

## 14 STRATEGIC MANAGEMENT

### 14.1 LOCAL SAFEGUARDING CHILDREN BOARD (LSCB)

#### DUTY TO ESTABLISH LSCB

- 14.1.1 Each children's services authority (CSA) in England must establish a LSCB for its area and the Board must include such representative or representatives of the authority by which it is established, and each 'Board partner' as regulations prescribe.
- 14.1.2 Each of the following is a 'Board partner' of a CSA:
- Where the authority is a county council for an area for which there is also a district council, the district council
  - The chief officer of Police for a Police area any part of which falls within the area of the authority
  - A local probation board for an area any part of which falls within the area of the authority
  - A YOT for an area any part of which falls within the area of the authority
  - A Strategic Health Authority (SHA) and a Primary Care Trust (PCT) for an area any part of which falls within the area of the authority
  - An NHS Trust and an NHS foundation Trust all or most of whose hospitals, establishments and facilities are situated in the area of the authority
  - A person providing services under s.114 Learning and Skills Act 2000 in any part of the area of the authority
  - CAF/CASS
  - The governor of any secure training centre in the area of the authority (or, in the case of a contracted out secure training centre, its director)
  - The governor of any prison in the area of the authority which ordinarily detains children (or, in the case of a contracted out prison, its director)

#### COMPOSITION

- 14.1.3 The LSCB Regulations 2006 (SI 2006 no. 90) indicate that a LSCB must include at least one representative of:
- The authority by which it is established and
  - Each 'Board partner' of that authority

## STRATEGIC MANAGEMENT

14.1.4 Two or more Board partners **may** be represented by the same person and the CSA or any other partner **may** have two or more representatives.

14.1.5 A LSCB **may** also include representatives of such other 'relevant persons or bodies' the authority consider, after consulting its partners, should be represented. 'Relevant persons and bodies' are persons and bodies of any nature exercising functions or engaged in activities relating to children in the area of the authority in question, e.g.:

- Local schools and FE colleges
- Sure Start Children's Centres
- Voluntary sector groups
- NSPCC (involvement of which, *Working Together to Safeguard Children 2006* suggests should be secured where a representative is available)
- Providers of specialist care to children with severe disabilities and complex health needs

14.1.6 Guidance suggests there may be some other organisations / individuals where (in spite of theoretical representation by Board partners) additional effort is needed to engage them, e.g.:

- G.Ps
- Domestic violence forums
- Dental health services
- Drug and alcohol misuse services
- Housing, culture and leisure services
- Local authority legal services
- Local Multi Agency Public Protection Arrangements (MAPPA)
- Sports bodies and services
- Sexual health services
- Coroner
- Crown Prosecution Service
- Local Family Justice Council
- Local Criminal Justice Board
- Registered Social Landlords
- Representatives of service users
- Witness support services

### CHAIRING

- 14.1.7 It is the responsibility of the authority which establishes an LSCB (in agreement with the Board), to appoint a chair who may be:
- A local authority employee e.g. a Director of Children's Services (DCS) or Chief Executive Officer (CEO)
  - An employee of one of the Board partners or
  - Independent
- 14.1.8 Where the chair is not a senior person from the local authority such as the DCS or CEO, s/he should be clearly accountable to the DCS for the effectiveness of her/his work.
- 14.1.9 The chair has a crucial role in making certain that the Board operates effectively and in securing an independent voice for the LSCB.
- 14.1.10 S/he should be of sufficient standing and expertise to command the respect and support of all partners, have a firm grasp of local operational issues, and must ensure the LSCB retains its objectivity, arbitrating when necessary any conflicts of interest that might arise.

### DUTY OF CO-OPERATION & FUNCTIONS

- 14.1.11 In the establishment of an LSCB, the authority establishing it **must** co-operate with each of its Board partners and each Board partner **must** co-operate with the authority.
- 14.1.12 The effectiveness with which Board partners approach and discharge their shared responsibilities will be evaluated through new integrated inspection arrangements.
- 14.1.13 The overall objectives of LSCBs are to:
- Oversee and co-ordinate 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
  - Ensure the effectiveness of what is done by each such person or body for those purposes
- 14.1.14 In order to achieve these objectives, the LSCB needs to:
- Develop policies and procedures for safeguarding and promoting the welfare of children in the area e.g. enquiries and other action concerning children who may be at risk of harm, thresholds for intervention; provision of training; recruitment of persons to work with children; investigation of allegations concerning persons working with children; safety and welfare of children who are privately fostered; cooperation with neighbouring authorities and their Board partners

