COVENTRY LOCAL SAFEGUARDING CHILDREN BOARD

Annual Report 2014/2015

Coventry Partnership

Working Together to Safeguard Children

www.coventrylscb.org.uk

Chair's Introduction

It has been a privilege to work with the Coventry Safeguarding Children Board (CSCB) over the last twelve months. It has also been hard work because safeguarding in Coventry was not in a good place when I arrived last September. There were almost 900 children on child protection plans, three new Serious Case Reviews (SCRs) had been commissioned in the previous month and both morale and confidence were very low. In spite or perhaps because of this, Board members were ready to engage wholeheartedly with a new approach and take on the difficult work of getting the Board back on track, volunteering their time and expertise unstintingly when they were needed. The picture now is very different. There are 532 children on child protection plans, a year has passed without any serious incidents leading to SCRs and the Board is competent and confident in its role.

The CSCB has been on a long journey to arrive at a position where it is able to provide a rigorous assessment of the effectiveness and impact of local services on outcomes for children. It is still the case that some significant parts of the normal safeguarding board role are devolved to the Improvement Board (IB). The CSCB has been careful to avoid duplication of the IB's work. In addition, the CSCB needed to put its own house in order before it was in a position to fully fulfil its assurance role. The way forward for the Board began with a refocusing process designed to create a new start. Confidence had to be rebuilt and a sense of common purpose created. Recent circumstances in the city had resulted in a narrow focus on child protection, babies and young children on the part of the Board. This was replaced by a new emphasis on children and young people of all ages. The universal aspects of safeguarding were put firmly on the agenda alongside child protection and the voice of the child was put at the centre of the Board's thinking. Board agendas were carefully planned to foster participation and to create a culture of collective learning. A strengthened focus on improving outcomes for children was adopted. It was also agreed that we would learn from success, collecting and discussing Coventry case studies that had led to good outcomes for children and young people. We analysed these collectively to find out what was working well and learn from it. It quickly became apparent that there was some very good, effective, multi-agency safeguarding work going on in Coventry alongside that which was not good enough. Alongside this, regular Board scrutiny of outcome and performance data provided hard information.

From September, we also instituted a system of rotating meetings between venues and services in the city. Venues generally offer a pre-meeting tour and briefing, led by young people where possible. This has given members greater insight into the workings of other services. We have also been privileged to learn, mostly from the children and young people who have been supported, about some outstanding safeguarding work in secondary and primary schools, in a children's centre, in City College Coventry and in the University Hospital Coventry and Warwickshire maternity service. For further learning, Board members have been offered opportunities for visits or work-shadowing in services other than their own. Key gaps in Board membership have been filled by a named GP, a lay member and a college principal.

In order to move on, the Board had to have assurance that services were compliant with statutory responsibilities. A Section 11 audit of services was carried out and where gaps were identified, the process of putting things right was rigorously monitored. For the education sector, there was a Section 175 schools audit. This had an impressive 100% response rate and where minor issues were identified, these too were followed up and dealt with. All single agency audits from services are now regularly vetted by the Board's Effectiveness and Quality subgroup.

Once the Board machinery was put into good working order, Board members volunteered their time unstintingly to chair or serve on sub-groups or task and finish groups. These have worked hard and to good effect to improve multi-agency processes and so make safeguarding in Coventry more effective. For instance, the Child Sexual Exploitation (CSE) group has ensured that young people at risk of CSE and victims are now supported, that all agencies are alert to this issue and take preventative action and that would be perpetrators are disrupted.

At the same time, the retrospective Serious Case Review (SCR) into CSE is measuring current procedures and practices against the situation in the past to ensure that things have improved. To absent, the newly created Policy and Procedures subgroup has developed an integrated policy and procedure for children who go missing, whether from home, care or school. The Effectiveness and Quality subgroup has audited children's experience of domestic violence and modified processes for responding to it in the light of what children said. The Training subgroup has run a programme of briefings on private fostering to raise awareness so ensuring that children privately fostered are better protected. The SCR subgroup has acted on SCR findings, for example by producing and disseminating information sharing guidance materials across Coventry and on a cross-border basis with Warwickshire following a joint learning event that identified the need for such guidance. Alongside the work to improve multi-agency processes and thereby improve outcomes for children and young people, the Board has also worked to raise public awareness of safeguarding and of its own role. It now produces a newsletter. The website has been redesigned and made more accessible and the Board has a Twitter account. It has also instituted regular governance meetings with other strategic boards in the city, namely the Safeguarding Adults Board, the Police, Crime and Community Safety Partnership Board and the Health and Wellbeing Board. These meetings reduce duplication and ensure clarity about responsibility for issues of shared concern such

as domestic violence (DV) and female genital mutilation. They enable support of each other's work.

The learning from the Voice of the Child has been invaluable. The live testimony has been a powerful factor in building the common commitment of Board members to shared priorities. Some of the things learned have gone into the Board's newsletter for general dissemination, some have changed how some services do things and some set out standards for services to aspire to longer term. For example, testimony from a care leaver about his experiences as a fostered child when his birth mother went into hospital led to the Board's hospital member making sure that procedures were changed to ensure that children fostered when their parents were ill could visit them in hospital at all hours. Fears expressed by primary school children about dealing with the police were set to rest by regular police visits to schools. A message delivered resoundingly by children, young people and their parents has been about the central importance of a support professional who is in it for the long haul and who can always be contacted when needed. We cannot engineer change on this in the short term, but we can and have responded by ensuring that young people are always informed when they are having a change of social worker. We can also make sure that this message about continuity is passed on as clearly as possible to those managing the multi-agency safeguarding workforce.

An area of difficulty for many safeguarding boards is ensuring that members really understand how other services work and have some sense of the quality of practice in services other than their own. We have set up a peer review panel system which gives Board members the opportunity to question other services in detail about their practice. The first such panel looked at early help offered in the voluntary sector, by GPs and in other parts of the health service. Findings are being acted upon, in particular the key finding that there is currently too little known by key professionals such as GPS about the sorts of early help that are available in the city.

It is clear that offering effective early help to families with children who need it is key to safeguarding children and preventing serious harm. Coventry has been developing its early help offer and the Board has been kept well informed. It has paid particular attention to the Acting Early initiative which ensures that information about 0 to 5 year olds is shared between agencies. The good communication and multi-agency working that has been developed between health services, social care, children's centres and early years education is clearly bearing fruit. Issues in families such as domestic violence that have sometimes been missed in the past and have subsequently surfaced in serious case reviews, are now mostly being communicated and dealt with early on, thus preventing escalation.

The past year has been a very busy one for members of Coventry Safeguarding Children Board. The Board has made many demands on them and I would like to thank them for their generosity in giving of their time in order to move the Board forward, for their professionalism in tacking the issues that have arisen and for their strong and manifest commitment to safeguarding children.

Janet Mokades,
Chair Coventry Safeguarding Children Board

Contents

1. Introduction

This report outlines the achievements and challenges of the Local Safeguarding Children Board (LSCB) from September 2014 to September 2015. It assesses progress on outcomes for children and young people. It evaluates the impact of Coventry's services on outcomes for children and shows how the work of the Board has contributed to improving outcomes. It details the Board's progress in implementing its former and current priorities. The period covered by this report is September 2014 – September 2015, which covers the tenure of the new Independent Chair of the Board.

The objectives of an LSCB are clearly set out within Section 14 of the Children Act 2004:

a) To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
b) To ensure the effectiveness of what is done by each such person or body for those purposes.

In order to fulfil its statutory functions under Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 as a minimum an LSCB should:

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

LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations and Board partners retain their own lines of accountability for safeguarding, safeguarding boards do have a role in making clear where improvement is needed.

This annual report provides an assessment of the performance and effectiveness of local services in improving outcomes for children. It details how the LSCB has helped to create better outcomes for children and young people through improving multi-agency processes and co-ordination, assessing the effectiveness of what is being done by agencies and feeding back to them, quality assuring practice, developing and providing multi-agency training and ensuring that agencies are fulfilling their statutory responsibilities. The Board challenges partners but also supports them to improve. It listens to the voices of children and young people and directs its work accordingly.

2. Local Background and Context

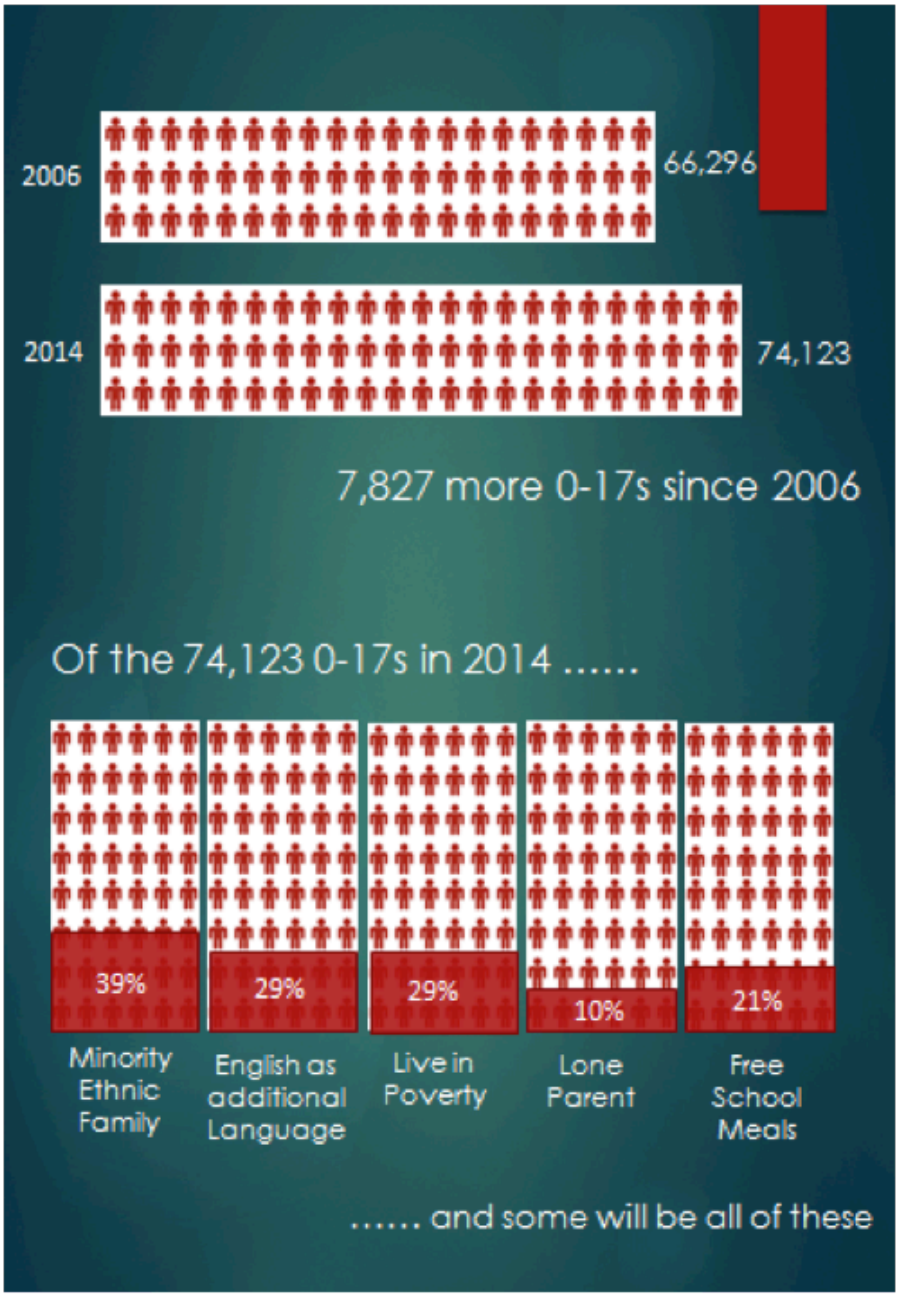
Coventry Children's Services and LSCB were inspected by Ofsted in January 2014 and judged to be inadequate. Since that time an Improvement Board has been established and the Department of Education have been monitoring progress. A new independent Chair of the LSCB took up post in September 2014. She reports regularly to the Secretary of State and the Improvement Board on progress.

Agencies working together to safeguard children in Coventry are working in a challenging context. There is a growing population, including child population; a diverse ethnic mix and higher than average levels of poverty.

There are currently approximately 74,123 children and young people in Coventry aged 0-17 out of a total population of 337,428 (22%). This includes 14,204 children under three years old. Recent years have seen an increase in the birth rate from almost 4,000 per year in 2005 to approximately 4,500 a year in 2014. Population increases are also due to an increase in net international migration from 3,700 in 2005 to 5,953 in 2014. If current population growth trends continue then by 2026 the total population of Coventry will rise by 18%, with the total number of children projected to rise faster than the adult population (Source: 2012 Sub National Population Projections, Office for National Statistics).

Approximately 39% of children living in Coventry are from minority ethnic groups, this remains a larger percentage than the national average of 26% (Source: Mid 2011 Census based population estimates, Office for National Statistics). There are over 80 languages spoken in Coventry, with 8.7% of households in the city where no one speaks English as their main language (Source: 2011 Census, Office for National Statistics). The 2013 School Census also shows that the proportion of children and young people with English as an additional language is higher in Coventry than the average for England.

18% of Coventry residents live in neighbourhoods that are among the most deprived in England. The End Child Poverty campaign estimates that, in 2013, 29% of Coventry's children were living in relative poverty. This equals 21,200 children living in Coventry from households that have an annual income less than 60% of the national average and is higher than the national average. Coventry also has a higher than average percentage of children living in lone parent households. The 2013 School Census indicates that there are higher than average numbers of children in primary schools who are known to be eligible for and are claiming free school meals.



3. Outcomes for Coventry Children

3.1 Summary

The picture on outcomes for children in Coventry is a mixed one. Some things are clearly getting better whilst others remain stubbornly the same. There has been a significant reduction in cases at the core end of the spectrum where children are seriously at risk. Both reportable serious incidents and cases leading to serious case reviews have declined. This may be because a greatly increased number of children are getting early help. In general, early years indicators are better than those in similarly deprived areas. School readiness has improved. Children who are missing are more likely to be on someone's radar and be offered help as are those at risk of or involved in child sexual exploitation. On the health front, most children have had their immunisations and teenage conception is showing a downward trend. Looked after children are getting greatly improved healthcare. Amongst young people, both first time offending and youth re-offending have reduced. These are all important indicators of improved outcomes for children and young people.

However, school achievement has not improved. In line with national trends, there has been a small dip in GCSE A-Cs. Worryingly, education achievement shows significant inequality. Educational achievement for looked after children over five years shows a small improvement but is poor in absolute terms.

It is clear that services in Coventry have worked hard and to good effect to achieve the improved outcomes noted above. Improved and improving processes in social care and multi-agency arrangements have ensured that referrals mostly lead to the right level of response. The creation of the multi-agency safeguarding hub has meant that fuller intelligence is gathered more quickly. A wider early help offer has meant that fewer cases escalate to need child protection.

3.2 Child Protection

In September 2014, 882 Coventry children had child protection plans. By September 2015, this inordinately high figure had reduced to 578. This is still very much higher than the norm in similar areas and work to understand why this is so and ensure that children get help earlier, so avoiding escalation, continues. Children in serious need of help are getting it much more quickly. In September 2015, all initial child protection conferences were held within 15 working days. 93% of children and families assessments are now completed within 45 days, up from 70%. The number of children becoming the subject of a child protection plan for a second or subsequent time has reduced from 18.8% to 15.1%. This is lower than the all England average. Overall, work to safeguard children at the high end is becoming more focused and efficient which means that children are better protected.

