
DARLINGTON SAFEGUARDING – POSITION STATEMENT

**Responsible Cabinet Member –Councillor Chris McEwan,
Children and Young People Portfolio**

Responsible Director – Murray Rose, Director of Children’s Services

SUMMARY REPORT

Purpose of the Report

1. To provide Members with information regarding Darlington’s child protection system.

Summary

2. This report outlines the policy, procedure and practice of the child protection system.
3. It also identifies the monitoring and quality assurance processes, including the Local Safeguarding Children Board.

Recommendations

4. It is recommended that Members :-
 - (a) note content of the report; and
 - (b) agree to regular updates and briefing sessions.

Reasons

5. The recommendations are supported by the following reasons :-
 - (a) The protection of children within Darlington is a key statutory responsibility of the Council; and
 - (b) Members need information and understanding of the child protection processes and performance of services to ensure these responsibilities are fulfilled.

**Murray Rose,
Director of Children’s Services**

Background Papers:

The Children Act 1989
'Working Together' Guidance
The Green Paper – 'Every Child Matters'
Lord Laming Review / Victoria Climbié Inquiry
Darlington Joint Area Review
Findings from the Haringey Inquiry

Jenni Cooke: Extension 2861

S17 Crime and Disorder	Criminal activity relating to children.
Health and Well Being	Child protection is a key issue
Sustainability	Not applicable
Diversity	Safeguarding issues affect all groups
Wards Affected	All wards
Groups Affected	All groups
Budget and Policy Framework	No immediate impact
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Child protection is linked to the 'Safer' theme of the Sustainable Community Strategy

MAIN REPORT

Information and Analysis

Policy

6. Childcare policy, as it relates to child abuse and child protection, has been formulated mainly as reaction to specific events. The Maria Colwell case in the early 1970's, was key to the establishment of Social Services in 1974. The need for a 'whole family' approach to provision of services, was highlighted in the findings of the Colwell enquiry.
7. In 1987 the 'Cleveland Crisis' led to a public and media outcry following the intervention of social workers based almost solely on medical opinion. The Children Act 1989 which followed, laid the foundation of current practice – a focus on multi agency accountability ('Working Together' Guidance) and a clear child protection process following the 'risk of significant harm' being established.
8. The Victoria Climbié Inquiry led to concerns that the focus on child protection left the majority of children, known only to universal services, at risk. The Green Paper – 'Every Child Matters' was subsequently issued – this sought to bring together all who work with children in a 'Children Trust' to consider outcomes for children – including 'Stay Safe.' The current Children's Services and Trust arrangements have their origin in Laming Review following the Climbié Inquiry. Social policy has turned full circle to some extent, as it seeks to react and respond to public and media reaction to child death.

9. The current 'Baby P' Inquiry in Haringey may also result in a shift in social policy. Government advisors are however, recommending no immediate change, but rather a consolidation of current policy and a focus on workforce training.
10. The number of children killed by their parents (or carers) has remained relatively consistent for several decades (55-60 per year) – this figure is lower than most European countries. The current Child Protection Policy and processes are also recognised internationally as effective and used as a model throughout Europe.
11. The challenge for Government is to react proportionately to the issues without undermining the good practice that exists across the country. Society has changed significantly since the early 1970's in its tolerance of behaviour (e.g. attitude to smacking) and the increase in expectations on public services as to what they can achieve and/or prevent – this needs to be included in any policy review, for it to be effective, and gain consensus across different groups in society.
12. In Britain, legislation does not clearly state expectations regarding parental responsibilities and rights – the law assumes 'reasonable parent' and the expectation of working in partnership with services to support family life. This lack of clarity can result in a range of legal judgements and, therefore, outcomes for a case in the court setting.

Darlington

13. The Child Protection policies in Darlington are based on the 'Working Together' guidance. The policies are agreed by key statutory agencies and issued by the Local Safeguarding Children Board. Some of these functions were previously undertaken by the Area Child Protection Committee.
14. The procedures are regularly reviewed and updated in line with any new guidance (LSCB policy sub-group). Darlington has worked regionally and sub regionally, with other LSCB's to ensure consistency of procedures – taking into account families mobility across the region.
15. The Policy, and Practice Guidance, are now available in a web based version and can be accessed via Darlington website and the Regional Safeguarding Website (supported by Government Office –NE).