## STRATEGIC MANAGEMENT

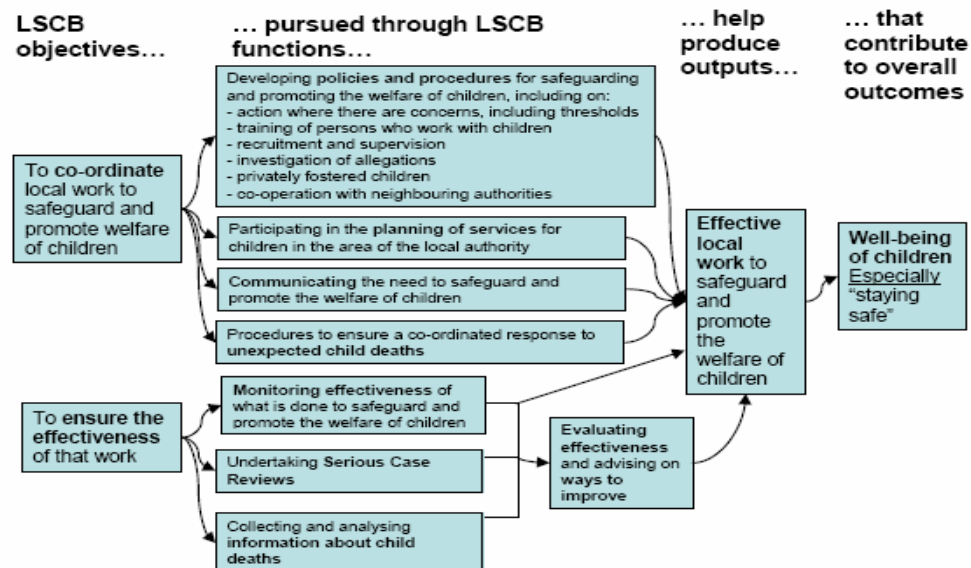
- Raise awareness of the need to safeguard and promote the welfare of children and encouraging participation of persons and bodies in the area in raising awareness
- Monitor and evaluate the effectiveness of what is done by the authority and its Board partners individually and collectively to safeguard and promote the welfare of children, and advise them on ways to improve
- Participate in the planning of local services for children
- Undertake reviews of cases where a child has died or been seriously harmed in circumstances where abuse or neglect is known or suspected and advising the authority and its Board partners on lessons to be learned

14.1.15 An LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its main objectives.

14.1.16 *Working Together to Safeguard Children* indicates that the work of LSCBs fits within the wider context of children's Trust arrangements that aim to improve the overall wellbeing for all children in the local authority area by improving the five outcomes for children set out in *Every Child Matters*:

- Staying safe
- Being healthy
- Enjoying and achieving
- Making a positive contribution to society and
- Achieving economic wellbeing

14.1.17 Whilst the work of LSCBs contributes to the wider goals of improving the wellbeing of all children, it has a particular focus on aspects of the 'staying safe' outcome.



14.1.18 LSCBs are **not** front-line delivery organisations. Their objectives are to co-ordinate and ensure the effectiveness of what member organisations do, and to contribute to broader delivery / commissioning arrangements through the Children and Young People’s Plan (CYPP).

14.1.19 Guidance suggests the role of the LSCB includes safeguarding and promoting welfare of children in the following three broad areas.

### Promotional / preventive work

14.1.20 Activity that affects all children and aims to prevent maltreatment, or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care e.g.:

- Mechanisms to identify abuse and neglect wherever they occur;
- Work to increase understanding of safeguarding children issues in the professional and wider community;
- Work to ensure that organisations working or in contact with children operate recruitment and HR practices that take account of the need to safeguard and promote the welfare of children;
- Monitoring the effectiveness of organisation’s implementation of their duties under s.11 Children Act 2004.

### Proactive / targeted work

14.1.21 Work that aims to prevent maltreatment, or impairment of health or development, and ensure children are growing up in circumstances consistent with the provision of safe and effective care, e.g.:

## STRATEGIC MANAGEMENT

- Procedures for work with families whose child has been identified as 'in need', but where the child is not suffering or at risk of suffering significant harm
- Work to safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population, e.g. children living away from home (including privately fostered children) or children with disabilities

### Responsive / individual work

14.1.22 Practice based work to protect children from maltreatment or abuse of all kinds and in all settings including:

- Children abused and neglected within families, including those harmed in the context of domestic violence
- Children abused outside families by adults known to them
- Children abused and neglected by professional carers, within an institutional settings, or anywhere else where children are cared for away from home
- Children abused by strangers
- Children abused by other young people
- Young perpetrators of abuse
- Children involved in prostitution and
- Children who misuse drugs and alcohol

### LINKS WITH CHILDREN & YOUNG PEOPLE'S PARTNERSHIP & LOCAL AUTHORITY

14.1.23 The LSCB should contribute to, and work within, the framework established by the Children and Young People's Strategic Partnership (CYPSP).