Diagram 1: Number of Children on a Child Protection Plan

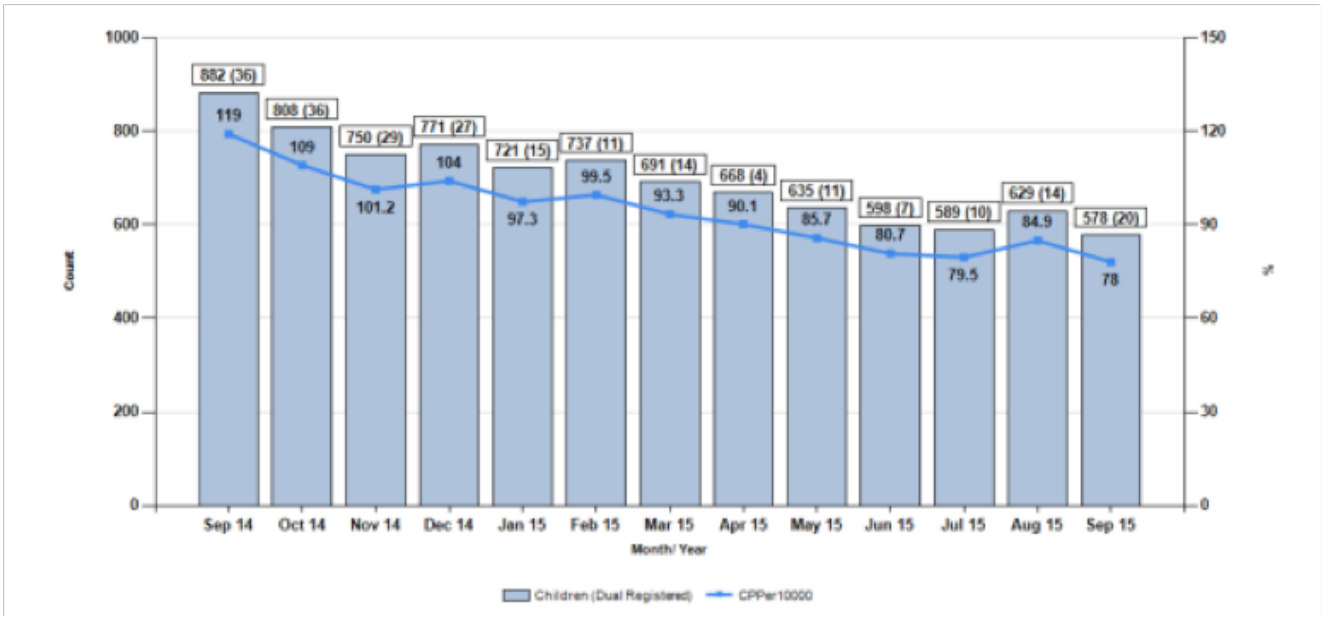


Diagram 2: Children on a Child Protection Plan by Age and Category of Abuse

Percentage of Children on Child Protection Plans by Category of Abuse		Percentage of Children on Child Protection Plans by Age	
Category of Abuse	YTD for 15/16 (Q2 September 2015	Age	YTD for 15/16 (Q2 September 2015
Emotional	47.8%	Unborn	4%
Physical	3.8%	0 - 3	28.2%
Sexual	5.2%	4 - 11	50.2%
Neglect	43.3%	12 - 16	16.8%
		17 +	0.9%

An increased number of children are now receiving early help through common assessment framework (CAF) arrangements. Universal services such as schools, which are supporting over a thousand vulnerable children, and children's centres along with midwifery and health visiting, are all playing their part in identifying and responding to problems sooner rather than later. The Troubled Families programme is working with over 600 families and can demonstrate improved outcomes for children in key areas such as improved school attendance and behaviour. All these initiatives are reducing escalation to crisis point and referrals to statutory services.

3.3 Common Assessment Framework (CAF)

The number of CAFs has steadily increased, from 1543 open cases in April 2014 to 1887 open cases in September. Health colleagues in particular have increased their use of CAFs , ensuring that more children and families who need support can access it. Schools now hold 20% of all CAFs in the city. Children's centres hold 19%.

Diagram 3: CAFs Open by Lead Agency – September 2015

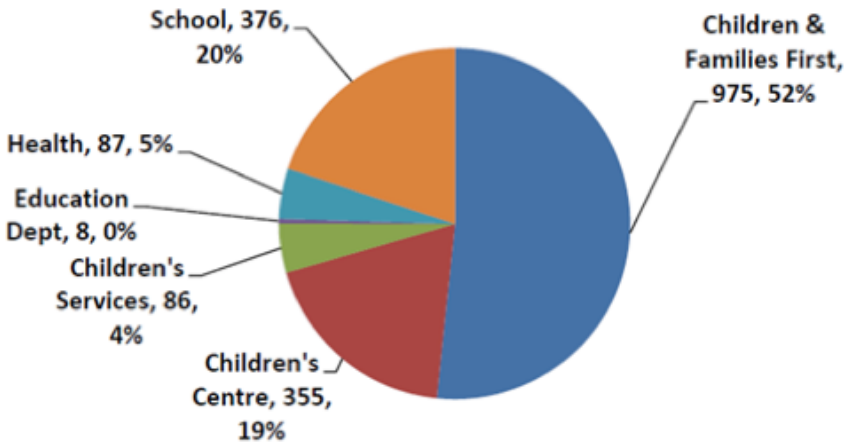


Diagram 4: CAF outcomes

CAF Outcomes	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep15	Total	% YTD
Action Plan completed NFA	102	158	114	122	129	101	110	94	123	139	159	66	147	730	66.5
Child moved to another LA	3	14	1	5	4	9	2	12	11	8	0	7	3	51	4.7
Non-engagement	5	22	24	19	15	13	8	19	13	19	5	8	7	71	6.5
Referral to social care	57	57	42	38	58	42	67	30	25	59	51	10	35	210	19.2
Referral to outside agency	5	9	3	2	9	13	5	5	1	2	5	3	3	19	1.7
Service request-ed unavailable	0	2	2	1	0	0	3	0	4	2	4	5	0	15	1.4
% Action plan complete NFA	59.3	60.3	61.0	65.2	60.0	56.7	56.4	58.8	69.5	60.7	67.9	66.7	75.4	66.5	
% Referral to Social Care	33.1	21.8	22.5	20.3	27.0	23.6	34.4	18.8	14.1	25.8	21.8	10.1	17.9	19.2	

The figures above indicate some outcomes for children who have been involved in the CAF process. What they do not show is whether life has improved for these children. The Board is now working with schools to gather and analyse information on the impact CAFs have had on the wellbeing of children.

3.4 Looked After Children

The overall number of children looked after by Coventry is broadly stable and is higher than the all England average, reflecting levels of deprivation in the city. Some things have improved for Coventry's looked after children in the last year. In particular, healthcare for them is better.

Coventry and Rugby Clinical Commissioning Group have made changes to the commissioning process to improve the uptake of initial and review health assessments for looked after children, particularly those placed outside of the city. Previously only 40% of these were undertaken within the statutory timescale. This figure is now 93%. More looked after children now have a care plan that reflects their healthcare needs.

The Clinical Commissioning Group (CCG) monitors the local performance in relation to initial and review health assessments through a contractual KPI There is consistently high performance by CWPT and our data trail and audit show 100% of initial and review health assessments are completed within the statutory timescale for children placed within 20 miles of Coventry once requested by the local authority.

For those placed out of area, the CCG has commissioned health assessments however there has been difficulty in this when children are moved and health are not informed, or where there is no available team in the area where the child has been placed to do the assessment despite best efforts to arrange. This is a nationally recognised challenge for all CCGs, reducing the number of children places out of area will help. As a result, the CCG is reviewing how these children can be supported by one health provider which will have full responsibility for ensuring the children receive their health assessment regardless of where they are placed in the country.

There has been some improvement in the educational attainment of looked after children at KS2, where the numbers achieving Level 4 and Level 4 plus in 2014 rose strongly. At KS1, Level 2 achievement was above the national for looked after children. But the headline provisional figure for children achieving 5 plus A-Cs at GCSE is just over 10%, which is poor.

Historically, looked after young people have been particularly vulnerable to child sexual exploitation (CSE). Services in Coventry are now much more alert to this danger and have better intelligence about who is at risk. Looked after young people

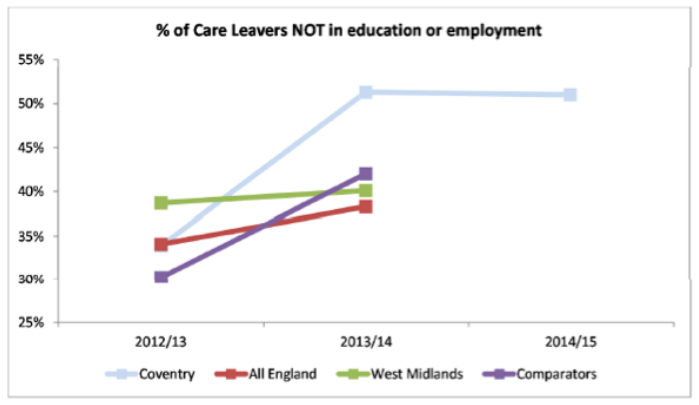
in this risk category now have specific support. Education institutions in the city are now well aware of this issue and some are providing exemplary support for young people at risk of CSE. For instance, vulnerable looked after young people who attend Lyng Hall school have personal safeguarding support and those at City College Coventry have personal mentors.

Coventry has a good success rate of care leavers attending university, however in many cases the young people take a few years out of education or extend their further education experience beyond Year 13. In September 2014, eleven care leavers started university and nine care leavers successfully gained a place to commence their studies in September 2015.

96 percent of Year 12 and 76% of Year 13 eligible[1] looked after children are in a positive destination. For example, in the academic year 2014 -15 there was 100% retention of students, who were looked after, at City College Coventry and all of those students passed their exams. Of those that are not in education, employment or training this may be because of illness or disability, pregnancy or parenting. It may also be because they are not available as a result of housing or because they are in custody. Looked after children may also be actively seeking education, employment or training but have yet to secure a place.

However, the headline figures for care leavers who are not in education or employment have remained too high at over 50% between 2013 and 2015.

Diagram 5: Care Leavers not in education or employment



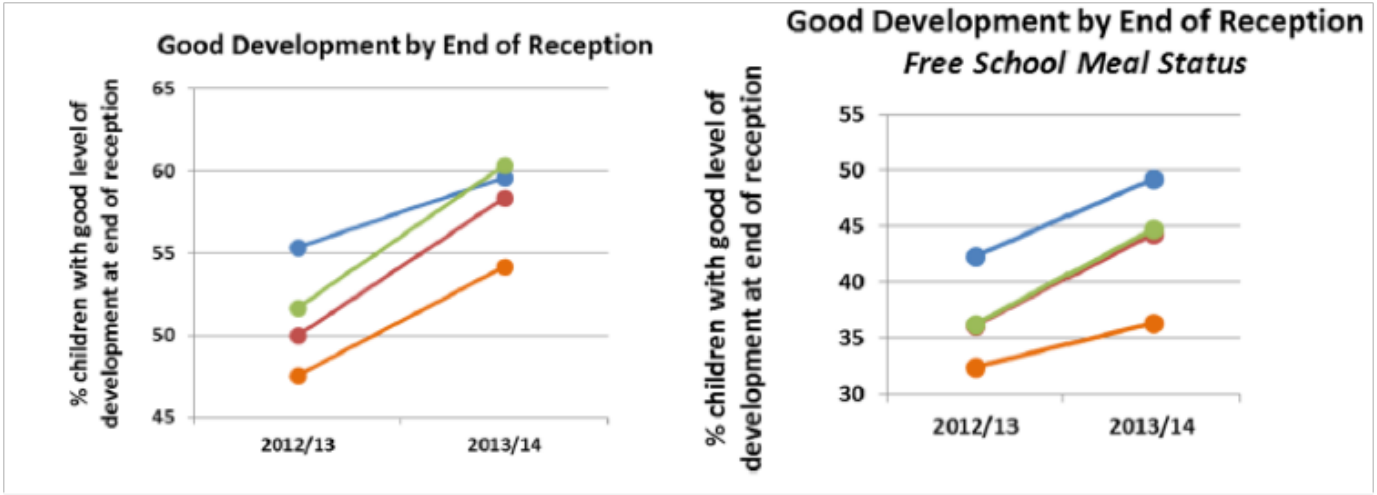
3.5 Early Years

There are encouraging figures for improvement in children's lives in the early years. In most early life indicators, Coventry performs better than regions with a similar level of deprivation. As an indicator for school readiness, the proportion of children achieving a good level of development by the end of reception is used. In Coventry, as with other comparators, there has been an increase in the proportion of children achieving a good level of development from 55.4% in 2012/13 to 59.6% in 2013/14, although there is still a large inequality within the city. For those eligible for free school meals, the proportion of children achieving good development is lower than the average for all children (49.3% for children eligible for free school meals vs. 59.6% for all). However, for children eligible for free school meals, the proportion achieving good development in Coventry is significantly higher than that of all other comparators.

Diagram 6: Giving every child the best start in life

1. In this context eligible is defined as those children who are post 16 and still classed as looked after. This group would not include care leavers.

Diagram 7: School Readiness



3.6 Missing Children and Child Sexual Exploitation

Young people at risk of or involved in child sexual exploitation are now on the radar of all key agencies in Coventry. They are therefore better protected than before, though neither the risk nor the reality of such exploitation has disappeared. The number of children missing at any one time and the frequency with which they go missing are now known.

There is now action both to try and reduce these episodes and to make it much harder for would be perpetrators to draw vulnerable young people in. A more coherent picture of the risk across the city has been drawn up. This has enabled work to take place in identified hotspots to alert the community to the issue. The Licensing Officer has worked with a range of licensed premises. Awareness training has been provided for hotels, takeaway outlets and taxi drivers.

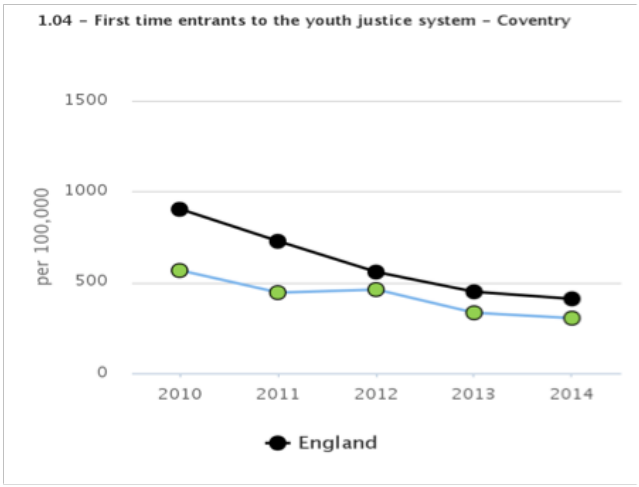
3.7 Crimes Against Young People

Throughout the year the child victims of crime, as a percentage of all victims of crime has remained relatively static at 7%. Total recorded crime where the victims are children has risen across the year but child victims of knife crime have fallen. In the last year child abuse non crime incidents[2] have fallen, but recorded crime in relation to child abuse has risen slightly.

3.8 Youth Offending

Across Coventry fewer young people are engaging in crime, so there is a downwards trend in first time offending, with rates consistently below the national average. There is also a downward trend in terms of youth re-offending.

Diagram 8: First time entrants to the youth justice system



3.9 Educational Attainment and Attendance

There is a clear upward trend in reading, writing and maths at key stage 2, and the 2015 data (unvalidated) suggests this upward trend has been sustained.

An average of 52.3% of children in Coventry achieved 5 A* to C grades at GCSE last year. This is lower than the previous three years and the national average but reflects the trend seen elsewhere.

2. A child abuse non crime incident is an incident where the attending officer assesses that there is a safeguarding issue for a child or children that falls short of being criminal activity.

Diagram 9: GCSE Attainment (5 A- C Grades)*

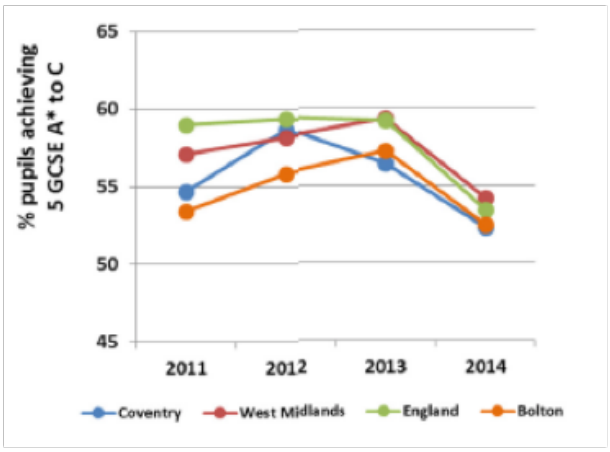
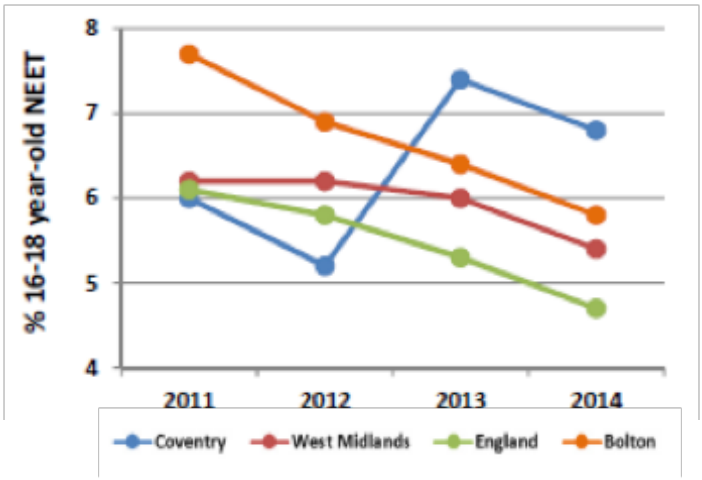


Diagram 10: 16-18 Year olds not in education, employment or training



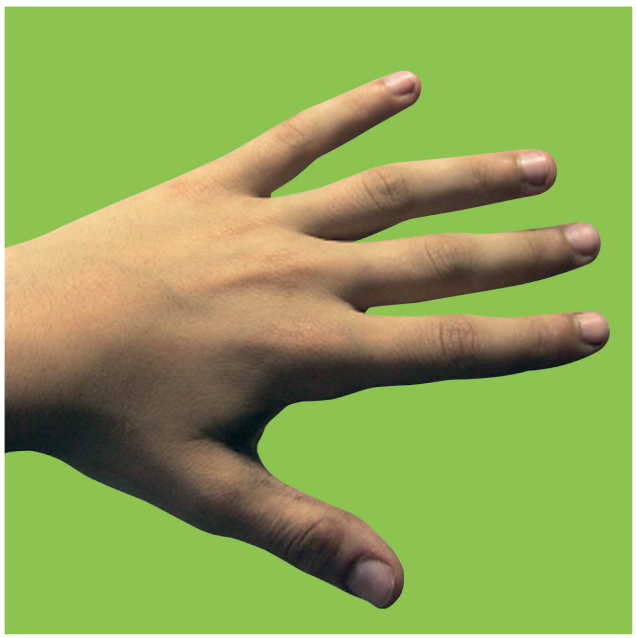
In Coventry, 6.8% of 16 to 18 year olds are not in education, employment or training (NEET). This is significantly higher than comparators although there was a drop from 2013-14.

