Coventry City Council
Minutes of the Meeting of Education and Children's Services Scrutiny Board (2) held at 2.00 pm on Wednesday, 16 December 2015

Present:

Members:	Councillor M Mutton (Chair) Councillor S Bains Councillor L Bigham Councillor D Kershaw Councillor P Male Councillor J Mutton Councillor H Noonan Councillor J O'Boyle Councillor E Ruane Councillor P Seaman Councillor S Thomas
Co-Opted Members:	Mrs S Hanson and Mr R Potter
Cabinet Members and Deputy Cabinet Members:	Councillor D Kershaw Councillor E Ruane Councillor S Thomas
In attendance	J Mokades – Independent Chair of the Coventry Local Safeguarding Children Board
Employees (by Directorate):	
People:	C Parker
Resources:	G Holmes, L Knight
Apologies:	Councillors N Akhtar, J Lepoidevin and C Miks

Public Business

42. **Declarations of Interests**

There were no discloseable pecuniary interests.

43. **Serious Case Review**

The Scrutiny Board considered a briefing note of the Business Manager for Adult and Children Safeguarding Boards, which detailed the outcome of the serious case review (SCR) relating to Child S.

Following the death of Child S in 2013, the Independent Chair of Coventry Local Safeguarding Children Board (LSCB) at that time agreed that this case should be the subject of a serious case review. The SCR Report, including recommendations, and the resulting action plan were appended to the briefing note submitted. Councillor M Mutton, Chair of the Scrutiny Board, reminded

members that their role was not to hear the review, but to scrutinise the recommendation and review them.

Janet Mokades, current Independent Chair of the LSCB, attended the meeting and presented the recommendations and action plan that resulted from the SCR. The Scrutiny Board noted the background to the case which, in summary, was that during the autumn of 2013 Mother S had called an ambulance to her home and Child S was found to be suffering from a serious head injury. Child S was taken by ambulance to the University Hospital Coventry and Warwickshire (UHCW) accompanied by his mother, who stated that he had fallen down stairs at home. Mother S's partner, Male B, remained at home and did not attend the hospital.

It had been clear when Child S's arrived at UHCW that he was gravely unwell and later that day was transferred to Birmingham Children's Hospital (BCH) due to the nature and seriousness of his injuries. Upon arrival, he was taken straight to the operating theatre for emergency surgery. Staff at both UHCW and BCH became concerned that, upon examination of scan results, the injury was not consistent with the explanation provided and the Coventry Emergency Social Care Duty Team were contacted along with West Midlands Police. Following the surgery, Child S was taken to the paediatric intensive care unit and, despite the efforts of medical staff, he died the following day as a result of the injuries he had sustained. Later the same day both Male B and Mother S were arrested on suspicion of murder. In Autumn 2014, following a Police investigation, Male B was charged with murder and Mother S with neglect and allowing Child S's death.

The purpose of the SCR was to establish the role of services and their effectiveness in the care of Child S, whether information was fully shared by the professionals involved, and whether procedures were appropriately followed. This process would ensure that any deficiencies in services could be identified, and lessons learned to minimise the risk for another child. This should also reassure the public and prevent the need or demand for further external inquiries. In addition to an independent chair and a lead reviewer, the SCR panel included senior managers from each of the following key agencies:-

- Coventry Social Care
- West Midlands Police
- West Midlands Fire Service
- Coventry and Rugby Clinical Commissioning Group
- Coventry and Warwickshire Partnership NHS Trust
- University Hospitals Coventry and Warwickshire NHS Trust
- Coventry Head of Safeguarding
- Staffordshire West Midlands Probation Trust

The Scrutiny Board noted that the review covered, in detail, the period from early summer 2010 to the end of 2013, which included the period that Mother S was pregnant with Child S, through the child's entire life, to the post mortem stage of early evidence gathering. The report included details of Mother S's early years, the story of Mother S and Child S, the relationship between Child S and his mother, what Child S was like, the relationship between Mother S and Male B, and significant events in the life of Child S.

The SCR identified that all of the agencies involved had a picture of Child s and it was not one that raised concern. There was evidence that he was seen, checked and spoken to and at no point did any professional raise any concerns about his health and wellbeing. The review found no evidence that any signs of distress were missed or ignored by professionals. The report identified a number of good examples where individuals and agencies were particularly adept at considering the voice of Child S. However, it was found that there were some occasions where insufficient weight was applied to the voice of Child S and these were also highlighted in the report submitted.

The SCR had found no evidence that any agency or professional in Coventry could have prevented the death of Child S. The review did highlight a number of areas where agencies in Coventry could improve their systems and work more effectively together, but it was felt that these improvements would not have affected the final, tragic outcome. Whilst there were missed opportunities by agencies to intervene and place support around Child S and his mother, those interventions would not have prevented Mother S resuming her relationship with Male B, or prevented him from being in the house, alone, with Child S. There was nothing anyone, except Mother S, could have done to prevent him being there. None of the authorities or organisations that had involvement in Child S's life could have foreseen the events that occurred; they could not have prevented his death.

The SCR made three recommendations to further improve safeguarding in Coventry. These recommendations were those that required a multi-agency response. The Scrutiny Board noted that the review had also identified a number of areas that individual agencies needed to consider and take action against and, in those cases where issues have been identified for a single agency, that agency should produce action plans that should be monitored through the LSCB performance framework. They should continue to be subject to regular scrutiny by the Board until completion.

The recommendations that required a multi-agency response were:-

1. The Coventry LSCB should monitor the plans for changes in structure, policy and service provision by agencies to assess how they will dovetail; ensuring that levels of child safeguarding are maintained.