14.1.24 The LSCB should produce an annual plan that sets out a work programme for the forthcoming year, including measurable objectives; a detailed budget; relevant management information on activity in the course of the previous year; and progress against objectives the previous year.

14.1.25 The LSCB plan could be part of the overall CYPP, but in any case should both contribute to and derive from the framework of the CYPP, and should be endorsed by all the Board members.

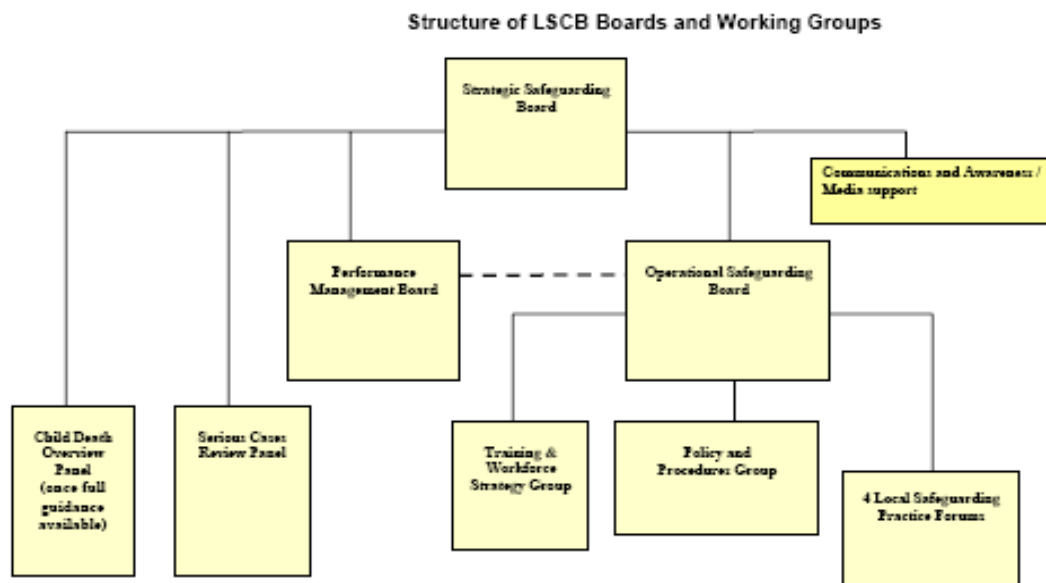
14.1.26 LSCB outputs should be open to scrutiny e.g. by the local authority scrutiny committee, and/or by other local partners as well as by the inspectorates.

## 14.2 HERTFORDSHIRE LSCB

### INTRODUCTION

14.2.1 In response to the above requirements, Hertfordshire has developed and put in place the following arrangements:

- **Strategic Board:** senior managers in each agency setting the overall strategy for the LSCB, overseeing the annual business plan and allocating resources to meet key targets (chaired by an independent person)
- **Operational Board:** a senior group overseeing the effectiveness of inter-agency work to safeguard children (chaired by the CSF Deputy Director Social Care)
- **Performance Management Sub-Board:** A senior group overseeing the performance management and quality assurance of safeguarding activity within all the agencies – this consists of senior managers and specialists in managing data and quality assurance (chaired by a senior manager from an agency other than CSF)
- **Policy and Procedures group:** to develop effective policies and procedures to underpin joined up working to safeguard children
- **Training and Workforce Strategy Group:** Will produce and oversee the annual multi agency training programme and will also link closely with the wider Children's Trust workforce strategy (chaired by the LSCB training managers)
- **Communications and Awareness group:** to oversee the LSCB communications strategy and drive the development of the wider public information function of the new Board
- **4 x Local Safeguarding Practice Forums:** to cover the same localities as the 'Area Monitoring Groups' they will replace (these groups will deal with local operational issues and report into the Operational Board and will also link closely with the District Children's Trust Partnerships +
- **Serious Cases Review Panel:** A group of senior managers to be consulted whenever an agency considers a SCR should be undertaken – usually following death or serious injury of a child (see 14.4)



14.2.2 Respective terms of reference (purpose, specific responsibilities, relationship to other groups, inter-connections and proposed membership of each of the above ongoing forums) are summarised below.