Children who attend school regularly are generally at less risk than those who do not. Over the last year absence figures have risen slightly. Analysis of this is needed. National data is not yet available so the figure cannot be compared with national trends.

Diagram 11: Percentage of Pupil Absence

		2013-14	2014-15
Primary	Coventry	3.8%	4.2%
	England	3.9%	

		2013-14	2014-15
Secondary	Coventry	5.1%	5.6%
	England	5.2%	



3.10 Health Outcomes

Coventry children are at less risk of serious childhood diseases as a result of a good uptake of immunisations for five year olds. All immunisation uptakes are significantly above the national average. Infant and child mortality is slightly above the all England rate. Teenage conception shows a downward trend. However, the rate for children killed or seriously injured on our roads remains higher than the national average and is something the Board will need to consider in the future.

4. Progress against priorities

The Board's current priorities were agreed in April 2015 following the Board's Development Day. On that day the Board evaluated itself against the Ofsted criteria and assessed its progress over the last six months. It was agreed that the priorities needed to be sharpened and updated to reflect progress made.

Current priorities:

1. To listen to and learn from the voice of the child and young person and to ensure that this learning shapes the way in which services safeguard young people in Coventry.
2. To ensure that the learning from Serious Case Reviews is used to improve outcomes for children and young people and that reviews are carried out efficiently and to timetable.
3. To evaluate the impact of Early Help arrangements on outcomes for children.
4. To ensure that missing young people and those at risk of sexual exploitation are protected by effective multi-agency arrangements.
5. To ensure that children and young people are protected from domestic violence by effective multi-agency arrangements.

The work that is undertaken by the Board is focused sharply on these priorities. Single agencies also contribute. Progress to date is outlined in the tables below.

For progress against priorities covering the period from September 2014 to April 2015 see Appendix 1.

Priority 1: The voice of the child - progress

This priority is central to the way the Board now functions. Services are also strengthening engagement with children and their families to ensure that the voice of the child is heard. As detailed by the Chair in the introduction to this report, live testimony from children and young people is the first agenda item at all Board meetings. Meetings take place in venues used by children such as schools, children's centres and the hospital so that members can better understand aspects of children's lives. The issues raised by children are followed up, for example the hospital have changed their policy in relation to children and young people in care visiting their parents following this being raised as an issue by a care leaver. Police have re-established regular contact with a school following feedback that from pupils that they rarely saw the police. The extensive work that agencies have undertaken to listen to the voice of children includes:

- In Children's Social Care (CSC), some key processes have been redesigned to incorporate the voice of the child and implementation of these has been audited. Audits show good improvement in involving children and listening to their voices. Reduced caseloads across the Referral and Assessment Service, neighbourhood teams and the children's safeguarding service have resulted in a significant increase in visits to young people. Direct feedback from young people and parents on child protection conferences is now being sought.
- The safeguarding team for Coventry and Warwickshire Partnership Trust (CWPT) coordinate all audits for 'children admitted to adult wards' and have during the year developed this tool to ensure that it reflects the voice of the child. This voice is fed directly to the operational units so that they can improve their practice.

- West Midlands Fire Service (WMFS) has developed a Community Member Scheme, which involves the local community in shaping and delivering the services that it provides.
- Young people are routinely involved in recruitment to relevant jobs in the Council. They were also involved in the recruitment of the Board's lay member. Young people from the Voices of Care Council have been involved in improving the services of the Route 21 (care leavers) service with a positive impact. Young people have also recently been involved in the design and establishment of the CSE team.
- The children's emergency department at UHCW was expanded incorporating children's design ideas.
- Child and Adolescent Mental Health services (CAMHS) have undergone a full pathway review across Coventry and Rugby and been redesigned. As part of this process child, carer and parent workshops were held in November and December 2014. The feedback received (including views related to quality of communication and the use of technology) from the workshops has been used when forming ideas on the new service design. The introduction of a CAMHS acute liaison team which is operational in identified peak times has improved the quality of the service available to young people who self-harm.
- Last autumn the Board heard high praise as well as stress on the need for consistency in workers from a young person who had been a client of the Family Nurse Partnership service. There are now plans to develop a Shadow Board for young women who are clients of the Family Nurse Partnership to better understand their needs and views.
- The CSE team have implemented a meeting structure which involves young people and parents/carers so their perspective is heard and they have an opportunity to engage.
- A Coventry safeguarding app for children and young people is in the final stages of development. This will enable young people with safeguarding concerns to communicate anonymously with services.
- Following the comprehensive and thoughtful police debrief on their Operation Encompass CSE cases and regional work on CSE, the police have completely redesigned the way they work with young people involved in CSE to ensure that their voices are heard and they are responded to appropriately.
- The voice of the child is routinely incorporated into all single and multi-agency training. For example, West Midlands Police have developed an awareness package titled 'Improving our services to children' to address the need to improve practice and record information obtained by police officers from their interaction with children.
- Coventry Community Rehabilitation Company (CRC) uses service user feedback to inform practice and services and are working on ensuring that people are supported to maintain contact with their families when they go to prison. They held a staff conference which focused on voice of the child and the iHOP project, which ensured that all frontline officers are aware of working with prisoners with children.

Conclusion

Overall, there has been good progress on this priority, with partners working well to shift their focus on to listening to children and acting on what they are told. Nonetheless, pressure needs to be maintained as there is still much to be done. In particular the Board needs to acquire more in-depth knowledge and understanding about the lives of particular groups of vulnerable children and young people, such as young carers or children with disabilities, so that it can feedback to services and help them to improve.

Priority 2: Serious Case Reviews - progress

There has been a heavy volume of work around this priority. At the beginning of the period that is covered by this annual report the serious case review subgroup inherited three recently commissioned new reviews, and one historical review. Of these, one has been completed and published, another has been completed and is being finalised and a third will complete very shortly. The historical review which was held, pending the completion of the criminal proceedings relating to the case, is now ready to publish. In addition, two inter-active multi-agency reviews, one initiated prior to the period of the report and one initiated during the period of the report, have been completed. Following the police debrief of the" Operation Encompass" child sexual exploitation cases, the Board initiated a new serious case review covering five cases. An absolute priority for the Board has been ensuring that these reviews are completed efficiently and that they set out clearly what can be learned from the cases. There has been learning from all these reviews throughout the year as they are carried out.

The completed reviews are published below:
http://www.coventry.gov.uk/info/206/coventry_local_safeguarding_children_board/2524/serious_case_reviews_children

This work has consumed a great deal of time over the year. Much of this was initially expended on ensuring that the subgroup operated efficiently and that procedures were in place, were clearly understood and were adhered to by all concerned. Once this had been done, attention was refocused on making sure that the learning from reviews led to necessary action to improve things.

Most of the reviews that were dealt with during the reporting period date from a time when Coventry was subject to particular difficulties. Much has been done to improve matters since then and current arrangements differ significantly from those pertaining at that time. It has therefore been necessary over the year to ensure that the important messages flowing from reviews are given due weight and that debate relating to arrangements that are now substantially different does not distract attention from the enduring issues arising from these cases. Essentially, these are clustered around the need to exercise professional curiosity and judgement and the difficulty of protecting the children of people who do not want to involve themselves with services. The first issue is one of which staff need constantly to be reminded. Accordingly, the Board has now organised refresher training for key staff. The second is much more difficult. Policies and procedures are being tightened but this alone will not solve the problem and further thought is needed as to what can be done.

In the case of the published Child T report, all the single agency recommendations have been implemented. A standardised letter to GPs that notifies when a CAF is opened and then closed is being developed. This will ensure that they are properly informed of CAF activity. The report also recommended monitoring by the Board to check that simplification of the ecaf system and processes are having a positive impact on the lives of children and families. This is being carried through by the E and Q subgroup. Safe sleeping was an issue in the Child T report and it recommended that a standard physical check of the room in which the child sleeps in the day and night, and the bed/cot/basket in which the child sleeps be undertaken and recorded by UHCW and CWPT. This has been introduced, and single agency auditing is taking place to ensure compliance. In addition, the Child Death Overview Panel have led work on formulating a SIDS (Sudden Infant Death Syndrome) risk assessment tool, to be inserted in the Personal Child Health Record (red book),which Community Midwives will complete at the first home visit post discharge. The assessment will include a physical check of where baby sleeps (both night and day time) and if any risk(s) are identified, a plan will be agreed with parent(s) to reduce the risks. New tenancy arrangements to protect children have also been put in place in line with the recommendations of the report.

Single agency recommendations of the historical review that is now completed have also been implemented. For example, the Council has revised its commissioning arrangements with refuges

to ensure better protection for children. The multi- agency recommendations concern changes to services, domestic violence and families that are hard to engage. All these recommendations are being implemented on a continuing basis. The Board has a standing item under which it discusses major changes to services and the potential impact on safeguarding. New domestic violence services were launched last September and action on improving joint working to combat domestic violence continues. The new commissioning arrangements for domestic violence services have significantly strengthened the requirements to share information and coordinate support with relevant agencies. Individual agencies are progressing recommendations to ensure that domestic violence is recognised. The Coventry LSCB is working more closely with the Police and Crime Board ensuring clarity on the lead responsibility, which sits with that Board. In addition, domestic violence content in LSCB training programmes, which is designed to ensure that front line staff are well informed and to affect change for the families they work with, has been reviewed. Over the coming months, domestic violence training across all agencies will be reviewed, to ensure that there is clarity and consistency for practitioners.

The need to improve procedures for reaching families who are reluctant to engage is a recommendation of this review and a theme that has emerged from other events this year. Single agency policies for these families have all been reviewed and revised where necessary and new overarching multi- agency Board guidance is being drafted.

Information sharing has emerged as a persistent background issue in reviews generally. Cross border sharing with other authorities was a key matter discussed in the joint event held with the Warwickshire Board. Following this, the Board produced information sharing materials which have been and continue to be, in demand.

A multi- agency lessons learned event following a failed suicide in the summer highlighted the challenges faced by some communities in engaging with statutory services, and the impact that this has on their safety. Although community police teams and schools have developed joint services for young people where they can safely discuss/disclose their concerns without fear of repercussions within their community, it was clear that some young people would not engage with this kind of support. It was identified that different ways of improving engagement were needed. The Board is involved in 'Project Ignite' which aims to work differently in neighbourhoods, using the assets that exist to improve relationships. In addition, an app which will enable young people to access safeguarding advice and support in a way that feels right for them is in development with the Virtual College.

Conclusion

Overall it is clear that the work done around SCRs has led to some improvement for some children. Those living with domestic violence are now somewhat better protected as are children living in refuges. Safer sleeping arrangements mean safer babies. Better information sharing means better protection. There is some improvement in creating channels for alienated young people to communicate through and raise concerns about their safety.

Priority 3: Evaluating Early help - progress

Evaluating the impact of early help on outcomes for children is a difficult and onerous responsibility for any safeguarding board. In essence, this is because the measureable impact on outcomes is likely to be medium to long term. It is all too easy to fall back on detailing the high level strategies and processes that have been put in place without assessing their impact. Re-focusing the Coventry Board on outcomes for children from the outset was therefore particularly important in relation to this responsibility.

The Board has been able to hear directly from children, young people and families about the impact of early help on their lives. We know that the expertise and commitment of the Family Nurse Partnership (FNP) has enabled at least one troubled young person to become a good parent. We know from the family in question that good multi-agency working by a children's centre with others enabled a family whose earlier children were taken into care, to parent their new baby successfully. We know that a teenage parent supported by midwifery's IBumps project has a flourishing baby. We know that young people with very serious problems who are lucky enough to attend Lyng Hall school get such strong personal dedicated support that they can make it through school and on to university and more. But we do not know how widespread this excellent practice is.

The council has reported to the Board regularly on its early help strategy, CAF and the Acting Early work. The Acting Early work has a formal evaluation framework and reports impact under a number of headings. It can therefore evidence some good improvement. In addition the Chair has undertaken two observation and evaluation visits. In order to gain a clearer view of the quality of other early help practice, the Board's peer review panel ran a session on early help.

The panel found that there was a wealth of early help available in Coventry but that it is fragmented. The quality of practice was variable, with some very good aspects. The biggest quality issue is the lack of knowledge amongst practitioners of what is available in services other than their own. This leads on occasion to default referrals to social care. The voluntary sector offers a substantial amount of early help but too few practitioners know this. The Board is stressing the need to engage effectively with them.

Individual agencies have undertaken work this year to ensure that early help services are improved. These include the following:

- The Council's work on early help is becoming better coordinated. A local vision for Early Help has been produced, and the Council has appointed a new Head of Early Help. An outcomes framework is in development.
- The Acting Early pilots (an approach which creates multi-disciplinary area based teams, working with families from children's centres) have proved successful and have now been rolled out to cover 11 sites in the City where partners are actively working together in support of pre-school children. A ground breaking information sharing agreement between pregnant women, health and other partners has been key to ensuring that far more problems are detected early and help is given in good time.
- More CAFs are being created and a wider range of professionals, particularly in health, are initiating and holding them. However, there is no mechanism to assess the outcomes of CAF, beyond that they are completed. 66 per cent of common assessments are closed because there is said to no longer be any need for support, but we do not know what impact the CAF has had on the life of the child in question. The Board is now carrying out an audit of the impact of CAF on children in order to see whether it has made their lives any better. This will report in 2015.
- CWPT have piloted a mental health project, focusing on seven schools to build the resilience of school pupils to deal with problems earlier. The project has included training school staff

to identify issues early and to feel confident in addressing these issues, and also to raise awareness and understanding amongst parents.

- Whitefriars Housing (Part of the WM Housing Group) launched the 'do the d's' campaign in October 2014 to raise staff awareness of the signs of abuse and neglect. The campaign focuses on 'triggers' relating to safeguarding, these include; Damage, Dirty, Distress, Delay, Drugs, Doubt, Dress and Deception.
- West Midlands Fire Service (WMFS) actively engages with children's centres to make staff aware of the services and to enable families to access them. The service is undertaking an evaluation of the work undertaken in partnership with children's centres to understand the outcomes it has achieved for children accessing the services. The work engages with local communities, and provides home safety checks. Since the project begin in 2013, accidental and deliberate dwelling fires and resulting casualties have begun to reduce. This work is contributing to creating safe homes for children and young people. 93% of those families who received the home safety check were from BAME and new communities. The project is continuing to expand to additional children's centres.

Conclusion

Although there has been significant progress on this priority, more needs to be done at a strategic level to put together a comprehensive picture of the disparate provision that has developed and to ensure that practitioners and managers are fully aware of all the early help that is available in the city. The rapid expansion of CAFs has not yet been matched by evaluation of their effectiveness in improving outcomes for children and young people.

Priority 4: Missing and CSE - progress

The Board developed a CSE strategy for the city last autumn and this, together with the associated plan, has been evolving steadily over the year. There has been a strong focus on understanding the picture of CSE locally and identifying victims, perpetrators and locations. Alongside this, services have evolved so that they are better able to respond to CSE.

It is not yet easy enough to access clear information about Coventry children who are missing, though the information is now available from various sources. A year ago it was not, so progress has been made. The policies for children missing education and children missing from home and care have finally been combined. This should make it easier to provide an effective multi-agency response for children who go missing. The process of monitoring children missing has been made more robust. This will allow patterns to be spotted and more effective cross agency responses to be delivered. A creative approach to completing return home interviews has resulted in a high number now being completed. Information from these is now being used to inform effective responses and prevention activity.

The structure and governance for child sexual exploitation and missing groups (CMOG) from a police perspective has continued to develop and improve; the volume of cases is a challenge in terms of being able to progress actions and to obtain effective updates, however the excellent relationships within the CMOG and the commitment by all agencies has ensured that each child has a robust and appropriate plan in place, updates are provided by partners at each meeting and outcomes are being tracked. This helps to ensure that there is not drift for young people, and agencies are accountable for improvements. The CSE team have implemented a meeting structure which involves young

people and parents/carers so their perspective is heard and they have an opportunity to engage. A perpetrators forum has been established to ensure robust multi-agency management.

The need to raise awareness of CSE and how to respond was identified as a priority and the LSCB has led work on this. There has been a structured de-brief of the Operation Encompass, a large police CSE investigation, both at Board and in other settings. There has been extensive taxi driver training, and the awareness training is now a mandatory condition of a taxi license. This means that a key group across the city are aware of the issue. The training has been well received, and feedback positive. It has also provided a platform for press coverage of the issue. Training has also been delivered at hotels. Training on CSE for GPs was arranged by the CCG, as protected learning time, and attended by over 200 local primary care employees. In addition, the CSE sub group has participated in the regional communications, through the 'seemehearme' campaign, complemented by a strong local presence of 'Say Something if you See Something'. Bus ticket advertising has also been used, with approximately 537,000 bus tickets circulated to passengers. Twitter and Facebook campaigns designed to be understood by young people have also increased the reach of the message.

