or assessment discounts them.

Priority Action 14. Agencies to review current practice

Priority action 15. Follow up audit to determine compliance across partnership.

16.7 Children's Social Care need to assure the LSCB, via an audit of compliance, that effective processes are in place to ensure that there is appropriate and consistent feedback to professionals who make safeguarding referrals, of the work undertaken in response to those referrals.

Priority Action 16. LA to provide LSCB with periodic data that identifies feedback to partners. Parameters: >How many contacts in period, >How many resulted in referrals taken, >The % of contacts and referrals where feedback was provided to referrer

Priority Action 17. Agencies to refresh staff awareness of their own escalation policy and/or the CSCB Escalation and resolution of professional disagreement policy

16.8 The LSCB must consider the need to initiate multi agency training or generate professional development opportunities in respect of the detection and identification of severe emotional abuse and neglect in children and young people, and include the details from this case to enhance the learning. The training will need to provide clarity regarding the responses necessary to address such abuse.

Priority Action 18. LSCB to review its multi agency training strategy to ensure emotional abuse and neglect training is in place

Priority Action 19. To ensure lessons from this SCR are included in any commissioned training

Priority Action 20. To provide the Board with six monthly updates on numbers of professionals trained in this area.

16.9 The LSCB will need to review the adequacy of multi-agency and individual training in respect of domestic abuse and its impact upon children, and promote that such training in the future includes their role in any revised systems for joint screening of domestic abuse concerns.

Priority Action 21. The LSCB to be provided with an update report on both multi agency and single agency training in respect of domestic abuse

Priority Action 22. Partners to provide the Board with half yearly updates on numbers trained

Priority Action 23. Training sub group to evaluate quality and effectiveness of training and report to Board annually

16.10	The LSCB must review the adequacy of child protection training for school staff in terms of its sufficiency of provision, its take up and of its effectiveness in improving and developing child protection practice.	**Priority Action 24. LA to provide the Board with a needs analysis report on child protection training required for schools, specifically highlighting any immediate shortfalls in provision**
		Priority Action 25. LSCB to be advised of audit data that identifies any inadequacy provision of training for Designated staff; Teaching staff; Non teaching staff; Governors
16.11	The LSCB must be assured by the Local Authority that education settings which are under their control, and assured by governing bodies for those schools which are not maintained **by the Local Authority, have:-** a robust system for recording any injuries or welfare concerns identified or noticed about a child by staff, and of necessary actions to address those concerns- and that the role and responsibilities of the designated professional for safeguarding are clearly understood and utilised effectively.	**Priority Action 26. LSCB to survey all schools on following: >Recording of concerns, >Roles of DTs and collate findings into a report**
		Priority Action 27. LSCB to work with LA on any improvements identified as required and to monitor progress.
16.12	The LSCB should monitor developments within the Coventry health visiting provision in ensuring its progressive delivery of the Healthy Child Programme in line with increased health visiting capacity. The Local Area Teams representatives of NHS England on the LSCB will need to ensure that the LSCB receive updates on the progress of such developments.	**Priority Action 28. LSCB to meet with health commissioners to determine current position of health visiting capacity.**
		Priority Action 29. Commissioners to provide periodic updates on progress towards national health visiting targets.
16.13	Paediatricians and other medical staff who are required to assess the welfare of children who present with unclear concerns, should always consider child abuse as a differential diagnosis as part of an holistic assessment of the child. The LSCB will need to be assured by the relevant health body that this practice has been consistently adopted.	**Priority Action 30. The CWPT and UHCW to provide the LSCB with periodic audit data identifying that the Royal College of Paediatrics and Child Health guidance is being adhered to within the respective Trusts**
16.14	The LSCB should develop a protocol which will help to ensure that individual agencies consistently utilise interpreter services with families who do not have English as a first language and especially in cases where there are concerns about the welfare of children. The protocol will need to stipulate that interpreters must be used to interview children alone or to enable them to understand their wishes and feelings, when they are the subject of safeguarding concerns.	**Priority Action 31. LSCB to develop and ratify new interpreter protocol**
		Priority Action 32. Partners to provide updates for annual report on activity relating to improving responses to language issues in child welfare.