## STRATEGIC BOARD

### Purpose

- Improve outcomes for children and young people in Hertfordshire in relation to all aspects of the 'stay safe' outcome
- Ensure that appropriate structures and working arrangements are in place for the co-ordination of work to safeguard and promote the welfare of children in Hertfordshire
- Ensure that the LSCB has a business plan which is properly resourced by the constituent bodies in order to safeguard children in Hertfordshire
- Monitor and evaluate the effectiveness of the contribution of the LSCB and all agencies to the safeguarding of children
- Ensure full and effective implementation of the Working Together guidance, including those aspects of the guidance which deal specifically with the operation of the LSCB itself
- Ensure that the SCB makes efficient and effective use of its resources

### Specific responsibilities

- Develop, sign off and monitor the implementation of an overall LSCB business plan
- Receive reports on outcomes for children in relation to all aspects of the 'stay safe' outcome and determine the priorities for the safeguarding work programme of the LSCB and its constituent agencies accordingly
- Define the strategy and priorities for the LSCB and its subgroups to form a programme of continuous improvement in safeguarding work
- Receive reports from boards and sub-groups of the LSCB and monitor their work
- Receive reports on serious case reviews and ensure that findings are disseminated appropriately, understood by the public and professionals and that recommendations are implemented
- Ensure that the LSCB and its subsidiary groups have the appropriate resources to implement the work plan of the LSCB
- Ensure that safeguarding issues are fully represented in the Children and Young People's Plan and in services commissioned by agencies and by the Children's Trust
- Ensure that each constituent agency produces an annual report on its safeguarding work
- Monitor the contribution of constituent agencies to the LSCB and the effectiveness of the safeguarding work they undertake
- Report on safeguarding work as required to the Director of Children's Services, the Council Executive and the Children's Trust Partnership Executive (and to CSCI and other inspection and regulatory bodies as necessary)
- Provide an annual report on safeguarding to the Children's Trust Board which fully reflects the work of the board and the constituent agencies
- Ensure that the LSCB complies with requirements of guidance in relation to the roles and responsibilities of the Child Death Overview Panel when these are published
- Oversee the LSCB communications and awareness strategy
- Ensure that the LSCB complies with its responsibilities in relation to training and workforce development

### Accountability & relationships with other groups

- 14.2.3 The strategic board meets quarterly. Its chair will report regularly to the Director of Children's Services and be a member of the Children's Trust Partnership Board.

## STRATEGIC MANAGEMENT

- 14.2.4 The board will provides an annual report to the Children's Trust Partnership Board and reports will also be provided to CSCI and other inspection bodies as required.
- 14.2.5 The following sub-boards and working groups of the LSCB report to the strategic board:
- Operational board
  - Performance management sub board
  - Child death overview panel
  - Serious cases review panel
  - Communications and awareness group

### Proposed membership

- Chair - an independent chair appointed by the Director of Children's Services and members of the Children's Trust Board / Executive Group
- LSCB staff: LSCB manager and LSCB administrator
- CSF Deputy Director (Social Care)
- Strategic Health Authority - membership to be agreed
- Primary Care Trusts - executive level members of PCTs
- Acute Health Trusts - executive level members of acute trusts that operate exclusively or predominantly within Hertfordshire and provide services for children or adults which may impact on children's welfare
- Hertfordshire Partnership Trust - executive level member
- Hertfordshire Constabulary - Detective Chief Superintendent with responsibility for child abuse services
- Connexions -Chief Executive
- District Councils -two District Councils will represent the ten under the terms of a written agreement, ratified by the Director of Children's Services
- YOT -Assistant Director Youth Offending
- Probation –membership to be agreed
- County School Effectiveness Board - Deputy Director School Effectiveness
- CAFCASS - membership to be agreed
- Hertfordshire County Council
- Voluntary sector representative
- Legal advisor
- Other members by invitation subject to the development of the LSCB business plan and structure

## OPERATIONAL BOARD

### Purpose

- Improve outcomes for children in relation to safeguarding by ensuring that the overall co-ordination of safeguarding work of constituent agencies is as effective as possible and that staff in all agencies are able to implement best practice approaches in their day to day working

### Specific Responsibilities

- Keep an oversight of the current range of services provided for safeguarding and make proposals on developments required to improve safeguarding work, for inclusion in the children and young people's plan
- Develop proposals for the LSCB business plan and recommend them to the strategic board of LSCB
- Co-ordinate the implementation of all aspects of the LSCB business plan relevant to operational service delivery
- When shortcomings have been identified in practice (both within individual agencies and in inter-agency working), develop and implement solutions through the LSCB and through constituent agencies
- Share examples of good practice between constituent agencies and across Hertfordshire
- Make sure that all relevant elements are include in the work plans for the policy and procedures group; manage and co-ordinate the implementation of new policies and procedures
- Set specific objectives for the training and workforce group in relation to multi-agency training and workforce development, based on the recommendations received from the relevant working group. Monitor their implementation by receiving regular reports from the training group
- Support the development of the local practice forums, set them an agenda of practice improvement; resolve problems they identify if required and monitor their effectiveness
- Maintain effective links with the Performance Management sub-board.