The improved focus of all partner agencies in this area of child abuse is leading to the early identification of victims and offenders. Thus the reporting of child sexual exploitation cases is continuing to increase. A multi-agency CSE team (Horizon) has been established, with good contributions from partners. The CCG will jointly fund, with Public Health, a clinical post to be a key part of the team. Coventry Police Child Abuse Team have ring-fenced a resource to focus on CSE offences. Although there has been good work on identification, implementing the risk assessment tool has been challenging due to staff shortages. Over the coming year, the process of managing risk for young people will be a key focus of the CSE and Missing Sub-Group.

The Board organised a multi-agency learning event on CSE, aimed at improving the interagency understanding of one another's services so that all agencies can recognise and respond appropriately and promptly to the needs of victims. The shortfall in statutory provision when young people legally become adults at age 18 was identified as an issue. Work is underway to determine whether some of the good voluntary sector initiatives in the city might be able contribute to plugging this gap. In addition, a directory listing all the agencies working in the city to address CSE is being compiled.

The Board has recently carried out a multi-agency audit of CSE cases. The results have not yet been analysed but will, when available, be fed back to fuel improvement.

Conclusion

From a low base, there has been very good progress on this priority. Awareness has been thoroughly raised across the city and arrangements put in place to try and protect, prevent and disrupt. The task now is both to monitor those arrangements and ensure that they are working effectively and to find ways of supporting young people who have been victims of CSE to turn their lives around.

Priority 5: Domestic violence - progress

There has been good progress this year in ensuring that the various agencies dealing with domestic violence work well together and that multi-agency arrangement are fit for purpose, but domestic violence still blights the lives of too many Coventry children.

The Board audited the domestic violence screening process and found that it was carried out thoroughly. It examined the impact on children and found that primary aged children did feel safer as a result of action taken following screening. At secondary level the picture was less positive. In addition, the domestic violence steering group has reported to the LSCB that sharing of information flowing from the current screening process is variable. Work remains to be done to ensure sharing of information from the screening process with GPs. Outcomes of the joint screening process are currently shared with maternity services in a timely way. This enables midwives to respond by offering additional visits/support/signposting.

In addition, the Board is working jointly with the Police and Crime Board to ensure that domestic violence training across the city is well coordinated. This will help protect children by ensuring that there is a common understanding across the city and clarity on when to act.

Single agency work relating to this priority includes:

- The CCG monitors providers to ensure that policies are in place, and employees have training to assess risks within families around domestic abuse.
- UHCW's domestic violence policy has been rewritten to be more applicable to the whole trust, rather than focusing on maternity.
- CWPT have a Named Professional for Domestic Abuse to provide specialist support and supervision to front line staff as required.
- UHCW are completing an audit to demonstrate practice compliance against policy and guidance. The audit focuses on explicit routine questioning on the presence of domestic violence in the ante-natal period. This will help identify domestic violence at an earlier stage, and seek to effectively safeguard children.
- West Midlands Fire Service have included a detailed awareness session on domestic violence in their safeguarding refresher training. The service works in partnership on Coventry's Sanctuary Scheme, and receives referrals when arson is a threat or risk.
- The National Probation Service are working to ensure that pre-sentence reports provided to the court on index domestic abuse offences are based on accurate information from a range of appropriate sources.
- Coventry City Council has set up a Perpetrator Forum. The forum works with perpetrators to address their offending behaviour.

Conclusion

There has been some progress this year in creating a more coherent response to domestic violence across the city. Work continues to help victims involved in violent relationships understand that there are alternatives and it is encouraging that work is underway to try and change the behaviour of perpetrators. Nonetheless, domestic violence continues to be a recurrent feature of too many of the city's child protection cases.

5. Statutory responsibilities and other work

As highlighted in the introduction to this report, as a minimum the LSCB is required to:

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

The following sections detail what the LSCB has done in relation to these matters.

5.1 Assessing the effectiveness of early help

This is a stated priority for the Board, please see section 4.1 priority 3.

5.2 Statutory responsibilities

The Board assesses the basic compliance of members with their statutory safeguarding responsibilities through the biennial section 11 audit. Failures in basic compliance identified through this process are monitored by the Effectiveness and Quality (E and Q) subgroup of the Board and progress reported back to main Board. All gaps identified by last year's audit have been filled as reported to Board in March 2015. Where schools are concerned, it is the section 175 audit that assures the Board of compliance. The 2014-15 S175 schools audit was completed and presented to Board last Easter. There was a very good response from maintained schools, academies, free schools, pupil referral units and colleges, with 100% completing the audit. No major deficiencies emerged from the findings. Where there were shortfalls, these have been followed up with advice and recommendations. Schools are expected to confirm that they have complied with requirements and compliance is being monitored. Of particular interest to the Board was the number of children in need of safeguarding who are being monitored by schools – there are 1,136. These are children who do not meet the thresholds for external agency referral. It is clear that a great many Coventry children are receiving early help from schools, a key universal service. The Board carried out a small investigation of the nature of these cases and the help being given by schools revealed a spectrum of needs to which schools are responding.

The completion of the S11 and S175 processes simply provides assurance of basic compliance. It does not provide any insight into the quality of practice. To gain this, the Board's E and Q subgroup has a programme of multi-agency audits, surveys and scrutiny of single agency audits which, taken together with children's live testimony to Board, visits to key venues, findings and learning events flowing from serious case reviews and the peer review process, provides some assurance of the quality of multi-agency practice.

Agencies are responsible for their own quality systems. Children's Social Care (CSC) is the lead agency for core child protection work, work with looked after children and work with children in need. Numerically the most important interface where these cases enter or exit CSC is with the Children and Family First service. This is the high volume, high risk end of safeguarding and consequently any safeguarding board needs to have a finger on its pulse constantly. Yet at the moment, there is no single focus of expertise or point of reference within CSC for the quality of practice across these areas. Nor is there a single system across all these domains for controlling and assuring the quality of what is done. During the last year, audits have been carried out in response to particular concerns and areas for improvement in CSC and these have, quite properly, been reported to the Improvement Board. However, there is currently no system in place that can give the CSCB evidence to assure it of the overall quality of practice in CSC and the Children and Family First service. Thus the Board is currently reliant on its own (necessarily small scale in relation to any single agency) endeavours to form a view. Based on documentation, reports to the Board, testimony from children and families, SCR evidence, first line visits and observation by the chair and reports to

the Improvement Board, the quality of practice is inconsistent, with some being very good and some unacceptable.

Until September, the local authority designated officer (LADO) function was carried out by two people within two different services and the Board had no overall information about allegations. From September when an interim LADO was appointed, the Board received regular LADO reports. These initially raised some serious issues about historical cases which the Board identified as a risk. Work was undertaken to address these and to update and streamline LADO procedures. Members adopted the new procedures and these appear to be working.

In the last year, the E and Q group has carried out two major multi-agency audits, one of the domestic violence screening process and its impact on children and one of CSE cases . It has also developed and administered a large scale survey of the views of the multi-agency safeguarding workforce. Following a pilot CAF audit, further CAF assurance that uses the voice of the child by proxy (through working with schools) is now being undertaken. Alongside carrying out and coordinating multi-agency audit the Effectiveness and Quality sub group monitors all single agency audits. This ensures that learning is shared and potential multi-agency issues arising are identified and dealt with.

The extensive staff safeguarding survey has given the LSCB a snapshot of how the wider children's workforce views its safeguarding work. Over 1,100 responses were received, with the majority of respondents being from education. (It should be noted that not all questions were answered by all respondents). The findings have not yet been analysed in depth but some headline findings are that 90% out of 728 respondents know who to contact and are satisfied with the response when they have to raise safeguarding issues. 82% out of 731 respondents are very satisfied or satisfied with the training they receive and a high proportion of respondents (86% out of 730) are either very satisfied or satisfied with the management support they receive. However, only 64% of 729 respondents said they have sufficient time to do their safeguarding work. Detailed analysis of these findings will provide useful information about safeguarding issues for the safeguarding workforce. The multi-agency CSE audit was undertaken in July 2015 to review the responses to cases identified within the CSE team. The process of completing the audit was complex and resulted in a follow up session in September 2015 to involve schools. Initial feedback reported that the audit highlighted the complexity of engaging with these vulnerable youngsters who do not always recognise that they are in need of help. Detailed analysis of the findings is currently being carried out and will indicate how effective current multi-agency approaches are or are not and how they could be improved. This will be fed back to the CSE subgroup and action to implement improvement will then be monitored.

The newly established Policy and Procedures sub-group of the Board is responsible for ensuring that policies and procedures are up to date and fit for purpose. In addition, as new areas of concern such as radicalisation emerge, the subgroup will develop new guidance. The group has completed a major piece of work that brings together policies and procedures for children missing from home, school and care. This will help to ensure that missing children and young people are more easily found and protected. It has also reviewed and amended policies on forced marriage and families that are hard to engage.

5.3 Training

The LSCB quality assures single agency training, and delivers a programme of specialist multi-agency training and development. It has good information about agency participation in its multi-agency training and it regularly evaluates the impact of such training on practice. It does not yet have good enough information about levels of safeguarding training within the overall safeguarding workforce.

5.3.1 Evaluating the impact of training on practice

The Board's multi-agency training programme is regularly evaluated to ensure that the impact on practice is understood. Courses are selected each term for follow up after 3 months to ask if participants found them useful and whether they have been able to use learning in practice.

This process began in March 2012 examining the impact of training from a range of courses. The interagency training officer carries out an analysis of end of course and post course feedback specifically linked to impact on practice. This is based on information provided by participants and line managers providing evidence of demonstrable changes in practice as a result of training plus evidence of how training has resulted in better outcomes for children.

The courses which have been evaluated during 2014-15 include:

- Level 3- Child Sexual Exploitation Awareness
- Level 3- Parental Mental Ill-Health and Safeguarding Children
- Level 3- Skills for Working with Resistant Families (Motivational Interviewing)

The courses which are being evaluated during 2015-16 period are:

- Level 1- Introduction to Safeguarding Children
- Level 3- Child Sexual Exploitation Awareness (this is a further evaluation following changes and updates to the training)

The following are examples from two different courses of how training has had a direct impact on outcomes for children:

Parental Mental Ill Health and Safeguarding Children

All those who responded after 3 months said that they had used the course material and learning at work. This had impacted directly on outcomes for children in the following ways:

- A mother with mental health difficulties thought that she was protecting her children from her behaviour but it was impacting on them. The worker enabled her to recognise this so that she could address the concern.
- A worker in a one to one role recognised a child protection concern around parental mental health difficulties and informed her supervisor so ensuring that preventative action was taken.
- A young person with risky behaviour was helped to see how what she was doing was risky.

Motivational Interviewing Skills (for working with resistant families)

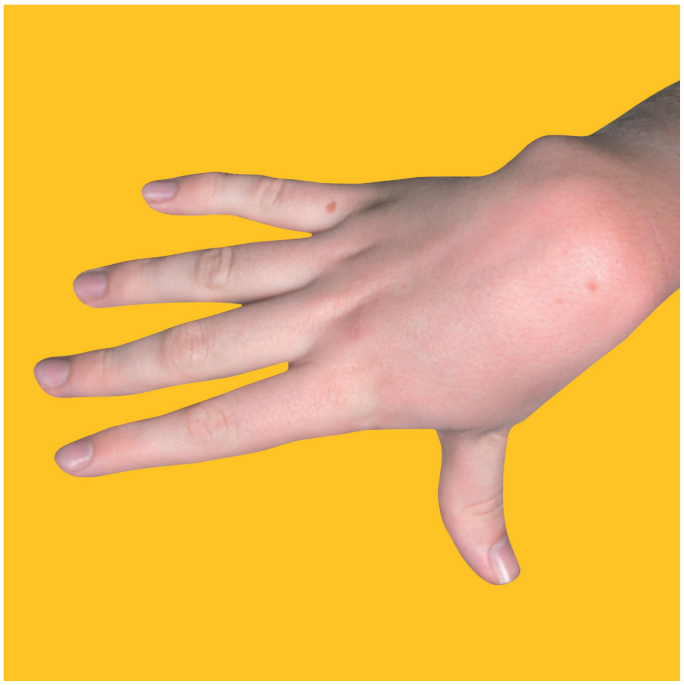
All those who responded after 3 months said that they had used the course material and learning at work. Outcomes for children:

- Communication between the agency and mother improved considerably and the mother became more involved with the agency as a whole (which in turn had a positive effect for her child).
- Parents became more engaged in a whole range of areas which they hadn't previously (which again had positive effects for the children).
- A student who hadn't been attending school started to attend.

Evaluation of course impact on practice consistently shows that participants become more effective by drawing on what they have been taught in the Board's multi-agency courses.

5.3.2 Interagency Training Statistics April 2014 – September 2015

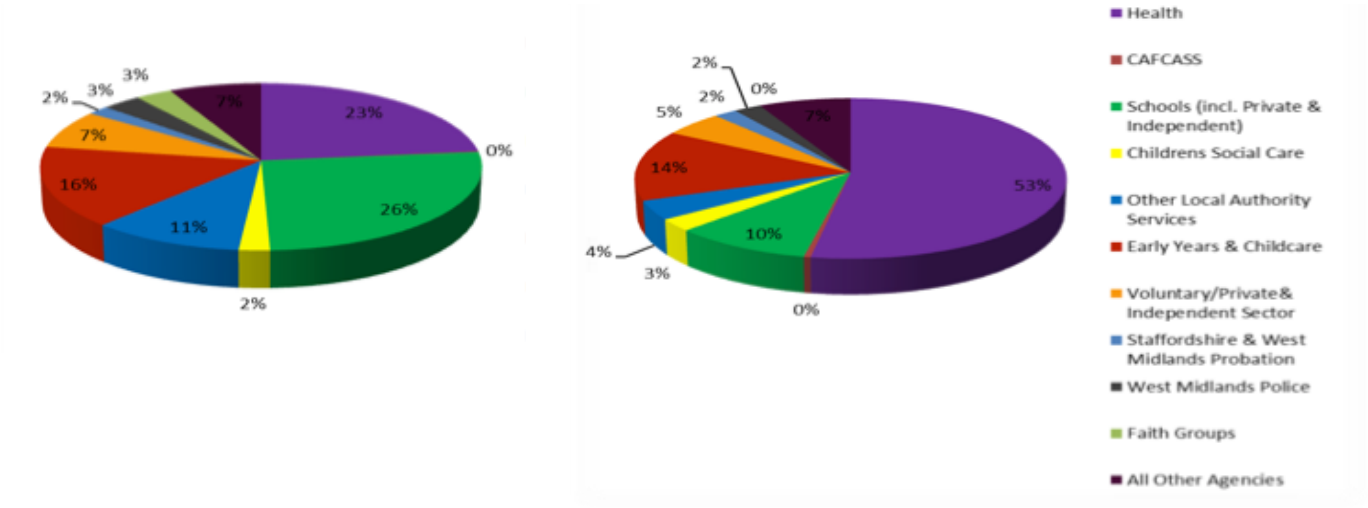
Agencies provide some in-house single and multi-agency training of their own. They are not required to send staff on LSCB training. The period under review for the annual report, covers April 2014 to September 2015. As this crosses years, the data is provided in two sections.



2014-15 Programme Year (Apr - Mar 2015) and 2015-16 Programme Year (Apr – Sep 2015) - Total numbers of attendees per sector

Category	Total Trained in 2014-15	%	Total Trained in 2015-16 (Apr-Sept)	%
Health	306	23%	334	53%
CAFCASS	2	0%	3	0%
Schools (incl. Private & Independent)	344	26%	61	10%
Childrens Social Care	28	2%	16	3%
Other Local Authority Services	137	11%	25	4%
Early Years & Childcare*	208	16%	90	14%
Voluntary/Private & Independent Sector	97	7%	31	5%
Staffordshire & West Midlands Probation	23	2%	12	2%
West Midlands Police	41	3%	14	2%
Faith Groups	38	3%	0	0%
All Other Agencies	96	7%	47	7%
TOTAL	**1,320**		**633**	

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.