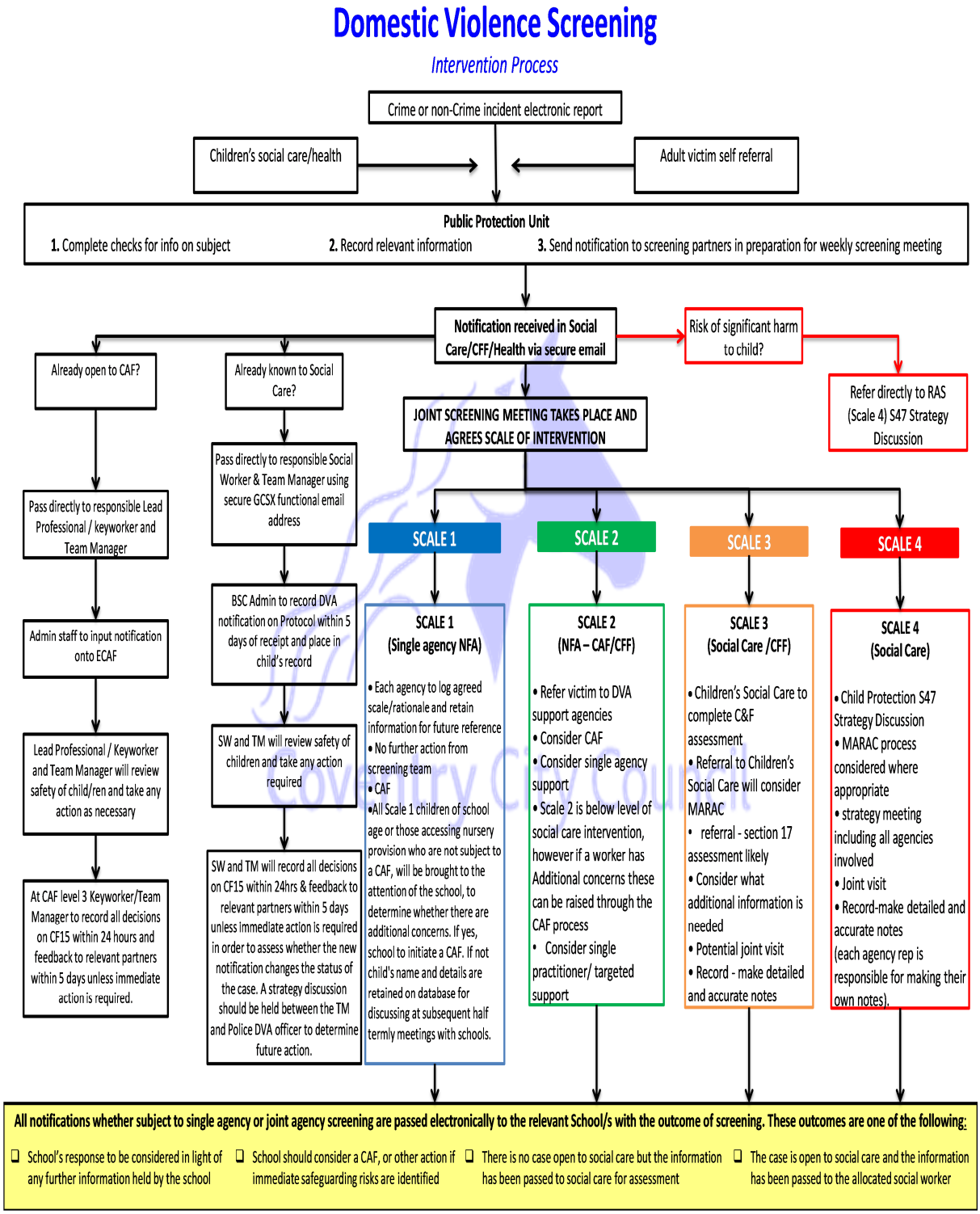
16.15 The lessons learned from this SCR and detailed in paragraphs 15.1 – 15.14 must be disseminated to relevant staff working with children throughout Coventry, and a process identified to ensure that these lessons have been learned and as far as possible be integrated into safeguarding practice. Particular opportunities should be afforded to those individual practitioners, managers and their teams who were directly involved with Daniel and his family, to consider the findings from this SCR in a learning environment, identifying how to use this as a supportive experience to develop and improve safeguarding practice of children in the future.