### Accountability and relationships with other groups

- 14.2.6 The chair of the Operational Safeguarding Board will be a member of the LSCB strategic group and a senior manager with operational responsibilities in the Children, Schools and Families Department. Other members will be senior managers in all agencies with operational child protection responsibilities and professional expertise in child protection.

## STRATEGIC MANAGEMENT

- 14.2.7 The LSCB strategic board, the performance management board and the operational board will each hold quarterly meetings at separate times within each three month period
- 14.2.8 The operational board reports to the strategic board.
- 14.2.9 The following sub-boards and working groups of the LSCB will report to the operational board and these groups will be chaired by members of the operational board:
- Policy and procedures working group
  - Training and workforce strategy group
  - Local practice forums
- 14.2.10 The chair will meet regularly with the independent chair of the LSCB and the chair of the performance management board in order to ensure that the activities of the operational and performance management boards are properly co-ordinated and that all aspects of the LSCB business plan are being implemented.

### Proposed membership

- Chair - Operational Director CSF / Deputy Director
- LSCB staff -LSCB manager, LSCB Administrator
- HCC CSF - Head of Social Care & Community Services, Children's Services Manager & Head of Child Protection
- LSCB groups - chair of Training & Workforce Group, chair of policy and procedures group and chairs of four local safeguarding practice forums
- Primary Care Trusts - membership to be agreed
- Acute Health Trusts and mental health trust - membership to be agreed
- Designated Professionals - membership to be agreed
- Hertfordshire Police Service - Detective Inspector with responsibility for CAIU
- Connexions -membership to be agreed
- District Councils- membership to be agreed
- Youth Offending Team - membership to be agreed
- Probation -membership to be agreed
- County School Effectiveness Board -Head Teacher representatives to be appointed by Deputy Director School Effectiveness and the Heads' forums
- CAF/CASS -membership to be agreed

## PERFORMANCE MANAGEMENT SUB BOARD

### Purpose

- Provide management information about outcomes and performance for which the LSCB is accountable to the Director of Children's Services, Children's Trust Partnership Board and Executive Group, central government departments and inspection bodies
- Use a variety of methods to monitor and evaluate the effectiveness of all aspects of safeguarding work and report on the performance of the LSCB and all constituent agencies.
- Develop a culture within the LSCB in which agencies can challenge and be challenged over their performance in relation to safeguarding and in which reliable information is produced which enables services and outcomes to be improved.

### Specific responsibilities

- Develop a strategy for performance management for the LSCB linked to the national framework of Joint Area Review and Annual Performance Assessment
- Define a set of management information and performance data on all aspects of work to safeguard children
- Take steps to ensure that this information is collected regularly both by the LSCB and by constituent agencies so that it can be analysed and presented in a way that shows how effective safeguarding services are in Hertfordshire
- Prepare statistical information about performance in relation to all aspects of safeguarding and the 'staying safe' outcome every three months with an accompanying report identifying themes and recommending areas requiring action.
- Bring findings and recommendations on performance to the attention of the strategic board and to the operational board as required
- Manage the LSCB complaint process and report on key findings and other user feedback to the LSCB
- Monitor the annual reports and work plans (on safeguarding) of constituent agencies and report on key areas of activity and any areas of concern to the LSCB
- Ensure that all constituent agencies have in place systems of quality assurance and audit; receive reports from them and evaluate their effectiveness in securing good outcomes for children. Report to the LSCB as required
- Develop a multi-agency quality assurance programme (which may include multi-agency audit) and report key findings to the LSCB

## STRATEGIC MANAGEMENT

- Identify best practice and make information on this available to other boards and working groups of the LSCB
- Devise and implement measures to consult with users and make recommendations in response
- Maintain effective links with the Operational sub-board.

### Accountability and relationships with other groups

- 14.2.11 The chair is a member of the LSCB strategic group and a senior manager in a statutory agency other than the Children, Schools and Families Department.
- 14.2.12 Members are managers and expert / professional advisors from all constituent agencies. The group as a whole will require a combination of skills in the following areas:
- Child protection policy and practice
  - Performance management / quality assurance / clinical governance
  - Production and analysis of management information
- 14.2.13 The LSCB strategic board, performance management board and the operational board will each hold quarterly meetings at separate times within each three month period
- 14.2.14 The performance management board reports to the strategic board. It will also need to develop close working relationships with other working groups of the LSCB as required, particularly in relation to operations, training, serious case reviews and child death reviews.
- 14.2.15 The chair will meet regularly with the chair of the operational board in order to ensure that the activities of the operational and performance management boards are properly co-ordinated and that all aspects of the LSCB business plan are being implemented.