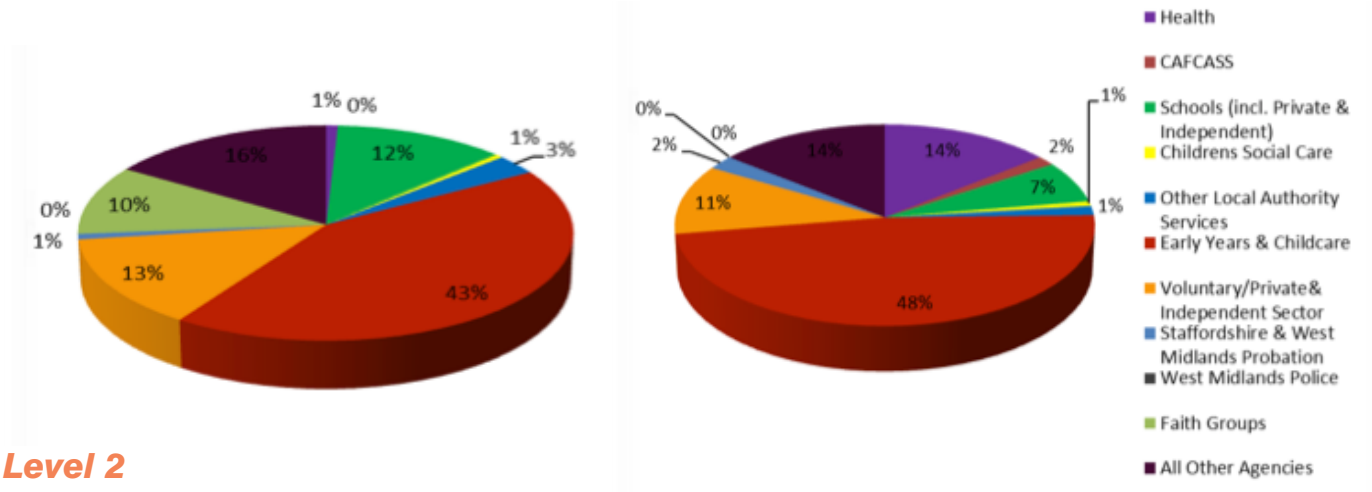
* Some Early Years organisations fall within the Local Authority but for these figures they are included in the separate category so that the whole range of Early Years organisations can be counted together. Those which are separate to Local Authority include private and voluntary nurseries, child-minders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

2014-15 Programme Year (Apr - Mar 2015) and 2015-16 Programme Year (Apr - Sep 2015) - Total numbers of attendees per level and sector

Level 1

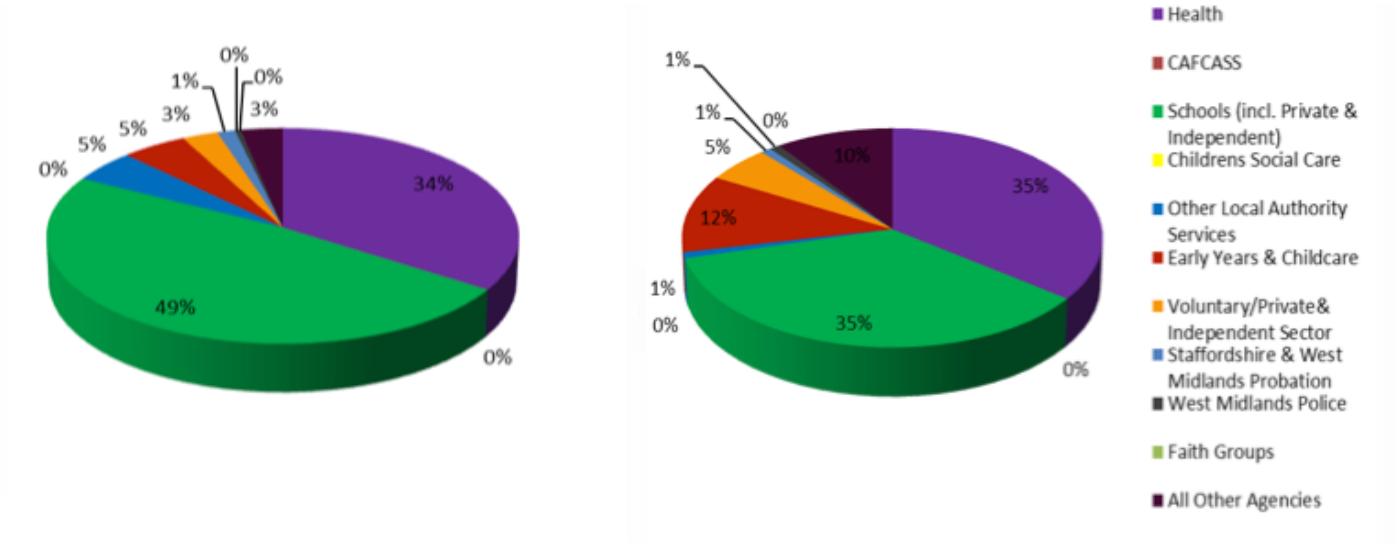
Category	Total Trained in 2014-15	%	Total Trained in 2015-16 (Apr-Sept)	%
Health	3	1%	19	14%
CAFCASS	0	0%	2	2%
Schools (incl. Private & Independent)	44	12%	9	7%
Childrens Social Care	2	1%	1	1%
Other Local Authority Services	11	3%	2	1%
Early Years & Childcare	156	43%	64	48%
Voluntary/Private & Independent Sector	49	13%	15	11%
Staffordshire & West Midlands Probation	3	1%	3	2%
West Midlands Police	0	0%	0	0%
Faith Groups	38	10%	0	0%
All Other Agencies	58	16%	19	14%
TOTAL	**364**		**134**	

Some organisations deliver their own in-house training which is equivalent to Level 1 training.



Level 2

Category	Total Trained in 2014-15	%	Total Trained in 2015-16 (Apr-Sept)	%
Health	78	34%	40	35%
CAFCASS	0	0%	0	0%
Schools (incl. Private & Independent)	110	49%	40	35%
Childrens Social Care	0	0%	0	0%
Other Local Authority Services	11	5%	1	1%
Early Years & Childcare	11	5%	13	12%
Voluntary/Private & Independent Sector	6	3%	6	5%
Staffordshire & West Midlands Probation	3	1%	1	1%
West Midlands Police	1	0%	1	1%
Faith Groups	0	0%	0	0%
All Other Agencies	7	3%	11	10%
TOTAL	**227**		**113**	



Level 2 CAF Training

The CAF training is delivered by colleagues from the CAF Team within the Children & Families First Service.

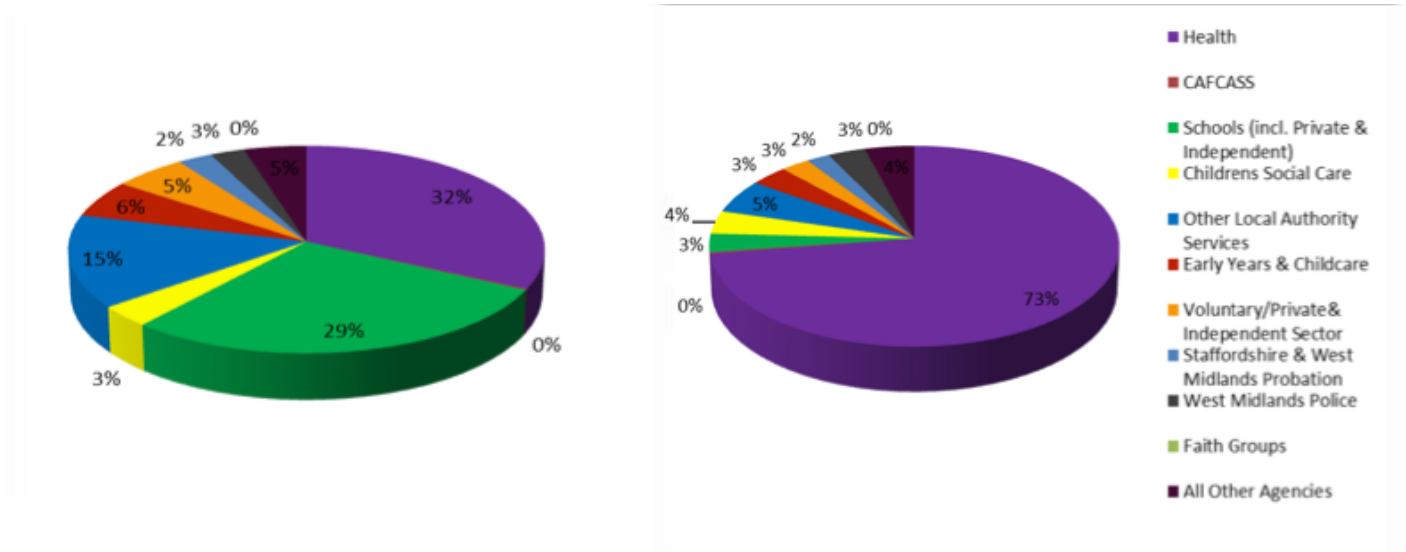
CAF awareness was developed for those who are not directly involved but require some knowledge of the process. These sessions have been delivered since April 2014.

'Training for Lead Professionals' are for those who will need to complete CAF assessments and hold CAF episodes. This is run alongside eCAF training which is training for users of the computer based eCAF system. The total figure for those completing training for Lead Professionals for 2014-15 was 329.

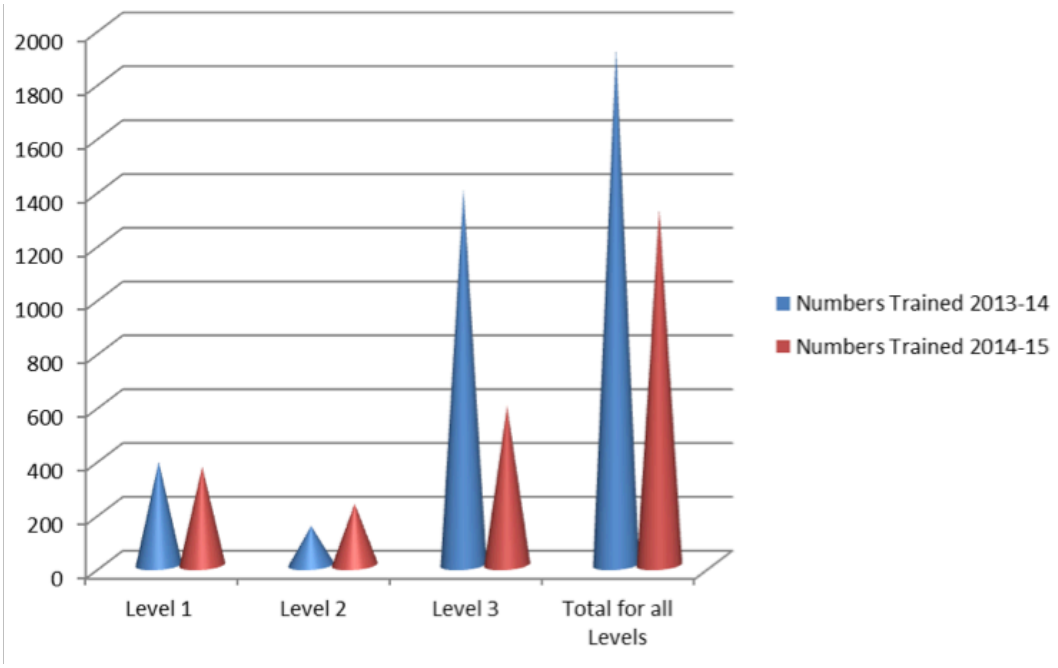
The total figure for those completing training for Lead Professionals for 2015-16 (April – September 2015) was 107.

Level 3

Category	Total Trained in 2014-15	%	Total Trained in 2015-16 (Apr-Sept)	%
Health	191	32%	294	73%
CAFCASS	1	0%	1	0%
Schools (incl. Private & Independent)	170	29%	12	3%
Childrens Social Care	20	3%	15	4%
Other Local Authority Services	86	15%	22	5%
Early Years & Childcare	34	6%	13	3%
Voluntary/Private& Independent Sector	32	5%	10	2%
Staffordshire & West Midlands Probation	15	2%	8	2%
West Midlands Police	15	3%	13	3%
Faith Groups	0	0%	0	0%
All Other Agencies	27	5%	17	4%
TOTAL	**591**		**405**	



	Level 1	Level 2	Level 3	Total for all Levels
Numbers Trained 2013-14	383	144	1393	1918
Numbers Trained 2014-15	364	227	591	1320
Numbers Trained 2015-16 (Apr-Sep)	134	113	405	633



In 2013-14, 1,918 professionals attended inter-agency training, in 2014-15, 1,320 professionals attended training courses. Some of the factors which contributed to the decrease in figures this time around are:

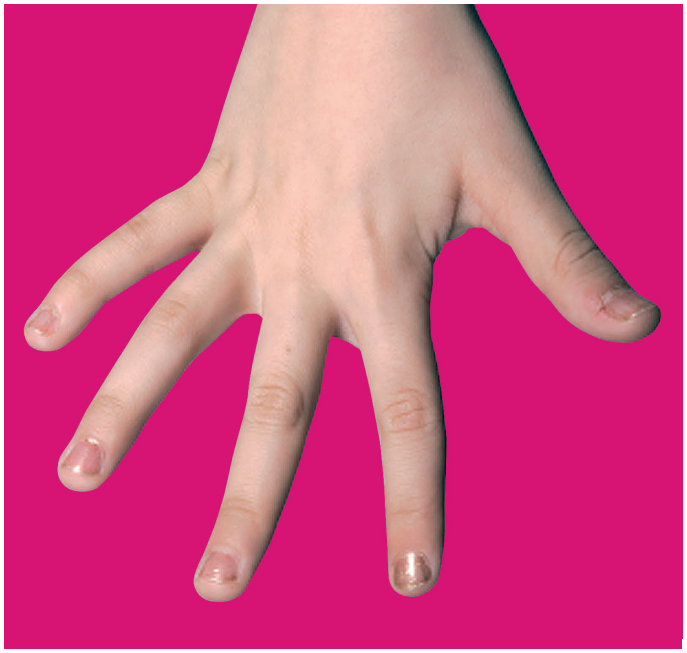
- In 2013-14 there were several Chelsea's Choice sessions (raising awareness around child sexual exploitation). Professionals attended some of the sessions put on for young people but there were also separate sessions put on just for professionals.
- In 2013-14 workshops on the new Working Together guidance were delivered.
- In 2013-14 there were workshops for professionals to disseminate messages and learning from three serious case reviews.

5.3.3 Single agency training and development

All Clinical Commissioning Group (CCG) staff are required to undertake mandatory safeguarding children training on induction and on a three yearly basis. Training is delivered as an eLearning package for levels 1 and 2. The majority of CCG staff are only required to undertake Level 1 safeguarding training by virtue of the role. A small section of CCG staff are required to undertake Level 2 training. CCG Staff requiring specialist safeguarding training (Level 3 multi-agency training and higher levels) access this via external events. The CCG monitors safeguarding training figures to ensure that all staff are compliant with the required training.

UHCW have 92.3% of all eligible staff trained at level three in child protection.

CWPT have a safeguarding training strategy which has been approved by the respective local safeguarding boards training subgroups. Safeguarding Level 1 training is now included at induction for all new starters and is included with the Trusts' annual statutory and mandatory training on a rolling three yearly basis to ensure all staff maintain competence. The Trust Safeguarding Team provide in-house training to Trust and seconded section 75 staff at level 1, 2 and 3. There is an annual systematic training programme that has been developed for safeguarding that CWPT staff can access via the Training Department.



Interagency training is provided at Level 1, 2 and 3 through local authority partners although there are sometimes restrictions on the places available. These issues are common to all partners and have been significantly mitigated as part of the outcome of a deep dive into Level 3 Safeguarding Training in our Children and Family Directorate.

West Midlands Police have invested heavily in a structured learning and development training plan for all areas of vulnerability; this programme has now been delivered to the vast majority of operational 'front-line' police officers and supervisors. All dedicated child abuse investigators are either experienced, trained detectives or are working towards detective status on the nationally accredited ICIDP (investigative training) programme. All local policing officers and child abuse specialists have been given specific training on key areas of child abuse, including ensuring that; the voice of every child is captured and put at the heart of our decision making; children who are impacted on by domestic incidents are identified and referred for joint agency discussion and appropriate response; that appropriate processes used to capture evidence from children are utilised and specially trained officers deployed; and that indicators of CSE are identified and referrals made accordingly.

Whitefriars Housing (Part of the WM Housing Group) have worked in partnership with Barnardo's to deliver safeguarding training to staff. Across the group so far, approximately 533 staff have attended. The training itself has received positive feedback and has led to an increase in awareness and a greater understanding of roles and responsibilities in recognising, responding, reporting and recording safeguarding concerns. Staff were asked what they would do differently in their day to day roles as a result of this training; the number one response from staff was that they will now be more "aware alert, observant and vigilant." The group plan to introduce a training tool to support managers and staff embedding the training as well as promoting and supporting reflective practice.

In late 2014, audit work carried out by the City Council identified some issues with Section 47 approaches and training was rolled out to 211 relevant staff in early 2015. In addition 74 social workers received refresher child protection training

between January and March 2015. Further dip sampling showed the positive impact of this training on the quality of Section 47 work.

46% of Council staff have safeguarding training. In order to increase attendance figures for mandatory corporate training (which includes both safeguarding and data protection), Workforce Services have been delivering bespoke mandatory briefing sessions for children's teams across the Council. These sessions have been delivered on-site, some in the evenings, to enable better access to training for staff working flexible hours. Some employees cannot access city-centre sessions or e-learning systems. Delivery of bespoke sessions will significantly increase the percentage of training attendance figures for some teams.

5.4 Organisational Arrangements for Safeguarding

Board member agencies have reported to the Board in detail on their safeguarding arrangements. This section provides a short digest of key points.

5.4.1 Health Agencies

The NHS England "Safeguarding vulnerable people in the NHS – Accountability and Assurance framework" (2015) sets out clear governance arrangement for safeguarding in the NHS and outlines accountability arrangements.

The CCG Chief Nursing Officer is vice chair of the Board, and CCG safeguarding leads have clearly defined responsibilities to assist the Chief Nursing Officer. The CCG's designated nurse and designated doctor for child protection are the LSCB's health advisors in relation to child protection and safeguarding and are actively engaged in all the LSCB sub groups. Thus there is expert input from safeguarding health professionals into all sub groups of the LSCB. This is independent of providers and provides safeguarding leadership in relation to health practice.

The CCG has appointed a local GP for a year to work closely with the local medical committed and independent GP practices to foster engagement of this sector and to introduce the named GP to local providers. The named GP is facilitating a programme of safeguarding forums with lead safeguarding GPs and practice managers to support them to have effective safeguarding systems and to support the development of lead safeguarding GPs within their role in line with the RCGP safeguarding toolkit. The named GP supported by the CCG's safeguarding professionals is also running a programme of safeguarding education events commissioned by the CCG to ensure GPs have access to training.