Priority Action 33. LSCB to publish SCR information on website and signposted in LSCB newsletter

Priority Action 34. Ensure messages are included in LSCB commissioned and single agency training at all levels

Priority Action 35. LSCB to ensure these SCR messages are included in multi agency workshops

Appendix 2 – Joint Screening Process flow chart



Coventry Safeguarding Children Board

Appendix 3 – CSCB Schools Safeguarding Audit

Safeguarding and promoting the welfare of children and young people – Statutory responsibilities of schools and FE Colleges under section 175 and 157 of the Education Act 2002 and compliance with Safeguarding Children and Safer Recruitment in Education, DfES (2007)

School/FE College:				
Name, designation & contact details of Designated Safeguarding Officer	**Name:**		**Designation:**	
	Tel No:			
	Email:			
Please Return by-	**Completed by:**		**Designation:**	
	Approved by:		**Designation:**	
	Date:			

1	**PROCEDURES**		
1.1a	**Has the school/FE college a child protection policy and associated procedures?**	YES	NO
1.1b	**Does the policy describe the types of abuse covered?**	YES	NO
1.1c	**Does the policy and procedures include reference to the Local Authority Designated Officer (LADO)**	YES	NO
	Details:		
1.1d	**Are there procedures in place for allegations against the head teacher (ie to the designated governor), as well as staff and volunteers?**	YES	NO
1.1e	**Does the procedure include staff at all levels raising & recording concerns about poor or unsafe practice with regard to children?**	YES	NO
1.1f	**Date of when the child protection policy and procedure was last reviewed:**		

1.2a	**Are all staff (teaching, non-teaching, full time, part-time and volunteers) made aware of their role in safeguarding children and clear about the process for raising concerns about a child's welfare and safety?**	YES	NO
	Please comment on how they are made aware:		
1.2b	**When was the most recent whole staff training on recognising the signs & symptoms of abuse?**		
	What was its length?		
	Who delivered the training?		
1.2c	**Where are the reminders about safeguarding processes for staff generally, and designated staff for safeguarding, displayed around school/college?** **Please comment:**		
1.3a	**Has the school/FE college a procedure to ensure safer recruitment?**	YES	NO
1.3b	**Do all interview panels have at least 1 individual on the panel who has been trained in safer recruitment?**	YES	NO
1.4	**How are all staff made aware of the school's code of conduct for staff, including behavioural expectations of staff and staff use of social media?** **Please comment:**		
1.5	**Is there a single, up-to-date and complete central record of recruitment and vetting checks?**	YES	NO
1.6	**Has the school/FE college a procedure for the engagement of contractors on the school site?**	YES	NO
1.7	**Has the school/FE college a procedure for the use of supply staff and the use of instructors and other staff coming into contact with pupils off the school site?**	YES	NO

2	**INTER-AGENCY TRAINING IN SAFEGUARDING & CHILD PROTECTION**

2.1	**Please state below the dates of when the safer recruitment training was received for:**			
	The Headteacher:			
	Governors:			
	Others:			
2.2	**How many staff have been trained to complete or lead a Common Assessment Framework (CAF) assessment?**			
2.3	**In addition to basic child protection training the designated person for safeguarding and child protection should undertake training in inter-agency working that is provided by, or to standards agreed by, the Local Safeguarding Children Board, and refresher training at two yearly intervals to keep his or her knowledge and skills up to date (DfES, 2007). In Coventry the training in inter-agency working is provided through 'Working together to safeguard children', a level 2 course. Refresher training can take the form of any selected level 2 or 3 course. What are the dates of your designated person's attending:**			
	Training in 'Working together to Safeguard Children'?			
	Most recent refresher training?			
2.4	**The head teacher, and all other staff who work with children, should undertake appropriate training to equip them to carry out their responsibilities for child protection effectively that is kept up to date by refresher training at three yearly intervals (DfES, 2007). What is the date of the head teacher's most recent initial or refresher training? (If the head teacher is also the designated person for safeguarding then the training requirements of that role apply).**			
	Please state below dates of most recent training for other school/academy staff:			
	Member of staff	***Role***	***Safeguarding Training***	***Date of Training***

2.5	**It is helpful if all members of governing bodies undertake training about child protection to ensure they have the knowledge and information needed to perform their functions and understand their responsibilities (DfES, 2007). Governors may attend multi-agency training provided by the LSCB or governor specific training provided through the Governor Support Service. Please state below the safeguarding and child protection training (with dates) undertaken by members of your governing body.**		
	Governor	***Safeguarding Training***	***Date of Training***