### Proposed membership

- Chair -member of the strategic board who is an employee of a statutory LSCB member agency other than CSF
- LSCB staff – LSCB manager and LSCB administrator
- HCC Children, Schools and Families -Head of Social Care & Community Services, Children's Services Manager & Head of Quality Assurance
- Health - membership to be agreed
- Designated Health Professionals -membership to be agreed
- Hertfordshire Constabulary - Detective Inspector from a CAIU
- Connexions -membership to be agreed
- District Councils - membership to be agreed

- Youth Offending Team - membership to be agreed
- Probation -membership to be agreed

### POLICY & PROCEDURES SUB GROUP

#### Purpose

- Ensure that the LSCB has procedures for inter-agency working to safeguard and promote the welfare of children as required by *Working Together to Safeguard Children* and other government regulation and statutory guidance
- Ensure that LSCB member agencies have policies, procedures and guidance for safeguarding and promoting the welfare of children which are in line with the requirements of the LSCB and consistent with regulations and guidance
- Offer oversight of the policies and procedures of any local agency working with children and young people and to offer advice and guidance as to their suitability and whether or not they conform to the requirements of the LSCB

#### Specific responsibilities

- Review the existing Hertfordshire ACPC / LSCB multi-agency policies and procedures in the light of *Working Together to Safeguard Children 2006* and identify any changes required.
- Ensure that LSCB member organisations undertake a similar review of their own internal policies and procedures and to compile the findings.
- In the light of the above, to identify the priority areas and recommend to the Operational Board a programme of work to make necessary revisions to the LSCB multi-agency procedures (the programme of work may be undertaken by the group itself or commissioned externally)
- Ensure that constituent agencies make necessary, timely revisions to their policies and procedures so as to ensure that they are consistent with the policies of the LSCB and *Working Together 2006*
- Develop a strategy which will enable the LSCB to publicise its expectations on the suitability of their procedures and offer advice and guidance to organisations working with children in Hertfordshire who are not statutory members of the LSCB
- Implement work on the development of policy and procedures as required by the LSCB Operational Board, including for example work arising from serious case reviews, complaints and the findings of quality assurance exercises
- Keep under review all major developments in policy, research and practice (including the national publication of findings on serious case reviews) and advise the LSCB Operational Board of any implications for local policy, procedures or practice

### Accountability and relationships with other groups

- 14.2.16 The group will report to the LSCB Operational Board. The chair of the group will meet as required with the chair of the LSCB Operational Board.
- 14.2.17 The policy and procedures working group need to develop close working relationships with other working groups of the LSCB as required, particularly in relation to training and workforce development and the local child protection practice forums.
- 14.2.18 As a minimum the group will meet on at least two occasions in the period between the 3 monthly meetings of the LSCB Operational Board. Beyond this the group will set its meetings at the level required by the work programme. During periods of heavy workload more frequent meetings in combination with flexible informal meeting arrangements may be required.
- 14.2.19 Members will be child protection specialists and managers with substantial experience of child protection in all agencies. Designated and named professionals from health trusts are likely to play an important role.

### Proposed members

- Chair - to be agreed by HCC Children, Schools and Families
- HCC Children Schools and Families -membership to be agreed
- Health -membership to be agreed
- Hertfordshire Police Service - Detective Inspector from CAIU
- Connexions -membership to be agreed
- District Councils -membership to be agreed
- Youth Offending Team -membership to be agreed
- Probation -membership to be agreed
- School effectiveness, primary and secondary school representation -membership to be agreed
- CAFCASS -membership to be agreed

## TRAINING & WORKFORCE STRATEGY SUB GROUP

### Purpose

- To ensure constituent agencies have an effective training programme for their staff in relation to safeguarding and promoting the welfare of children and that additional multi agency training is provided in order to meet local needs in line with the requirements of *Working Together*
- As the workforce strategy of the Hertfordshire Children's Trust Partnership develops, the LSCB training and workforce strategy

group will play a key role in relation to training and workforce development strategy in relation to the safeguarding of children

### Specific responsibilities

- Obtain a full picture of the training provided on safeguarding within LSCB member agencies, determine its effectiveness against criteria agreed by the LSCB and report the findings to the LSCB Operational Board
- Evaluate the multi-agency training currently provided by the LSCB, determine its effectiveness against criteria agreed by the LSCB, and to report findings to the LSCB Operational Board
- Ensure that the local workforce development strategy reflects the training needs of staff and managers in local agencies in relation to safeguarding
- Propose a multi-agency training programme on safeguarding for the LSCB with priorities and specific objectives
- Develop, provide and review a multi-agency training programme on safeguarding based on national requirements and local needs
- Propose an allocation of funding from the LSCB annual budget for the delivery of the agreed training programme
- Provide information on training and workforce development in relation to safeguarding for the LSCB Annual Report
- Develop the capacity of staff in LSCB member agencies to contribute to local inter-agency training initiatives
- Ensure that the LSCB Operational Board is regularly updated about relevant training and workforce development issues