Coventry and Warwickshire Partnership Trust (CWPT) has a safeguarding team in place, which supports clinical staff with questions on child protection processes with additional support and oversight being given for court report writing and court attendance. The Trust has a safeguarding work plan and audit plan, which are monitored internally. A child protection (CP) supervision policy has been developed and a full time named professional for child protection recruited to support the role of child protection supervision.

5.4.2 City Council

Both the Executive Director, People, and the Director of Children's Services are core members of the Board. The Lead Member for Children's Services attends the Board, and the Shadow Cabinet Member is also in attendance.

The creation of the Multi-Agency Safeguarding Hub (MASH) during the course of the last year was a major innovation. Work continues to develop and improve its procedures, as staff learn from experience and develop better ways of doing things. The Council has continued half termly meetings for safeguarding leads in schools to share good practice and to deliver new information, for example in respect of the emerging Prevent agenda or work on referrals. Further work has been done to improve communication and understanding between schools and social care staff. Newly qualified social workers spend time in schools and new teachers in social work teams. Schools have linked social workers. All these measures have improved communication and understanding between these key services.

5.4.3 Police

In June 2014 Her Majesty's Inspector of Constabulary (HMIC) carried out an inspection of

the West Midlands Police response to Child Abuse.

The report made a number of recommendations that were accepted by the Force. An action plan was drawn up to address the issues highlighted and the work to improve the service to children in the force has continued.

West Midlands Police are facing considerable funding reductions over the next five years and the imperative to identify a sustainable resourcing model is clear; therefore, the need to work closely with partners to improve the early identification of risk and 'need' is vital to ultimately reducing the demand and volume of cases that present a greater risk.

The Coventry Child Abuse Investigation Team (CAIT) consists of 33 detective constables, five detective sergeants; supported by two centrally-led teams –

1. An online child sexual exploitation team (14 constables)
2. Central CSE team (15 constables)
3. Central referral unit (CRU) into which all referrals from partners regarding potential child protection issues are received and initially assessed before being forwarded to local CAIT for further action / strategy discussion and section 47 activity (joint agency response with children's services)

Local CAITs manage all investigations into sexual abuse of a child under 18, all neglect, physical and emotional abuse of a child under 18 where offender is inter familial, in a position of trust or by someone with responsibility for the child, all Honour Based Violence (HBV), FGM, FM on a child under 18 and all SUDI and SUDC's (sudden, unanticipated death of an infant under two (SUDI) or a child aged 2-18 (SUDC).

Detailed operating principles and service documents have been developed for every team and officer working within Child Abuse, which are accessible on West Midlands intranet page. There is a trained child abuse manager on duty between 8am and 4pm every weekday and on call from 4pm each night and at weekends. Standard operating principles have been developed determining the roles and responsibilities of all officers within child abuse, including on-call functions.

5.4.4 CAFCASS (Children & Family Court Advisory and Support Services)

A key focus for 2014/15 was continued improvement following the 'good' Ofsted judgement in April 2014. This judgement summarised that Cafcass consistently worked well with families to ensure children are safe and that the court makes decisions that are in the children's best interests. A dedicated action plan for improvements was established. There is a programme of internal audits to assure the effectiveness of safeguarding in both public and private law. Practitioners are subject to supervision and safeguarding practices are scrutinised. There are quarterly Performance Learning Reviews which formally assess safeguarding practice and evidence whether service objectives have been met along with effective adherence to polices.

5.4.5 Other Agencies

Whitefriars Housing (Part of the WM Housing Group) have set up a Safeguarding Working Group to provide strategic direction and coordination as well as monitor and evaluate the safeguarding improvement plan to ensure compliance. Work associated with the plan has been reported to full Board.

The National Probation Service (NPS) is a new organisation created when the previous Probation Trusts were split in to private Community Rehabilitation Companies (CRCs) and the publicly managed National Probation Service. Both agencies have re- mapped out their engagement with the LSCB in the light of these changes and are clear about their responsibilities under "Working Together".
The NSPCC works closely with the Coventry Board. NSPCC staff are very clear about their responsibilities to ensure compliance with Working Together. The NSPCC Concerns Resolution Procedure (CRP) provides a framework for action when a referral has been made to children's social care and police in relation to a child at risk of significant harm and despite normal problem solving processes being applied, no satisfactory outcome has been reached with children's social services as to the appropriate action to safeguard the child. This would include a referral to LSCB.

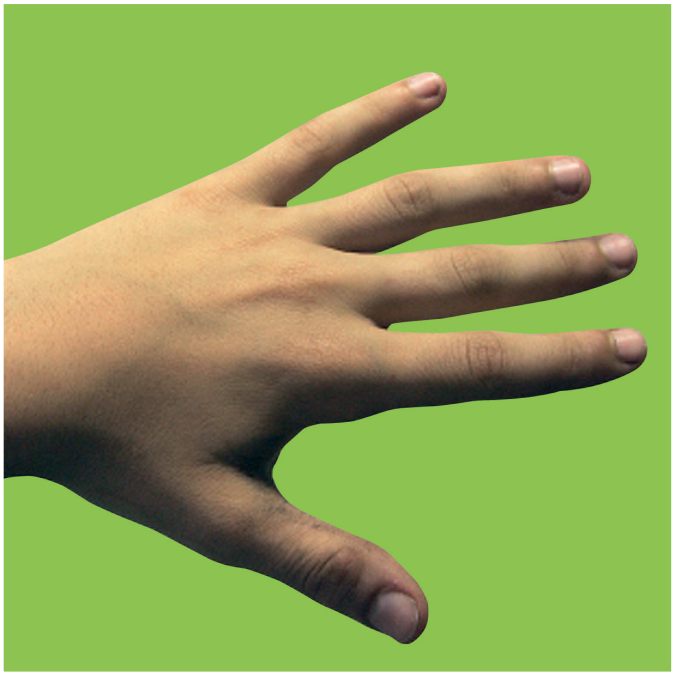
There have been no such referrals this year. An in-house review of the CRP is done yearly.

Although Working Together does not make specific reference to Fire and Rescue responsibilities West Midlands Fire Service (WMFS) have developed safeguarding policy and procedures.

5.4.6 Chair's Conclusion

Within the Board, partners work well together. There are however a few instances in which organisational arrangements do not fully support good partnership working. Within the Council, the structural divide between safeguarding and children's social care has not been conducive to the best possible communication around cases. Planned structural changes will rectify this. The police's central referral unit has not always been quick to respond to requests for information. The year began without a named GP for safeguarding and this has meant that vital work on ensuring good inter-agency working with GPs has been delayed.

However, structural changes that will integrate safeguarding and social care are now planned, the CRU's staffing difficulties are being resolved and the named GP who is now in post has already covered a lot of ground and has a clear plan for improvement action over the next year.

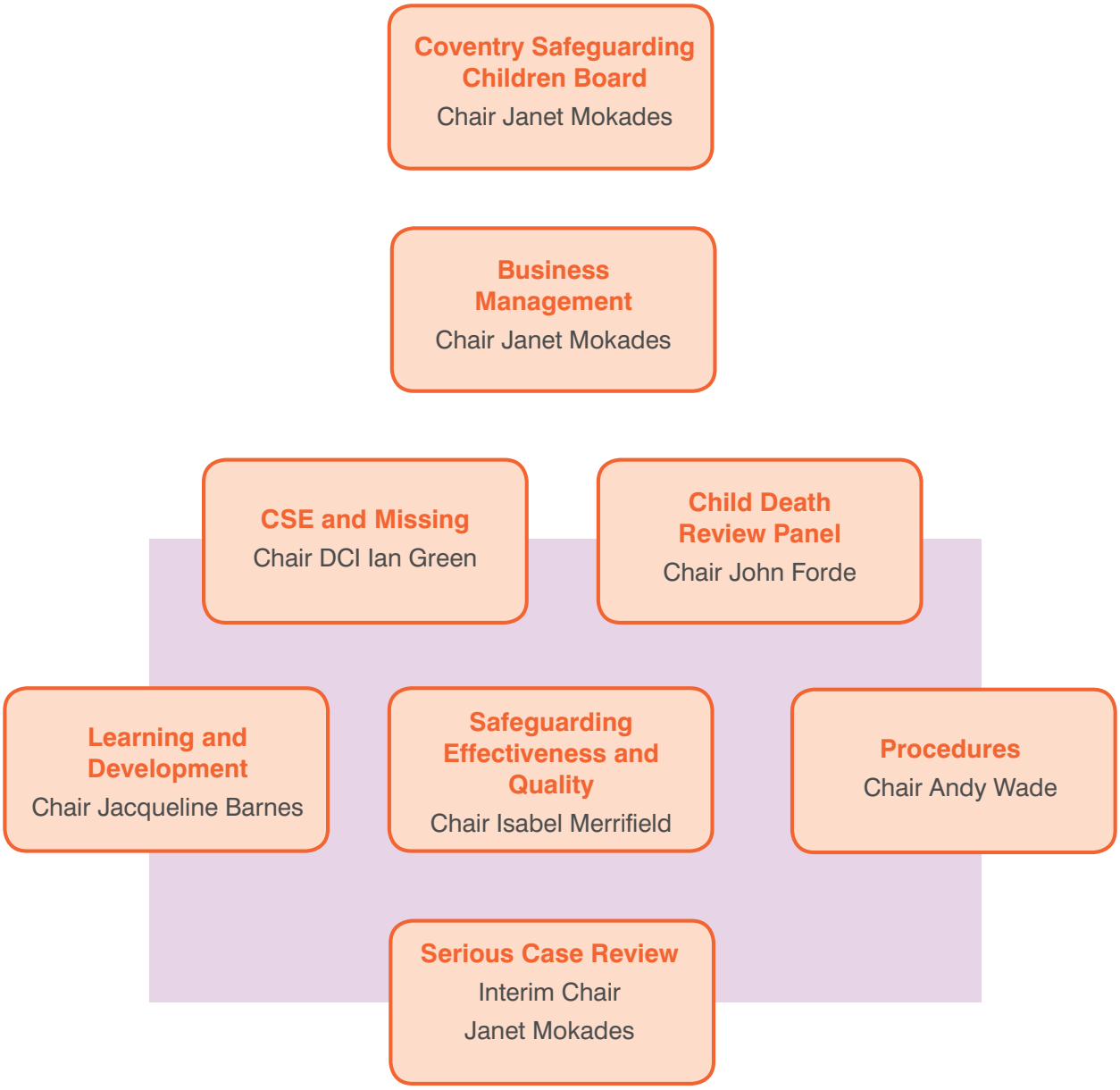


6. Governance and Accountability

6.1 Board Membership

LSCB membership is set out in Working Together 2015. The members of the Coventry Board and their attendance at Board are detailed in appendix 2. Attendance is good.

The Board is structured as follows:



6.2 Developing the Board

Within this year, Board development has been ongoing. This has happened within meetings, within subgroups, for example by participating in multi-agency audits and at events such as the Board development day. This enabled Board members to assess progress against key features of a good LSCB and develop plans to improve. Within Board, the Chair has led a series of group work sessions, focusing on outcomes for children. There is an active Business Management sub-group which deals with the non-strategic business aspects of the Board's work. There are regular meetings of subgroup chairs and the Chair where progress is reported, barriers identified and useful synergies between groups mapped. A work plan is regularly monitored by the independent Chair and Board manager.

A new website ensures that information from the Board is easily accessible and a Board newsletter and twitter page are beginning to reach frontline practitioners. Boards are hosted in a range of venues, and Board members are able to engage with young people/practitioners who offer tours and present at Board. This ensures that Board members understand and experience the range of outcomes for children and young people. This year, the Board has met at the CCG offices, at Lyng Hall School, at the University Hospital, at St John Fisher School and at City College Coventry.

A lunchtime seminar on the Family Drug and Alcohol Court was well attended, and enabled practitioners to hear about new areas of practice to keep children safer. Further lunchtime seminars are planned.

The Board Chair meets regularly with Chairs from other key strategic partnerships, namely the Safeguarding Adults Board, the Health and Wellbeing Board and the Police Crime and Community Safety Partnership Board, to plan work in areas of overlapping areas of concern such as combating domestic violence. This ensures that there is clarity over who leads on what and that efforts are not duplicated. For example, by agreement, the Health and Wellbeing Board leads on tackling Female Genital Mutilation (FGM) and is supported by the Safeguarding Board.

6.3 Budget

There is now a joint budget supporting both the work of the Coventry Safeguarding Children's Board and the Coventry Safeguarding Adults Board. In financial year 2014/15 the gross expenditure budget was £318,000. The actual expenditure was £361,000. Consequently there was an overspend of £43,000.

A breakdown of the expenditure can be seen below:

Category	Expenditure 2014/15 £000
Staffing Costs	116
Service Support Costs	30
Child Death Review	25
Policies & Procedures	6
Venue Hire and Catering	11
Training	16
SCR costs	68
Independent Chair Coventry Safeguarding Adults Board	5
Independent Consultancy for SCRs and LSCB Chair	82
Other	2
TOTAL	**361**

6.4 Learning and Improvement Framework

During this year a new learning and improvement framework was created (http://www.coventry.gov.uk/downloads/download/3915/learning_and_improvement_framework). Board members have the opportunity to shadow other agencies and individuals, and an induction is offered to new Board members.

6.5 SCR Learning

The Board has focused on ensuring lessons learnt from SCRs have impacted on practice. The detail relating to this can be seen in section 4, priority 2.

7. Report from Child Death Overview Panel

The focus for the Child Death Overview Panel (CDOP) has been to review cases in a timely manner, finalise outstanding areas of work, and progress actions arising from reviews while reviewing and improving the process as a whole. The report, available on the LSCB website, details the work that Coventry CDOP has undertaken in 2014-2015.

8. Report from LADO

The Local Authority Designated Officer (LADO) role is key to the LSCB. The report attached at Annex 3 summarises and analyses relevant data for 2014-15 and highlights areas for further development. It focuses on the management of allegations or concerns about people who work in positions of trust (PoT) with children and the process, monitoring and evaluation applied to these allegations.

9. Chair's Conclusion

There has been significant improvement in the safeguarding of children in Coventry this year, as this report makes clear. Some important outcomes for children are getting better. The safeguarding Board is now fit for purpose and fully functioning. Partnership working is good, sometimes very good. Where there are difficulties it is generally because resource pressures are affecting staffing levels. These pressures will continue and as resources shrink, innovative ways of working together will need to be found and colleagues will need to adapt.

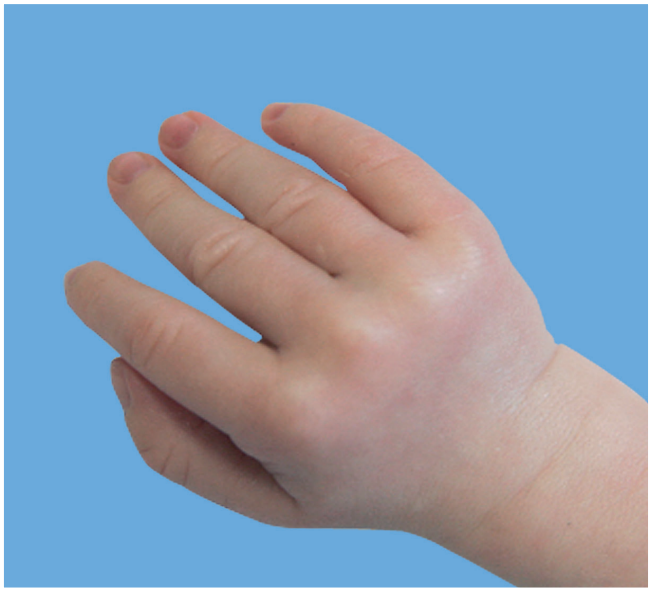
But there is still much to do to ensure consistency and quality across all safeguarding work. There has been considerable improvement in CSC over the last 12 months. This is evidenced by the data showing that more children are getting the right care and support when they need it. But there is also evidence that the quality of practice is still uneven. The lack of a consistent overall quality assurance system operating across the spectrum from CAF to child protection is compounded by the structural divide between safeguarding and children's social care. Taken together, these factors exacerbate the difficulty in gaining clear control of, and assurance about, the quality of practice.

The Council has now developed an overall strategy for early help. It is important that the strategy and planning flowing from it takes into account the full range and complexity of the early help on offer in the city and the need to ensure communication between providers. This ranges from children being supported by schools in schools, but not on any Council process, through those getting support from their GPS, to those who are being helped by the voluntary sector. Early help is more than CAFs and the impact of CAFs needs closer scrutiny. Much emphasis has been placed on increasing their numbers. It is now time to evaluate their efficacy in improving children's lives.

Two dominant issues that will continue to need attention have arisen from serious case reviews this year. One is the need for professionals to exercise greater professional curiosity and judgement in their dealings with clients. The other is the need for more thought to be given to how services can be helped to get to grips with families that are hard to engage.

The Board itself has more work to do to strengthen its knowledge and understanding of the lives of particular groups of vulnerable children. This includes children with disabilities, young carers and looked after children placed more than 20 miles from the city. It must keep up the pressure to get better and more timely information about missing children and assure itself that the new unified processes adopted are an improvement. It will also need to ensure that there is a coherent multi-agency response to safeguard children from radicalisation.

