SAFEGUARDING CHILDREN ANNUAL REPORT 2016-2017

1.0 Executive Introduction

The purpose of this report is to update and inform the Board of Directors with regards to the corporate safeguarding children processes and activity within this organisation during the past year.

For clarification a "child" is defined as anyone who has not yet reached their 18th birthday and safeguarding responsibilities also extend to unborn children.

Safeguarding children is the action we take to promote the welfare of children and to protect them from harm and is the responsibility of everyone who comes into contact with children and their families. Children's needs are paramount and safeguarding children is defined as:

- Protecting children from maltreatment (Child Protection)
- Preventing the impairment of children's health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcome (Working Together to Safeguard Children HM Government 2015)

2.0 Cheshire West and Chester Local Safeguarding Children Board (LSCB)

Currently the LSCB is the key statutory mechanism (CA 2004, S13) for agreeing how the relevant organisations in each local area will cooperate (CA 2004, S11) to safeguard and promote the welfare of children and for ensuring the effectiveness of agency responses. The aim of the LSCB is to work together with all local organisations so that children can be safe from abuse or harm at home and within the community. The LSCB strategic priorities are reflected in the work of all CoCH safeguarding children processes.

Section 11 audit

Is an electronic LSCB audit tool to monitor CoCH compliance with our statutory S11 duty to discharge all of our functions with regard to also safeguarding and promoting the welfare of children. The S11 audit tool also incorporates the CCG's commissioning standards for safeguarding children and lists numerous standards re core child protection functions and wider safeguarding children issues including for example HR process's re recruitment. The S11 is a 3 yearly undertaking for the LSCB but an annual undertaking for the CCG. We have to self – assess from grade 1-4, we then have to provide evidence to back up the self - assessment and attend moderation panel. We undertook this process for both the LSCB and the CCG in 2016 and I am pleased to report we are at level 4 for almost all standards and where we are not at level 4 we are at level 3 and regularly reviewing where possible lifting to 4. Action plans are only required for level 2 or below. At present we are undertaking our annual S11 audit for the CCG.

6.3 Local Area Designated Officer (LADO)

The role of the LADO is set out in Working Together to Safeguard Children (2015) and is governed by the Authorities duties under section 11 of the Children Act 2004 The LADO must be contacted within one working day in respect of all cases in which it is alleged that a person who works with children has: behaved in a way that has harmed, or could have harmed a child; possibly committed a criminal offence against or related to a child; or behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

There will be three strands in the consideration of an allegation: a police investigation of a possible criminal offence; enquiries and assessment by children's social care about whether a child is in need of protection or in need of services; consideration by the employer of disciplinary action in respect of the individual. In the event of no criminal proceedings, the end task may be for the organisation to make a decision regarding "the suitability" of an employee to continue to work with children. The CoCH should have a Senior Designated Officer to lead on LADO cases and this person will work closely with the LADO, the staff member's management line and HR until the conclusion of the case.

6.4 Multi Agency Risk Assessment Conference (MARAC)

The CoCH is represented at both CWAC and Flintshire MARAC each month, MARAC is a home office initiative led by the Police where all victims of Domestic Abuse assessed as at "High Risk" (at risk of serious or fatal injury) are reviewed in multiagency meeting chaired by the Police. The outcome from MARAC is the risk should be reduced by multiagency action planning. All high risk victims of DA who have an account at the CoCH who are reviewed at MARAC will have a MARAC alert placed on their records. This remains in situ for twelve months post last MARAC.

Full engagement in DA processes is essential if the CoCH is to work on a multi-agency level to reduce the risk of Domestic Abuse Homicides.(Domestic Violence, Crime and Victims Act 2004)

7.0 Child Sexual Exploitation (CSE)

CSE is an increasingly worrying issue on both a national and local level. The CoCH is in contact with victims of Child Sexual Exploitation and we have dealt with some particularly harrowing cases in our maternity services. The CoCH is represented on the CSE operational group that meets monthly at Winsford Police HQ. We have a CSE alert process and any child or young person who has an account at the CoCH who is identified as at risk from CSE will have an alert placed on their records until they are no longer at risk.

7.1 Sex Offenders

We have seen an increase in those who are registered as posing a risk of sexual harm to children needing access to the hospital for example the father of an unborn baby. In all case's robust working with Children's Social Care will be a fundamental part of our practice. With regard to people with this status being permitted access to the CoCH each case is dealt with on an individual basis in conjunction with the

care by the Local Authority their Initial Health Assessments (IHA) are completed in a timely way. This is closely monitored as CIC are already at their most vulnerable and all must be done to ensure their health and development is not further impaired. All late IHA requests are escalated & there is a clear process in place to address delays in health assessments. There is regular monthly monitoring of performance on the SAF & all out of area placements are included to ensure they have the same timeliness & quality of care. There is a quality assurance process to ensure children's health plans are reflective of their complex needs. Feedback from the child/young person is sought (Rate My Health Assessment) so the voice of the child is central and a health data form completed to monitor service provision locally for this vulnerable group.

11.5 Child Death Overview panel (CDOP): Update from Rajiv Mittal CoCH

The Pan Cheshire CDOP is a subgroup of the Local Safeguarding Children Board (LSCB), and has a statutory responsibility to review all infant/child deaths 0-18 years who reside in Cheshire, regardless of where the death took place. It also includes perinatal and neonatal deaths which were registered as a live birth.

CDOP representatives are drawn from key multi-agency organisations. Others may be co-opted to contribute to the discussion if appropriate, i.e., neonatologists, microbiologists etc. There are 2 inter-related processes (either of which can trigger a criminal investigation, safeguarding or /and Serious Case Review)

- **Rapid Response :** a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child also called as SUDIC (Sudden Unexpected Death In Infant or Child)
- **CDOP panel meeting** – A comprehensive review of all Child Deaths Expected & Unexpected (0-18 yrs.) and has the ultimate aim to prevent potentially avoidable deaths in the future.

COCH Neonatal Unit Investigation

There were a cluster of neonatal deaths identified between June 2015 and June 2016 at the Countess of Chester Hospital which are being investigated by the Cheshire Police. As a result of this inquiry, some changes have been made to the Pan Cheshire CDOP process called SUDIC protocol. The new protocol will be applicable to any baby who dies in neonatal unit or unexpected collapse in the neonatal unit or any neonatal death > 24 weeks gestation for the next 6 months (till 2017 end). It has also been identified the importance of understanding the CDOP process within North Wales and in maintaining effective communication with colleagues across the border.

The CoCH is represented on the Child Death Overview Panel by the Designated Dr for Safeguarding Children who is informed about all child deaths at the CoCH and all child deaths will be reviewed by the CDOP. Following the "Wood Review 2016", and as only 4% of child deaths relate to safeguarding, the Government has agreed to the transfer of national oversight of CDOPs from the Department for Education to the Department of Health, whilst maintaining the focus on learning in relation to safeguarding children issues if they arise in any child death. There are no open actions in relation to CDOP reviews at the CoCH at present.