Procedure

16. 'Working Together' provides the basis for a national multi agency assessment, decision making and review procedure. (**Appendix 1** Flow Chart). The Local Authority is the lead agency but the whole procedure is based on equal input and accountability from other statutory agencies (e.g. Police, Health).
17. In April 2008 the Child Protection Register ceased, however, children can still be subject to a Child Protection Plan via a Case Conference decision. This change stems from the Laming Report which identified the perception of 'Register' as in itself protection for a child, and therefore the focus of professional debate rather than the child. In addition, professionals often saw a child's name on the Register as a route to additional resources,

thus distorting the basis for decision making.

18. Key to the procedures being effective is the level multi agency working, including information sharing.

Darlington

19. The Darlington Joint Area Review (31 March – 11 April 2008) highlighted:

‘Child Protection assessment planning and review, procedures and practice are highly effective.’

‘Safeguarding arrangements are good.’

‘Outstanding close working with the Police.’

20. The procedures (as policy) are produced and agreed by the LSCB – a statutory multi agency board, created to hold all agencies to account for their safeguarding activities.
21. The LSCB was reviewed in September 2007 and a clear framework and work programme established. This includes regular review of the procedures, to address emerging issues. Sub-groups include practitioners to ensure the procedures are relevant and workable.
22. Regional and sub-regional work also takes place to share practice and update procedures as necessary.

Practice

23. Child Death Reviews have consistently identified communication as an issue – the failure to share full information about a family leading to decisions based on inaccurate information.
24. The importance of the assessment cannot be overstated. No one professional view should dominate (an issue in the Cleveland crisis) – continued checking of the facts and level risk is fundamental.
25. The Government has introduced the ICS (Integrated Children System) electronic recording system, as a means of capturing the full information regarding a child. It is essentially a data and workflow system – highlighting gaps in data.
26. In addition, there has been, over the last decade, a dramatic increase in documentation relating to all professional activity – social work, health and police. This provides an audit trail for decision making but does detract from direct family contact.
27. Social work training has significantly changed and moved to a three year degree which includes a significant practice element, however there has been a reduction nationally in people entering the profession.
28. Staff recruitment and retention is a significant issue – this of course has implications for the supervision and management of the Child Protection processes.
29. In early 2008, central Government introduced a new legal process – ‘Public Law Outline’ – which requires additional work to be actioned before a case is put before court. This is

based on the 'good practice' of assessing extended family etc, however, it has led nationally to a reduction in cases before court, while the system is embedding.

Darlington

30. Darlington (Key Data **Appendix 2**) JAR (April 2008) stated:

'Duty Team, highly effective and well managed.'

'Services to reduce risk and support children and families are having a clear impact.'

31. This 'snapshot' must not lead to complacency, however it is evident Darlington has very good relationships with key agencies and good information sharing processes.
32. Staff recruitment and retention, which has been an issue, has been relatively stable for the past year. The overall social work establishment is 26 workers (covering Children Looked After; Disability; Child Protection and Duty Teams.) If a vacancy exists it has a disproportionate impact on service delivery, agency staff have been used to maintain service. The number of agency staff currently is 3. This will reduce in the New Year when a post is advertised. Temporary and agency staff can destabilise the service and every effort is made to keep the number used to a minimum.
33. The front line management team is experienced and have worked in social work for a number of years. This level of experience is key to providing support and quality supervision to social workers – providing challenge and guidance.
34. Case loads are currently within the Climbie recommendations but recent dramatic increases in referrals are being monitored to assess impact on practice. (November – 100% increase on same period last year.)
35. The legal and operational services work closely together and there are no significant issues. Regular legal liaison meetings are held to track progress of cases.
36. The LSCB oversees a comprehensive training programme across all sectors. The take up of courses is monitored and reported to the LSCB to ensure any gaps are identified and acted upon.
37. The ICS electronic system has been introduced in Darlington. It is not fully in place – impact on workers practice is being monitored. Regionally concerns have been identified and are being discussed with GONE.
38. The quality of work with individual children and families has been externally inspected by JAR. These inspections are very limited – quality assurance checks must be built in the process – something that Darlington has ensured via the role of the manager and case conference chair.