2. The Coventry LSCB should progress its priority relating to domestic violence and abuse by:

    - Forging stronger links with the Police and Crime Board;
    - Refining and consolidating the post Daniel Pelka joint screening process; and
    - Championing the work being done in Coventry to counter domestic violence and abuse.

3. Coventry LSCB should ensure that all agencies:

    - Have policies and procedures in place for identifying those families that are proving hard to engage;
    - Scrutinise and, where necessary, tighten their procedures for working with families who are hard to engage;

- Have protocols in place to share information between agencies about families that are hard to engage; and
- Monitor staff compliance with the agreed procedures.

The multi-agency action plan appended to the report identified the actions required by each of the recommendations, which agencies were responsible for particular actions along with the expected outcomes and the current position.

Having considered the background to the SCR, the review findings and the recommendations, the Scrutiny Board expressed some concerns, in particular:-

a. The domestic violence screening process and how agencies work collaboratively, particularly where they were aware of perpetrators who could potentially cause risk to children. Members requested additional information from the Police and Crime Board on this issue and the numbers of perpetrators being monitored.

b. How stronger links can be built between various agencies, such as the NSPCC and Barnardos, ensuring that each organisation understands what the others do and how the Council may assist with this.

c. Understanding how the implementation of recommendations from all SCR's is monitored and assurance received that they have improved outcomes for children. Members requested that a progress report be submitted in 6 months time, to include the outcomes of implementation.

RESOLVED that the Education and Children's Services Scrutiny Board (2):

1. **Note the recommendations in the report and the associated action plan and updates.**

2. **Request that information be submitted to the Board about the Domestic Violence screening process, including information from the Police and Crime Board in respect of the number of perpetrators being monitored.**

3. **Request that information be provided to the Board on how stronger links can be built between various agencies, such as the NSPCC and Barnardos, and how the Council may assist with this.**

4. **Request a progress report in 6 months on the implementation of recommendations from all Serious Case Reviews, including the outcome of the implementation.**

44. **Annual Report of the Local Safeguarding Board**

The Scrutiny Board considered a briefing note of the Joint Safeguarding Board Business Manager, which presented the Local Safeguarding Children Board (LSCB) Annual Report.

Coventry Children's Services and LSCB were inspected by Ofsted in January 2014 and judged to be inadequate. Since that time an Improvement Board had

been established and the Department of Education had been monitoring progress. A new independent Chair of the LSCB took up post in September 2014 and she reports regularly to the Secretary of State and the Improvement Board on progress.

It was noted that agencies working together to safeguard children in Coventry were working in a challenging context with a growing population, including child population, and a diverse ethnic mix and higher than average levels of poverty. There were currently approximately 74,123 children and young people in Coventry aged 0-17, including 14,204 children under three years old. Recent years had seen an increase in birth rates and, if current population growth trends continued, it was anticipated by 2026 the total population of Coventry would rise by 18%, with the total number of children projected to rise faster than the adult population.

The report outlined the achievements and challenges of the LSCB from September 2014 to September 2015. It assessed progress on outcomes for children and young people. It evaluated the impact of Coventry's services on outcomes for children and showed how the work of the Board had contributed to improving outcomes. It detailed the Board's progress in implementing its former and current priorities.

The outcomes for Coventry children was reported under the headings of Child Protection; Common Assessment Framework (CAF); Looked After Children; Early Years; Missing Children and Child Sexual Exploitation; Crimes Against Young People; Youth Offending; Educational Attainment and Attendance; and Health Outcomes.

In respect of Child Protection, the Scrutiny Board were pleased to see that the number of Coventry children with child protection plans had reduced from 882 in September 2014 to 578 in September 2015. It was acknowledged, however, that this was still much higher than normal in similar areas and work to understand why this was so and to ensure that children get help earlier, so avoiding escalation, continued.

It was noted that the number of CAF's had steadily increased from 1,543 in April 2014 to 1,887 in September 2015. Health colleagues, in particular, had increased their use of CAF's, which ensured that more children and families who needed support could access it. Diagram 4 of the report provided details on the outcomes of CAF's. However, the Scrutiny Board expressed concern that, at a recent meeting, members were advised that a decision had been purposely taken by Coventry and Warwickshire Partnership Trust not to train health visitor staff on the use of e-CAF's and were of the view that this issue should be picked up through the re-commissioning of the service in April.

With regard to educational attainment and attendance, there was a clear upward trend in reading, writing and maths at key stage 2 and the un-validated 2015 data suggested that the upward trend had been sustained. An average of 52.3% of children in Coventry achieved 5 A* to C grades at GCSE last year. It was reported that this was lower than the previous three years and the national average but reflected the trend seen elsewhere. Scrutiny Board members requested clarification on whether this figure included Maths and English.

The report also set out the LSCB's current priorities and Appendix 1 of the report submitted provided progress against these priorities covering the period from September 2014 to April 2015.

The report concluded that there had been significant improvement in the safeguarding of children in Coventry during the year, with some important outcomes for children getting better. The Safeguarding Board was now fit for purpose and fully functioning, with partnership working good. It was noted that where difficulties were identified, it was generally because resources pressures were affecting staffing levels. These pressures were anticipated to continue as resources shrank and that innovative ways of working together would need to be found. It was acknowledged that there was still much to do to ensure consistency and quality across all safeguarding work. In particular, there were two dominant issues that would continue to need attention, which had arisen from serious case reviews during the year. One was the need for professionals to exercise greater professional curiosity and judgement in their dealings with clients and the other was the need for more thought to be given to how services could helped to work with families that were hard to engage.

RESOLVED that the Education and Children's Services Scrutiny Board (2) note the annual report from the Local Safeguarding Children Board, the progress made and the areas for future development.

45. **Any Other Business**

There were no other items of business.

46. **Meeting Evaluation**

No issues were raised through the meeting evaluation.

(Meeting closed at 3.30 pm)