### Accountability and relationships with other groups

- 14.2.20 The LSCB Training and Workforce Development Group is led by the LSCB Training Manager and reports to the LSCB Operational Board. The LSCB Training Manager is a member of the LSCB Operational Board.
- 14.2.21 The group meets approximately once a month. Arrangements for convening meetings are the responsibility of the LSCB Training Manager and the frequency of meetings may be varied throughout the year to accommodate the workload in planning and delivering training.
- 14.2.22 Membership of the group will be drawn from the main member agencies of the LSCB and will be established by the Operational Board and will include members:
- With sufficient knowledge of training processes to enable them to make informed decisions regarding the development and evaluation of a training strategy and

## STRATEGIC MANAGEMENT

- With organisational links to staff who will participate in training and with sufficient authority to make decisions in relation to training
- Who provide a link to the wider Children's Trust workforce strategy

### Proposed members

- Chair- Training Manager LSCB
- HCC Children Schools and Families -Training officer or other child protection specialist
- Health-members to be agreed from those representing clinical leadership and training
- Hertfordshire Police Service -trainer or interested officer at appropriate level
- Connexions -members to be agreed
- District Councils -members to be agreed
- Youth Offending Team - members to be agreed
- Probation -members to be agreed
- School effectiveness – primary and secondary school representation -members to be agreed
- CAFCASS -members to be agreed

## LOCAL SAFEGUARDING PRACTICE FORUMS

### Purpose

- 14.2.23 Four local safeguarding practice forums will be developed from the existing Area Monitoring Groups. They will cover the same areas as the AMG's and thus each will link with two or three District Children's Trust Partnerships. They will provide a regular local forum for managers and staff in all agencies involved in safeguarding work to raise the standard of safeguarding work by reviewing existing practice and improving the co-ordination of the contribution of different agencies.

### Specific responsibilities

- Enable key managers with safeguarding responsibilities to identify difficulties in local multi-agency working, resolve them by finding practical solutions and develop an agenda of local service improvement
- Take local initiatives to improve outcomes for children, within the framework of policy and procedures established by the LSCB
- Communicate developments in policy, procedures and practice agreed by the Operational Board of LSCB to key managers at a local level and to develop local strategies to implement changes

- Identify any issues affecting multi-agency safeguarding work that need to be brought to the attention of the Operational LSCB
- Highlight examples of good practice and bring them to the attention of the LSCB Operational Board
- Communicate the findings and key messages of serious case reviews and quality assurance exercises to local staff and ensure that they are implemented at a local level
- Review local performance indicators and take action where necessary
- Link with the relevant District Children's Trust Partnerships to ensure that Safeguarding issues are addressed in District Children's Trust Partnership plans
- Ensure that at a local level there is a good inter-agency working in relation to the arrangements for assessing and managing risk through the MAPPA and risk management panel arrangements.

### **Accountability and relationships with other groups**

- 14.2.24 A chair will be appointed for each local forum. The chair will be a manager with operational responsibility for safeguarding work in the local area. The manager will be drawn from one of the statutory partner agencies. Responsibility for chairing the local forums will be shared over time and geographically between the statutory partner agencies. The chair will be a member of the Operational Board of LSCB (or if not previously a member will attend the Operational Board meetings).
- 14.2.25 A representative of the local forum should be a member of each of the District Children's Trust Partnerships in the area.
- 14.2.26 At each of its meetings the LSCB Operational Board will draw together a series of action points to be discussed and implemented by the local forum. The forum chair is accountable for their implementation and will seek the involvement of the Chair of LSCB Operational Board to enable this if required.
- 14.2.27 The forum will meet at least once between each quarterly meeting of the LSCB Operational Board.
- 14.2.28 The local forum will provide a written report, through the forum chair, to the Operational Board at each of its quarterly meetings.

### **Proposed members**

- 14.2.29 The chair of the group must ensure that there is sufficient representation from agencies to ensure effective discussion of any matters of safeguarding policy and practice. The chair will ensure that the group has a nominated deputy chair to deal with matters in her/his absence.