Inspection/Scrutiny/Monitoring

39. Nationally, the Child Protection and Safeguarding System is inspected by Ofsted (previously through the JAR and future proposals by annual visit to Duty Teams.) Ofsted have also published a review of 'Serious Case Reviews' (SCR) undertaken by Safeguarding

Boards. They assess the reports based on how effectively the report complies with the 'Working Together' guidance and how clearly it links practice and outcome. They found approximately one third 'inadequate.'

40. The SCR's are also being analysed by East Anglia University – they are currently looking at those held between 2005 – 2007. Early findings indicate 17% of the cases were on the Child Protection Register – 18% of deaths were due to head injuries and the majority aged under 1 year.
41. Government Office North East has appointed a Safeguarding Advisor (Pauline Fogg) who will undertake a 'stock take' of LSCB's in the region. The guidance for LSCB's increasingly emphasises the monitoring and scrutiny role of the Board – a recent self-assessment 'tool kit' has been issued.

Darlington

42. The JAR found the Darlington LSCB to be:

'Effective in delivering broad safeguarding agenda.'
'Good training programme.'
'Effective leadership.'

43. Prior to JAR an external review of cases was commissioned and actions put into place as a result. A programme of internal file audits and checks takes place on a monthly basis by senior managers – this is in addition to case supervision (2-4 weekly).
44. On all related performance indicators, Darlington is in the top quartile. These relate primarily to timescales attached to the protection process.
45. There are a number of quality assurance checks built into the Child Protection process:
 - (a) Multi Agency Strategy leading to Investigation process
 - (b) Independent Chair of Child Protection Conference
 - (c) Legal Advisor – Preparation for Court
 - (d) Courts.
46. The LSCB has initiated (September 2008) multi agency review of joint working and audit of each stage of the child protection process, to assess compliance with policy and procedures. The LSCB is chaired by the Assistant Director Children and Families, the PCT representative is Vice Chair. This is reviewed annually by the Board.
47. The LSCB produces an annual business plan which includes data and work priorities. Darlington has not held a Serious Case Review in the last five years, although it has contributed to those of neighbouring authorities.
48. Details of the trend and numbers of those with a Child Protection Plan is reported in the Lead Member's Council Overview Report. A report on the Role of the LSCB was presented to Scrutiny on 15 September 2008.

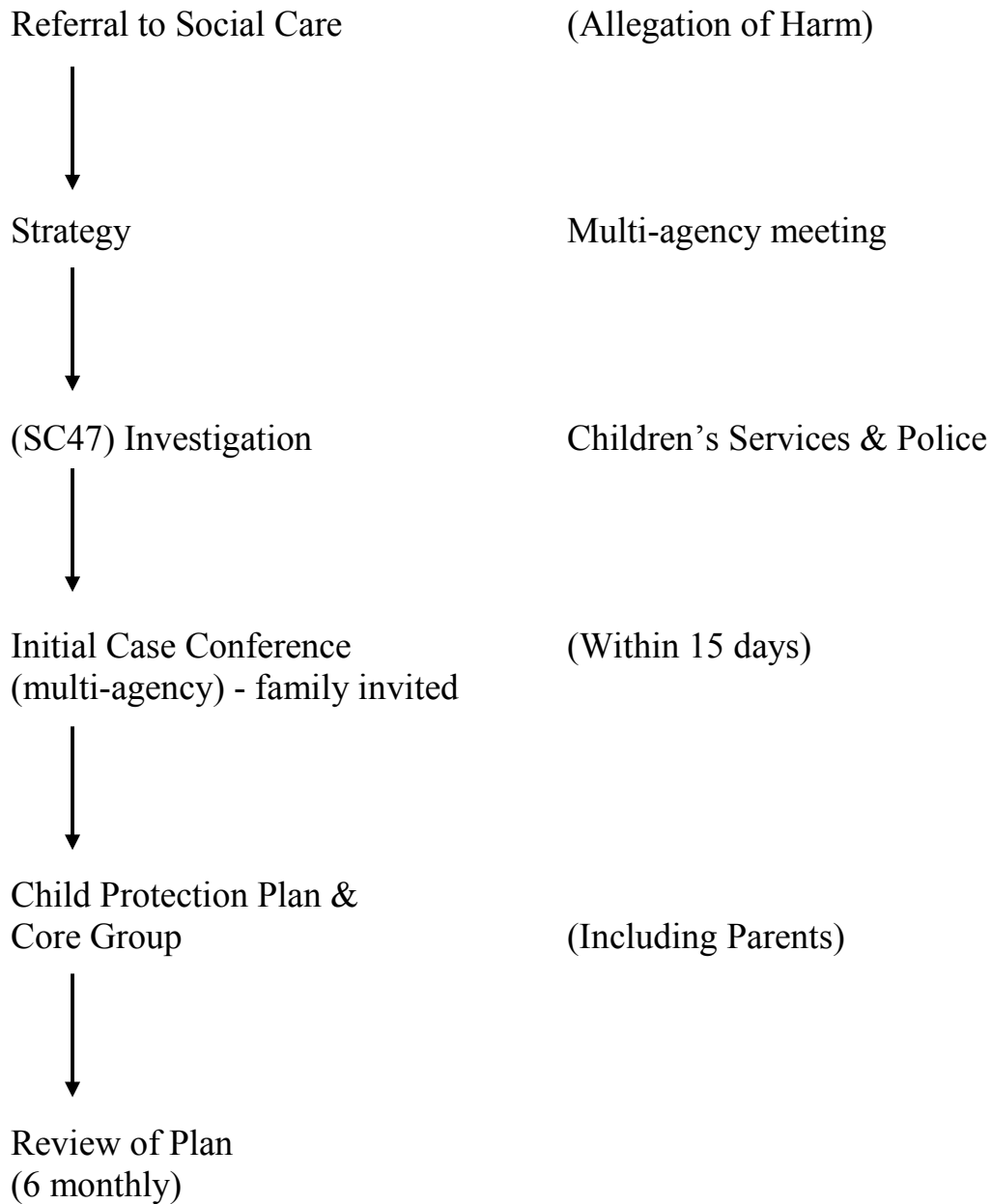
49. Child Protection Awareness Raising was held for Members on 7th May 2008, which 5 Members attended. The session will be repeated on an annual basis.