3	**DESIGNATED CHILD PROTECTION PERSON**		
3.1	**Does the designated person have additional time/resources allocated to enable him/her to discharge their responsibilities including attendance at child protection meetings and other inter-agency meetings?**	YES	NO
3.2	**Are records of the induction of the designated person held by the head teacher or the chair of governors?**	YES	NO
3.3	**Explain how the designated child protection officer and all those managing safeguarding concerns about children are receiving supervision both to discuss, reflect and guide activity in children's cases and also to enable staff to cope with the stresses that this work entails.**		

4	**SAFEGUARDING/CHILD PROTECTION ACTIVITY**		
4.1a	**Please describe how staff members are expected to share and record information with all relevant staff regarding specific safeguarding and child protection concerns about children and young people.**		
4.1b	**How do you know the process of raising concerns about children's welfare and safety is effective?**		
4.1c	**When raising a concern about a child's welfare or safety with the designated person for safeguarding are members of staff required to back up each verbal expression of concern with a written expression of concern that is place on the child's safeguarding file?**	YES	NO
4.1d	**Once concerns re a child's welfare and safety have been shared with the designated person for safeguarding what actions may follow?**		
4.1e	**Once concerns re welfare and safety have been raised and recorded how does the designated person for safeguarding decide whether this is a low level concern, or something that must be acted upon immediately? What guidance is used in the decision making?**		
4.1f	**Are safeguarding files kept separate from children's main school files?**	YES	NO
4.2	**How frequently are you having meetings with the CAF Coordinator to discuss children/young people about whom staff have concern? (at least half termly recommended). Please tick the appropriate box:**		

Monthly		***Half termly***		***Termly***		***Other***	

How useful have you found these meetings?	

Very Useful		***Useful***		***Not Useful***	

4.3	**How many CAF's are you currently holding?**	
4.4	**How many members of staff are lead professional for those CAFs?**	
4.5	**How many children are subject to a child protection plan?**	
4.6	**How many children/young people are subject to child in need processes?**	
4.7a	**How many children do you have concerns for who are not yet subject to any formal process?**	
4.7b	**What is the mechanism for discussing the progress of these children? Please comment:**	

5	**ATTENDANCE**		
5.1	**In the last full half term how many children/young people did you have with attendance below 85%?**		
5.2a	**How many of these children/young people were NOT subject to a CAF and why?**		
5.2b	**Why were these children/young people not subject to a CAF? Please comment:**		

6	**GOVERNING BODY MEETINGS**		
6.1	**A report to the governing body regarding safeguarding and child protection, including volume of cases and training issues, must be made at least annually. What was the date of the governing body meeting at which this report was last presented?**		
6.2a	**Has the governing body specifically nominated a governor to have responsibility for child protection issues?**	YES	NO
6.2b	**If yes, has this individual attended the Local Authority Safeguarding 'Just for Governors' training?**	YES	NO
6.2c	**If there is a designated governor for safeguarding and child protection, how frequently does the safeguarding governor meeting with the school's designated officer for safeguarding to discuss current concerns and planned actions? Please tick appropriate box:**		

Monthly		***Half termly***		***Termly***		***Other (please specify)***	

6.3	How frequently is pupil attendance discussed by the governing body?							
	Monthly		***Half termly***		***Termly***		***Other (please specify)***	

7	PRIVATE FOSTERING		
7.1	Are you and your staff able to identify students that are being privately fostered (i.e. children/young people under the age of 16 (18 if disabled) who are cared for by someone who is not their parent or a 'close relative' for 28 days or more).	YES	NO
7.2	If not what will enable you to do this? Please comment:		

8	BULLYING	
8.1	In the last full half term how many incidents were recorded?	

9	E-SAFETY							
9.1	Date when pupil access to the internet was last monitored							
9.2	Date when staff access to the internet was last monitored							
9.3	Does your school have an ''Acceptable Use Policy''						YES	NO
	When was your ''Acceptable Use Policy'' last updated?							
	Within the last 6 months		***6-12 months***		***Over a year ago***			

10	ANY OTHER COMMENTS
10.1	Any other comments/areas that you may need support or further guidance? (please note below)

Please return completed audit by the end of Friday 25th October to:

Safeguarding Children Service
4th Floor Broadgate House, Broadgate
Coventry, CV1 1NG

REPORT ENDS