On the positive side, next year the Board should be devising ways of disseminating knowledge of the good and successful safeguarding practice that there is in the city much more widely. Lessons learned from success are as valuable as those learned from failure, yet where safeguarding is concerned it is the latter that tend to be drawn to public attention. Finally, the Board needs to keep listening to children and speak more loudly to services about the need for them to do the same.



Appendix One – Previous priorities for the Board – September 2014 to April 2015

The priorities that were set by the Board as outlined below, with progress against these priorities outlined in the tables below:

Priority 1: Compliance with Working Together 2015 - child protection practice
Ensure that partners, including children's social care, health and police, fulfil the responsibilities for their roles as set out in Working Together to Safeguard Children (Department for Education, 2015) to deliver effective practice to safeguard and promote the welfare of children in Coventry. This will be achieved through LSCB challenge and evaluation of the impact of their activities.
Please see statutory responsibilities – section 5

Priority 2: Serious case reviews
Partners deliver improvements on time - Ensure that there is a timely response from partners to actions identified in serious case reviews, and that this results in evidence of improvement in outcomes for children.
Please see 4.1: Priority 2

Priority 3: Early Help
Co-ordination and Evaluation - Ensure - through challenge and evaluation of impact that all partners are fully engaged in the implementation and delivery of the Prevention and Early Intervention Strategy, so that children and their families have timely access to early help support.
Please see 4.1: Priority 3

Priority 4: Improve effectiveness of LSCB challenge and scrutiny
Ensure the Practice and Quality Assurance sub-group utilises all information available, including audit findings and performance management information, to undertake a robust analysis of the effectiveness of services to help and protect children; demonstrable evidence of the impact of activity will be required from partners.
The Board receives regular reports on performance, and is encouraged to interrogate performance. Where issues are identified that impact on effectiveness the LSCB takes account. For example, in relation to progressing issues related to strategy discussions the LSCB has undertaken a workshop, with clear actions to improve identified, and follow up will take place in October 2015.
The introduction of the Peer Review Panel has provided an opportunity to look at thematic areas in detail, testing the strategy aspirations and practice.

Priority 5: Ensure young people's views routinely inform service improvement and training programmes

Please see 4.1: Priority 1

Priority 6: Promote awareness of private fostering to ensure that more privately fostered children and young people are identified and supported

The Board has produced publicity to raise awareness of private fostering, and undertaken training for practitioners to ensure that they understand the risks and reporting mechanisms.

Four multi agency training sessions were held in January and February 2015, with a total of 63 people trained. These training sessions enabled participants to disseminate messages within their own organisations and raise awareness of the issue.

Private fostering was covered in the Section 175 audit, these identified that most primary schools (with only 11 saying that they cannot), and all but two of the secondary schools, said that they could recognise Private Fostering arrangements. UHCW have incorporated this issue into safeguarding training delivered at induction. CWPT have ensured that Level 2 training highlights private fostering and makes staff responsibilities clear in relation to this issue.

Appendix 2 - Board attendance July 2014 - 2015

Organisation	Member	Role/Title	7/31/14	10/9/14	11/27/14	1/30/15	3/24/15	5/20/15	7/24/15	Mtgs Att	Mtgs Expctd at	% Att	% rep by agency
Independent Chair LSCB	Amy Weir	Independent Chair, Coventry Safeguarding Children Board up until August 2014	ATT	N/A	N/A	N/A	N/A	N/A	N/A	1	1	100%	100%
	Janet Mokades	Independent Chair, Coventry Safeguarding Children Board from September 2014	ATT	ATT	ATT	ATT	ATT	ATT	ATT	7	7	100%	
Coventry & Rugby CCG	Jacqueline Barnes	Vice Chair, Executive Nurse- Coventry & Rugby CCG	ATT	APOL	APOL	ATT	ATT	ATT	ATT	5	7	71%	100%
	Imogen Mortiboys	Lead Nurse for Patient Safety & Experience, Coventry & Rugby CCG	N/A	ATT	N/A	N/A	N/A	N/A	N/A	1	1	100%	
	Jayne Phelps	Designated Nurse for Child Protection, CCG Coventry & Rugby (Chair, Health Advisory Group)	ATT	ATT	ATT	ATT	ATT	ATT	ATT	7	7	100%	
GPs	Dr. Tony Felt-bower	GP Clinical Lead, Coventry & Rugby CCG member from November 2014	N/A	N/A	ATT	APOL	ATT	APOL	ATT	3	5	60%	57%
	Dr James Burden	Designated Safeguarding GP, CCG	N/A	N/A	N/A	N/A	N/A	ATT	APOL	1	2	50%	
Coventry & Warwickshire Partnership Trust, NHS	Tracey Wrench	Director of Quality, Safety and Training – Service User experience	ATT	ATT	APOL	APOL	ATT	APOL	ATT	4	7	57%	100%
	Jamie Soden	Deputy Director for Nursing, CWPT (substitute for TW)	N/A	N/A	ATT	ATT	N/A	ATT	N/A	3	3	100%	
	Moira Bishop	Chair of Training Subcommittee, Named Nurse for Child Protection, CWPT	APOL	ATT	ATT	ATT	APOL	APOL	N/A	3	6	50%	
UHCW, NHS	Carmel McCalmont	Associate Director of Nursing (Women & Children's/Safeguarding), UHCW	ATT	ATT	ATT	ATT	N/A	ATT	ATT	6	6	100%	100%
	Mark Radford	Chief Nursing Officer, UHCW	N/A	N/A	N/A	N/A	N/A	ATT	APOL	1	2	50%	
	Gillian Attree	Named Nurse, Child Protection, UHCW	N/A	ATT	ATT	N/A	ATT	N/A	N/A	3	3	100%	
NHS England	Helen Hipkiss	Assistant Director Patient Experience, NHS England	ATT	APOL	ATT	APOL	ATT	N/A	APOL	3	6	50%	57%
	Lynne Renton	Designated Nurse for Safeguarding, NHS England	N/A	ATT	N/A	N/A	N/A	N/A	N/A	1	1	100%	
	Sue Doheny	Director of Nursing, NHS England	N/A	APOL	N/A	APOL	N/A	APOL	APOL	0	4	0%	
Public Health	John Forde	Consultant, Public Health, (Chair of Child Death Overview Panel) member from September 2014	N/A	ATT	ATT	ATT	APOL	ATT	ATT	5	6	83%	71%
West Midland Police (Policing)	Nick Walton	Superintendent, West-Midlands Police	ATT	N/A	N/A	N/A	N/A	N/A	N/A	1	1	100%	100%
	Claire Bell	Chief Superintendent, West-Midlands Police	APOL	ATT	ATT	ATT	ATT	ATT	ATT	6	7	86%	
West Midlands Police (PPU)	Ian Green	DI West Midlands Police, Chair of CSE	N/A	N/A	N/A	N/A	N/A	ATT	APOL	1	2	50%	86%
	Danny Long	Detective Chief Superintendent, West Midlands Police, PPU attends one meeting per year	N/A	N/A	ATT	N/A	N/A	N/A	APOL	1	1	100%	
	Dean Young	Detective Chief Inspector, Specialist Children Team, West Midlands Police	ATT	ATT	ATT	APOL	ATT	N/A	N/A	4	5	80%	
	Sally Simpson	Detective Inspector, West Midland Police Service, Public Protection Unit	N/A	N/A	N/A	N/A	N/A	N/A	ATT	1	1	100%	
	Jim Edmond	Detective Inspector, Public Protection Unit, West Midlands Police	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1	1	100%	
Local Authority	Brian Walsh	Executive Director, People Directorate, CCC	APOL	ATT	APOL	ATT	ATT	ATT	ATT	5	7	71%	100%
	Mark Godfrey	Deputy Director, Early Intervention & Social Care, People Directorat, CCC attends as and when required	ATT	N/A	ATT	N/A	N/A	N/A	N/A	2	2	100%	
	Yolanda Corden	Interim Assistant Director Children's Social Care, Targeted and Early Intervention Services, People Directorate from June 2014	ATT	ATT	ATT	ATT	ATT	ATT	APOL	6	7	86%	

Local Authority	Terri Cartwright	Interim Head Of Children's Safeguarding, Coventry City Council	N/A	N/A	N/A	N/A	N/A	N/A	ATT	1	1	100%	
	Eric De Mello	Interim Head Of Children's Safeguarding, Coventry City Council	N/A	N/A	N/A	N/A	N/A	ATT	N/A	1	1	100%	
	Susan Harrison	Head of Safeguarding	ATT	ATT	ATT	ATT	APOL	N/A	N/A	4	5	80%	
	Isabel Merrifield	Chair, Safeguarding Effectiveness Group, Assistant Director Strategy & Commissioning and Policy	ATT	APOL	APOL	ATT	ATT	ATT	ATT	5	7	71%	
Education & Inclusion	Kirston Nelson	Director for Education, CCC from July 2015	N/A	N/A	N/A	N/A	N/A	N/A	ATT	1	1	100%	43%
	David Haley	Director, Education & Inclusion, People Directorate member until July 2014	APOL	N/A	N/A	N/A	N/A	N/A	N/A	0	1	0%	
	Roger Lickfold	Strategic Lead, Inclusion SEND and Participation (Chair, Safeguarding Children in Education Advisory Group)	APOL	ATT	ATT	APOL	N/A	N/A	N/A	2	4	50%	
Primary Schools	Denise Mooney	Headteacher, Primary School	ATT	ATT	ATT	ATT	ATT	ATT	ATT	7	7	100%	100%
Secondary Schools	Paul Green	Headteacher, Secondary School	APOL	ATT	ATT	ATT	ATT	APOL	APOL	5	7	71%	67%
City College	Steve Logan	Principal, City College Coventry	N/A	N/A	N/A	N/A	N/A	N/A	ATT	1	1	100%	100%
Community Lay Member	Dawn Seth	Community Lay Member	N/A	N/A	N/A	N/A	N/A	ATT	ATT	2	2	100%	100%
Councillors (observers)	Cllr. Ed Ruane	Cabinet Member, Children & Young People member since May 2014	ATT	ATT	APOL	APOL	ATT	ATT	ATT	5	7	71%	100%
	Cllr. Hazel Noonan	Shadow Cabinet Member, Children & Young People mc, CCC	N/A	N/A	N/A	N/A	N/A	N/A	ATT	1	1	100%	
	Cllr. Julia Lepoidevin	Shadow Cabinet Member, Member Services	ATT	ATT	ATT	ATT	ATT	ATT	N/A	6	6	100%	
CRC Probation	Kobina Hall	Head of Service, Coventry, SWM Probation Service	ATT	ATT	ATT	ATT	ATT	N/A	APOL	5	6	83%	71%
National Probation Service	Andy Wade	Head of Service, National probation Service member since July 2014	APOL	APOL	ATT	ATT	ATT	N/A	APOL	3	6	50%	43%
NSPCC	Cathy Small	Service Manager, Coventry NSPCC	ATT	ATT	APOL	ATT	ATT	ATT	APOL	5	7	71%	71%
West Midlands Fire Service	Shashi Carter	Community Risk Reduction Officer, West Midlands Fire Service	N/A	N/A	N/A	N/A	N/A	N/A	ATT	1	1	100%	57%
	Andrea Simmonds	Partnerships Officer, West Midlands Fire Service	APOL	APOL	ATT	APOL	ATT through rep	ATT	APOL	3	7	43%	
Whitefriars Housing	Catherine Collis	Manager, Whitefriars Housing Group	N/A	N/A	N/A	N/A	N/A	N/A	ATT	1	1	100%	100%
	Kam Sidhu	Head of Tenancy Support, Whitefriars Housing Group	ATT	ATT	ATT	ATT	ATT	ATT	APOL	6	7	86%	
West Midlands Ambulance Services	Andrew Proctor	Head of Safeguarding , West Midlands Ambulance Service member since September 2014 agreement to attend 1 meeting per year	N/A	APOL	APOL	APOL	APOL	APOL	ATT	1	1	100%	100%
	Will Tansey	West Midlands Ambulance Service	N/A	N/A	N/A	N/A	N/A	ATT	N/A	1	1	100%	
NHS Coventry	Dr. Karen McLachlan	Interim Designated Doctor, Coventry & Rugby CCG	N/A	ATT	ATT	ATT	APOL	ATT	ATT	5	6	83%	71%
	Dr. Annie Callaghan	Designated Doctor, Coventry & Rugby CCG (long term absence from work)	APOL	APOL	APOL	APOL	APOL	ATT	APOL	1	7	14%	
Legal Services	Julie Newman	Legal Advisor, CLYP & Adults Manager, Legal and Democratic Services	APOL	ATT	ATT	ATT	ATT	N/A	ATT	5	6	83%	71%
Officers to the Board													
Business Manager, LSCB	Hardeep Walker	Business Manager, LSCB in post until Aug 2014	ATT	N/A	N/A	N/A	N/A	N/A	N/A	1	1	100%	100%
	Cat Parker	Business Manager, Safeguarding Children & Adults Board in post from Aug 2014	N/A	ATT	ATT	ATT	ATT	ATT	ATT	6	6	100%	
Training Coordinator	Anne Pluska	Training Coordinator, Safeguarding Children & Adults Boards	N/A	N/A	N/A	ATT	N/A	ATT	ATT	3	3	100%	100%
Administration	Mo Ali	Team Leader, Safeguarding Children Board (Minuting)	APOL	ATT	ATT	ATT	APOL	APOL	ATT	4	5	80%	100%
	Katy Carpenter	Business Services (Minuting)	ATT	N/A	N/A	N/A	N/A	N/A	N/A	1	1	100%	
	Lillian Ferraro	Team Leader Safeguarding Adults Board (Minuting)	N/A	N/A	N/A	N/A	ATT	ATT	N/A	2	2	100%	
Copies of minutes to:													
CAFCASS	Linda Cane	Enhanced Service Manager member since March 2015	N/A	N/A	N/A	N/A	APOL	APOL	APOL	0	3	0%	0%
	Liz Elgar	Head of Service, CAFCASS Coventry, Northamptonshire, Warwickshire & National Business Centre until July 2014	APOL	N/A	N/A	N/A	N/A	N/A	N/A	0	1	0%	
	Neville Hall	Head of Service, CAFCASS Coventry, Northamptonshire, Warwickshire & National Business Centre member from Oct 2014 agreement to attend 1 meeting per year	N/A	APOL	APOL	APOL	N/A	N/A	N/A	0	3	0%	

Appendix 3 - LADO Annual Report September 2014 - August 2015

AUTHOR: Elizabeth Macauley

Purpose of report

To update Coventry Local Safeguarding Children Board (LSCB) and provide an overview of the Local Authority Designated Officer (LADO) role, summarise and analyse relevant data for 2014-15 and highlight key areas for further development. The report focuses on the management of allegations or concerns about people who work in positions of trust (PoT) with children and the process, monitoring and evaluation applied to these allegations.

1. Action required by Coventry LSCB;

The Board is asked to note the report, specifically the following issues:

a) The number of referrals from some groups of key professionals remains low. Although the trend is worthy of note, there is no obvious presenting reason for this.

b) The need for partners to revisit staff expectations regarding the threshold process within their organisations.

c) The need for all partners to recirculate the LADO contact details to all staff, to help them access advice and guidance on potential LADO matters at the earliest point of a concern.

2. Introduction and Background

The management of allegations should continue to be seen in the wider context of safer employment practices, which have a number of essential elements:

1. Safer recruitment and selection practices
2. Protection of children and giving them a voice
3. Management of allegations or concerns
4. Safer working practices
5. Licensing
6. Promoting consistency of practice and good practice

This report will primarily focus on the third element but this activity should be seen in the wider context of Coventry LSCB's work in respect of safer recruitment and employment and guidance to support safer working practices across the children's workforce.

Appendix A outlines three case studies. These highlight the effectiveness of a dedicated LADO function, how learning is gained through the process and the significance of employers and agencies making use of their internal systems to safeguard children.

2.1 The criteria in respect of position of trust remains the same

The statutory guidance Working Together 2015 continues to establish three specific threshold criteria that underpin the allegations management framework. The LADO process is applicable in situations whereby a person who works with children is alleged to have:

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

This is in connection with the person's paid employment or voluntary activity and may involve concerns arising about the person's behaviour and raising issues of "suitability." Concerns within their own family, home or within the community may trigger LADO intervention. In consideration of a concern or allegation, there are three main safeguarding strands: (case study C)

- The investigation of any criminal offence;
- Whether a child protection investigation is required to safeguard the children or whether they are in need of support

- Any perceived need for disciplinary action in respect of an employee in relation to the allegation/s

Coventry LSCB procedures, together with the LADO practice guidance, detail the operation of these functions within Coventry. Working within these procedures will help ensure that allegations are dealt with consistently and fairly.
The LADO in Coventry works with representatives across agencies in Coventry and also regularly works with LADOs in other local authorities where individuals undertake activities with children across different local authority boundaries. Further the LADO will liaise with agencies outside of Coventry where allegations relate to those working in Coventry but whose employers may not be local (for example independent fostering agencies or education employment agencies based out of Coventry).

3.2 Impact of national policy context

Working Together 2015 guidance update:

Last year the Government carried out consultation on three main proposed changes to Working Together to Safeguard Children 2013. One of the outcomes concentrated on the referral of allegations against those who work with children. This particular consultation was carried out directly with LADOs nationally.