Conclusion

50. The evidence shows Darlington to have:
- (a) good policies and procedures, monitored by senior managers and LSCB;
 - (b) good training and supervision for operational staff;
 - (c) caseloads within Climbie recommendations for child protection;
 - (d) excellent multi agency working and information sharing; and
 - (e) LSCB providing effective oversight and monitoring.
51. The LSCB has initiated audit activity, in addition the Board has agreed multi disciplinary practise workshops (January-March 2008) which will include interview techniques; role play etc. Internally a review of current cases where a Child Protection Plan exists are taking place.
52. However, evidence and research available does indicate that child deaths due to abuse, take place in the majority of instances when the family/child are not known to the child protection process. The development of locality working; CAF and lead practitioner processes are relevant and need to ensure protection of children is a core component of training of all professionals.
53. Areas of risk include:
- (a) Retention and recruitment of experienced social work staff. Concerns have been expressed that numbers entering the profession will reduce following the ‘Baby P’ media attention.
 - (b) Since the ‘Baby P’ report, numbers of referrals have significantly increased. This will be monitored but if the level is maintained, existing social work capacity could not provide the current level of response.
 - (c) Following the increase in referrals, if these move to legal proceedings, there will be a budget pressure, as Courts now retrieve full costs.
 - (d) Should there be an increase in legal proceedings this would result in pressures upon current staffing levels and subsequent budget pressures within legal services.
54. The need to review how the LSCB itself is monitored and by whom, needs to be considered. Findings from the Haringey Inquiry will inform this process.
55. Additionally, the need to ensure Council is fully informed and by what means, must also be considered. Sessions for Members to discuss the issues and detail may be the most effective, in addition to receiving the LSCB Annual Report and supplementary information.

Outcome of Consultation

56. No consultation was involved in producing this information report.



Number with Child Protection Plan

30 November 2008	45
31 March 2008	50
31 March 2007	49
31 March 2006	64
31 March 2005	41

New Plans by Category

	2004/2005	2005/2006	2006/2007	2007/2008
Neglect	24	28	35	44
Physical	7	6	23	34
Emotional	5	7	3	7
Sexual	5	4	6	1
Multiple	21	51	6	-

New Plans by Age

	2004/2005	2005/2006	2006/2007	2007/2008
Pre Birth – 12 month	21	19	20	17
1 – 2 Years	11	12	17	14
3 – 4 Years	8	10	10	12
5 – 11 Years	14	37	22	34
12 – 18 Years	8	18	4	9