The government has reviewed the referral mechanism for allegations against staff,. The expectation that referrals should be routed through frontline social care has been removed and replaced with such allegations should be managed in a 'co-ordinated manner'.

The other change is in relation to the experience and qualification of the designated officer managing these allegations. All new appointments must be qualified social workers. An essential to this role, not made clear in Working Together 2015, is that they have a management background to support the role in respect of decision-making at an operational and strategic level. Those LADOs who are already in post and not qualified as social workers will not be affected by this change in policy.

The national and local position is that many local authorities continue to retain LADO as the name for the function and job title given its long standing currency and it clearly differentiates the role from other designated officer roles. Coventry LSCB has also agreed to retain the title of LADO.

Disqualification by Association Act 2006 (Feb 2015 Update):

A person who has been convicted of any one of a number of specified offences will be disqualified from registering as a childcare provider.

The list of offences is set out in the Disqualification under the Childcare Act 2006. The list of specified offences is long and detailed. In broad terms, it includes serious violent and sexual offences and offences against children.

In addition to the disqualification of an individual who has been convicted of any of the specified offences, the legislation provides that a person will also be disqualified from registration if they live in the same household as someone who is disqualified (or live in a household in which a disqualified person is employed).

This means in practice that even though, for example, a teacher may not have committed or been convicted of one of the specified offences they will still be disqualified if they live in the same household as someone who has.

Employees and volunteers have a responsibility to inform their employers. Employers will have to suspend them (schools usually ask staff to refrain from work while this is being sorted out) and the member of staff has 14 days to apply for a waiver from OFSTED. It is the employer's responsibility to ensure the employee follows procedure.

OFSTED will carry out a risk assessment and analysis and liaise with the headteacher, employee, offender, LADO and the Disclosure and Barring Service (DBS). An analysis of the risk assessment carried out by OFSTED showed this to be flawed. DBS will not provide feedback because the information being requested is about the offender not the employee concerned, therefore, the risk assessment remains incomplete.

3. Key developments in 2014-15

- The creation and establishment of a dedicated LADO function
- Removal of the LADO function from the Coventry LSCB risk register
- The LADO has worked with the ICT service to create a database on Protocol for LADO business. This is currently in the process of having bespoke reports written for the database. (N.B. statistics used in this report have been collated manually)
- Recruitment of the Safeguarding Compliance Officer for Education
- Practice guidance for managing allegations and clarifying thresholds of LADO involvement
- Development of a case management monitoring system
- Audit of paper case files (this has been previously reported on)
- Establishing the LADO function to provide for advice and guidance
- The LADO has delivered briefings to professionals in a number of sectors as well as continuing individual site visits across sectors to forge better working relationships and contribute to developing good safeguarding practice.

4. Local arrangements

Since January 2015 all LADO referrals are overseen by a dedicated post. Up until September 2014 the role of LADO was a shared one. Referrals were managed by the duty Independent Reviewing Officer (IRO).

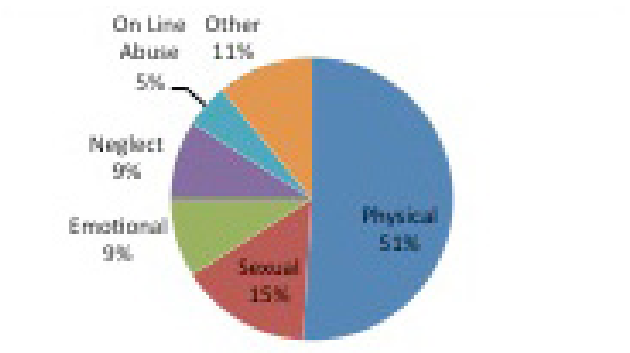
The chairing of Position of Trust meetings was shared between four managers. All education referrals went to the designated education officer. In effect two processes were in place to manage the LADO function. Following the OFSTED inspection in March 2014 the need for a dedicated LADO was agreed and thus was included in the City Council's Improvement Board Plan.

The LADO is currently part of the safeguarding service establishment and is located with IROs and Child Protection Conference chairs.

5.1 Local Activity

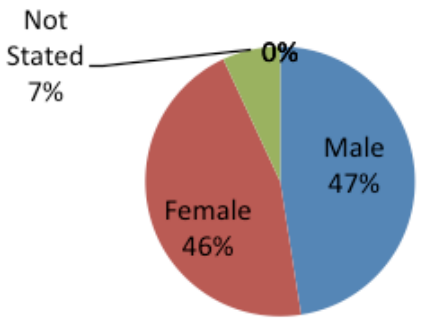
In the year 2014-15 there were 105 referrals to the LADO.

Category of referrals



	Number of Referrals	Percentage
Physical	54	51
Sexual	16	15
Emotional	9	9
Neglect	9	9
Online Abuse	5	5
Other	12	11
TOTAL	**105**	**100**

Gender



	Number of Referrals	Percentage
Male	50	48
Female	48	46
Not Stated	7	7
TOTAL	**105**	**100**

Source of referrals

	Number of Referrals	Percentage
Education	15	14
Police	7	7
Social Care	35	33
LAC Team	3	3
NSPCC	4	4
Adult service	1	1
Early Years	21	20
Parent	1	1
OFSTED	4	4
Scouts Association	2	2
Health	1	1
Coventry University	3	3
Route 21	4	3
Education Centre	1	1
Independent care agency	1	1
National Crime Agency	1	1
HR	1	1
TOTAL	**105**	**100**

Professional attendance at Position of Trust meetings

	Percentage
Police attendance	41%
Social Care attendance	40%
Employer attendance	44%
HR attendance	17%
Other	18%

Of the referrals 85 were sufficiently serious to progress to Position of Trust (PoT) meetings. The proportion of meetings tends to be higher for settings with less established referral pathways such as childminders, independent early years settings and faith settings where often only more serious referrals are identified. Those from Education, Social Care etc. are increasingly for advice and guidance, reflecting the increased use of the LADO in this way in sectors more familiar with the processes. This has been particularly noticeable for Education in 2014-15. This may be due to increased awareness of the LADO function. The proportion of cases progressing to a PoT meeting has been consistent, averaging at eight per month. For a high number of the cases progressing to PoT the outcome is unsubstantiated. Case studies A & C explore some of the complexities when cases are unsubstantiated.

5.2 Outcomes of Allegations

	Number
Substantiated	12
Unsubstantiated	27
Unfounded	6
Malicious	0
*No Active Involvement	
(LADO) advised after investigation)	16
Active/Monitoring	39
TOTAL	**105**

A substantial number of allegations are for physical abuse and these allegations, as with sexual abuse, are more likely to progress to a Position of Trust (PoT) meeting.

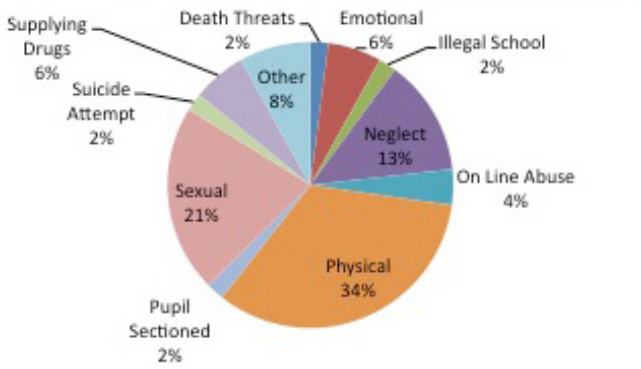
This has proved useful because there have been a small number of early years settings who have done this on more than one occasion. In these cases, referral to OFSTED has proved to be a helpful means to address this problem. On two occasions it has triggered early inspection of the settings that have previously been graded inadequate.

5.3 Advice

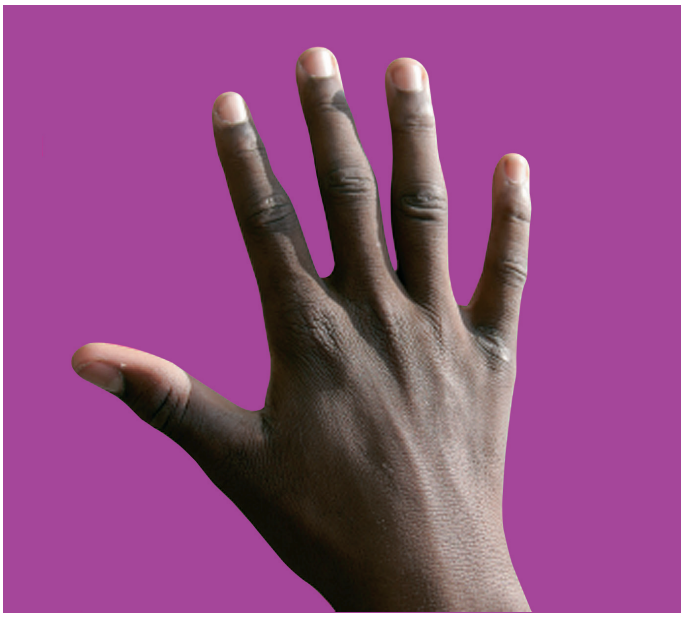
There does seem to be an overall increase in the use of the LADO for advice and guidance. There is no evidence prior to October 2014 that data was collected about enquiries for advice. This aspect of the work varies greatly in terms of time required for each call. Much depends on the level of concern and the anxiety of the caller (Case Study B).

When referrals do not progress to a PoT meeting the process allows for the LADO to oversee and agree actions with agencies to investigate concerns and address safeguarding and practice issues as well as providing data to help identify trends.

Advice and consultation by category



	Number	%
Death Threats	1	2
Illegal School	1	2
Physical	16	34
Pupil Sectioned	1	2
Sexual	10	21
Emotional	3	6
Neglect	6	13
Online Abuse	2	4
Other	4	8
Suicide Attempt	1	2
Supplying Drugs	3	5
TOTAL	**48**	**100**



Advice and consultation by category

	Number	%
Anonymous	1	2
Childminder	1	2
Children's Care Home	4	8
Children's Specialist Service	1	2
Diocesan S/G Advisor	1	2
Education	5	10
Internal CCC	2	4
LADO @ Nottingham	1	2
LADO @ Warwickshire	2	4
LADO @ Northampton	1	2
NSPCC	1	2
Nursery	2	4
OFSTED	5	10
Parent	2	4
Police	7	15
Route 21	1	2
School	1	2
Social Care	8	17
Travel Bureau CCC	2	4
TOTAL	**48**	**100**

6. Priorities for the coming year

1. Policy

- Continue to develop the role in line with statutory and national requirement
- Review and update current Coventry LSCB procedures for managing allegations

2. Practice

- Develop and promote the LADO advice service
- Continue work to improve the understanding of LADO procedures in sectors including Early Years, Social Care, and Fostering and Education, through briefings, communications etc.

3. Administration

- The LADO will work to integrate the functions of the Managing Allegations process with the new Protocol database which will allow for better reporting of LADO information and identifying trends
- Continue to develop and evaluate the use of the LADO service

4. Publicity

- Information poster to be disseminated to public access Council buildings and settings included in the Section 11 Audit
- Promote greater understanding of the role of LADO by producing a safeguarding newsletter

Appendix A - LADO Case Studies

The following case studies have been chosen to bring to life some of the features outlined in the figures above. All names and identifying information have been changed.

A. School / Unsubstantiated / PoT meetings / Outcome

X was a learning support assistant in a school for children with learning needs and mobility difficulties. The children in her class were seven years old. Concerns had been raised eight months prior to the referral being made to LADO. All the concerns linked to unusual events whereby "something" would happen and a child would be blamed by X. Examples included a child's wheelchair was forcibly pushed into the legs of another child, X had been observed to be pushing the wheelchair moments earlier. Washing up liquid was found to be in a number of children's hair at different times; the children never had any unsupervised access to the washing up area. A member of the public contacted the school because they knew that X worked at the school. The parent explained that X had worked for them via an agency. X provided in-home respite four hours a month at the weekend to a nine year old child. The parent went on to explain that she had noticed odd things occurring such as things being misplaced and X would find the items and blame the child. The items included small items of kitchen equipment. The child would not have known where these items were and due to her learning ability it is highly unlikely that she would have had a motivation to act in the way suggested by X. One evening after X had left, the mother was tidying up various play items. Somehow glue had been put in the tea-set teacups. On seeing this, the mother knew that her daughter had no access to glue and immediately became very concerned as X had been playing with the child with the tea set. The parent contacted X and ended the arrangement and contacted the school soon after.

The headteacher contacted LADO and following discussion it was agreed that the concerns justified multi-agency scrutiny. Following the decision to convene a Position of Trust (PoT) meeting much more information about the detail of the unusual occurrences emerged. Two members of staff had actually observed two events; one was wilfully smashing a plate at lunchtime and blaming a child and another was throwing a chip from a child's lunch plate to another's. The events are reported to have happened at "blink" speed. When the headteacher confronted X with the allegations she denied the above two incidents. These events, as with the others, involved children with significant communication difficulties. There had not been an allegation from any of the children. However, in this case, the focus was about safeguarding vulnerable children from a member of staff exhibiting behaviour that may pose a risk of harm.

The PoT meeting was attended by the school, police, human resources and another care agency.

The outcome was that it was unsubstantiated and there was not going to be police involvement.

It transpired at the first PoT that X had also been working with a care agency for six weeks. Up until the point of the PoT, X had not been matched with one family and was filling in when there were gaps on rotas. The agency provides in-home care to children who are not mobile and are tube fed. X had completed her training in tube feeding and was due to be matched with her first family. During the process the information was of sufficient concern that the head teacher, supported by human resources, took the decision to dismiss.

The decision was appealed though not upheld and a referral to DBS was made and all relevant information was sent to the barring agency. This case illustrates that an unsubstantiated outcome, by far the most common, does not

mean that there is no further action or nothing that can be done. There was a co-ordinated multi-agency approach which ensured that while there was no substantiated allegation against the learning support assistant the process highlighted significant concerns about her behaviours. It provided the opportunities and mechanisms to risk assess her suitability to work with children and particularly children who may not be able to tell if they are harmed.

B. Care establishment /advice/ staff behaviour in personal life

Y is a residential care worker, working for an independent agency. Y also does outreach work with children when they move placements. He has been with the agency for three years. He has a good work record and no concerns have ever been reported that might suggest unsuitability to work with children.
The manager of the care establishment received a call from the police, confirming Y had been arrested for being involved in a serious criminal act and had admitted to the offence. The non-sexual and non-violent offence was not related to children but is a very serious one involving another adult. The manager sought LADO advice as they believed it was a safeguarding issue.

Taking the manager through a sequence of questions identified that no children were at risk of harm and that the information had come from a third party because Y had co-operated with the police when interviewed. The manager initially was hopeful that by contacting the LADO they would get instruction as to what they needed to do. Advice was given that there were no safeguarding issues because the crime Y had admitted to was not related to children and had been against a person in another part of the country.

We discussed the role of human resources and the advice they had given to contact LADO. I was clear that it did not meet the threshold for LADO involvement and that the situation was required to be managed by employee contractual obligations. Towards the end of the call the manager volunteered that Y had actually used the staff computer to send communication to the individual who the crime was against.
The manager realised that through the advisory discussion with LADO the absence of the issue based on factual information was clear.
What was evident is that a member of staff had misappropriated use of workplace facilities to pursue a personal matter.

A couple of days later the manager emailed to confirm that individual had been suspended for misconduct.

The manager has a clearer perspective on the range and type of safeguarding concerns the LADO can be involved with. Although the person, while working with children, had committed a crime in their personal life the substance of the crime did not equate that the individual is now a risk to children.

The other learning point is that the agency had the procedures and process in place to respond to the employee's misconduct. However, this was clouded by the assumption that it was a safeguarding matter and that it was the responsibility of the safeguarding service to direct the service as to how they ought to manage their situation with a staff member.

C. Learning establishment / unsubstantiated / responsibility to safeguard

In January 2015 police intelligence revealed that on a particular date an email containing indecent images of children was downloaded on computer equipment at an address in Coventry. A number of people were lodged at this property on this date, including Z, a social worker in training. All the people who had lived at the house were dealt with separately. At the time of the report being made two others had been charged and were remanded in custody Z was arrested at his current residence in Birmingham and all his electronic devices were seized and sent for forensic examination to determine the content, specifically for any indecent images of children.

Z was interviewed by the police. During the course of the interview he admitted an addiction to pornography and that he accesses pornographic images once a day and sometimes up to three times. He volunteered that he had used the search term “child” in Google and had inadvertently found prohibited images of children.

The Police have no evidence to corroborate what Z had said in the interview. There being no criminal offences committed there was no further involvement by the police. Nothing was found of a criminal nature on Z’s electronic devices. Therefore the concern that Z was implicated in what may have been taking place at the house when he lived there was unsubstantiated.

Due to the quality of the information shared through the PoT process the learning establishment were sufficiently concerned and their representative took the matter through their establishment’s professional conduct procedures. Two months later an email was received confirming that Z will not be allowed to qualify to practice as a social worker. A referral to DBS was made.

This case highlights that where there is no ongoing police involvement the duty to safeguard becomes the responsibility of the employer in whatever guise that may be. As evidenced through the three case studies, in the legitimate absence of the police, employers, care agencies and learning organisations have the responsibility to manage concerning situations and behaviours to safeguard children.

This report is available online at:
www.coventrylscb.org.uk

If you require this report in another format or language please contact:
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e-mail: coventryLSCB@coventry.gov.uk