## STRATEGIC MANAGEMENT

- Chair - Senior local professional / manager with operational responsibility for aspects of safeguarding work
- HCC Children Schools and Families -membership to be agreed
- Health -membership to be agreed
- Hertfordshire Police Service - DI or DS in CAIU
- Connexions -membership to be agreed
- District Councils -specific managers and practitioners with expertise and interest in work with children and young people
- Youth Offending Team- membership to be agreed
- Probation -membership to be agreed
- School effectiveness – primary and secondary school representation, -members of the local SEB and other head teachers and Designated Senior Person for child protection work
- CAFCASS -membership to be agreed
- Other agencies where they make a significant contribution to local service delivery

## COMMUNICATIONS & AWARENESS FUNCTION

### Purpose

14.2.30 The purpose of the LSCB Communications and Awareness function is to enable the LSCB and its working groups to communicate in the most effective way about the need to safeguard and promote the welfare of children and to raise their awareness of how this can best be done. This function will be discharged by the LSCB Manager attending and liaising with Hertfordshire's Children's Trust Partnership Communication Group. The target audience will include the following:

- Staff and managers in member agencies of the LSCB and other bodies
- Individual professionals and practitioners
- Children and families, both current and potential service users
- The wider community including faith and minority communities
- The media

### Specific responsibilities

- Ensure that professionals with media and publicity responsibilities in member agencies work in a co-ordinated way on behalf of the LSCB
- Work with the LSCB and the operational and performance management board to identify priorities for a publicity and communications strategy to support the LSCB business plan

## STRATEGIC MANAGEMENT

- Support the work of the LSCB and all its working groups by providing information on agreed topics and developments in a range of formats for the community and professionals. This may include the development of newsletters or the use of a website to provide a regular flow of information from the LSCB
- Be pro-active in the development of a media strategy on behalf of the LSCB
- Advise and assist the policy and procedures working group of LSCB on the publication of policies and procedures
- Advise the independent chair of the LSCB, the Director of Children's Services and the LSCB Safeguarding Board Manager about issues relating to the media, communications and publicity
- Advise the LSCB and all its working groups on strategies to consult children and families in the planning and development of safeguarding services
- Co-ordinate communications strategies with those being developed by the Hertfordshire Children's Trust Partnership
- Develop structures and day to day working arrangements that enable the LSCB to provide a speedy multi-agency response when there is a need to communicate with the media urgently

### Accountability & relationships with other groups

- 14.2.31 The LSCB communications and awareness group will be led by the LSCB manager. The LSCB manager will report to each meeting of the LSCB strategic board.
- 14.2.32 Members of the LSCB strategic board will identify at least one person with media and communications expertise in their agency who can contribute to the discharge of this function.
- 14.2.33 The LSCB manager will liaise with the independent chair of LSCB and the chairs of the working groups to identify areas of potential activity. The LSCB manager will convene meetings of the group as required to implement the work programme of the group. The frequency and timing of meetings may be varied throughout the year to accommodate variations in the workload.
- 14.2.34 The LSCB strategic board will identify a group of key professionals with expertise in communications who can offer speedy advice to the independent chair and the Director of Children's Services and deal with urgent media enquiries as required.

### Proposed members

- Chair - Safeguarding Manager LSCB
- HCC Children Schools and Families -member to be agreed
- Health- member to be agreed

- Hertfordshire Police Service - member to be agreed
- Connexions -member to be agreed
- District Councils -member to be agreed
- Youth Offending Team -member to be agreed
- Probation -member to be agreed
- School effectiveness – primary and secondary school representation, -member to be agreed
- CAFCASS -member to be agreed

### 14.3 NOTIFICATION OF SERIOUS CHILD CARE INCIDENTS

- 14.3.1 LAC (2004)12 updated the arrangements for local authorities to provide statutory notifications when (on 01.04.04) CSCI took over the functions of the Social Services Inspectorate and the National Care Standards Commission (NCSC).
- 14.3.2 Notifications to CSCI on the pro forma supplied (which should be posted back to the relevant Business Relationship Manager BRM) are required about:
- A SCR that is confirmed or possible ([see 14.4](#))
  - Death of a looked after child
  - Death or serious harm to a child in a children's home
  - Serious harm to a child
  - Conduct of a member of staff

### 14.4 SERIOUS CASE REVIEW

#### INTRODUCTION

- 14.4.1 Regulation 5(1) (e) of the LSCB Regulation 2006 (SI 2006 NO. 90) requires LSCBs to instigate a serious case review (SCR) in specified circumstances.
- 14.4.2 *Working Together to Safeguard Children* 2006 defines in chapter 8 the circumstances in which a LSCB should initiate a SCR, and describes how it is to be conducted.
- 14.4.3 *Working Together to Safeguard Children* is issued under s.7 of the Local Authority Social Services Act 1970. It does not have the full force of law, but should be complied with unless local circumstances indicate exceptional reasons which justify a variation.

## PURPOSE OF SCR

- 14.4.4 The purpose of a SCR is to:
- Establish whether there are any lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children and promote their welfare
  - Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and
  - Improve inter-agency working and better safeguard children
- 14.4.5 When a child dies and abuse or neglect are known or suspected to be a factor in the death, the immediate priority for agencies is to consider whether there are other children at risk of harm who need safeguarding e.g. siblings, or other children in an institution where abuse is alleged, and take appropriate action.
- 14.4.6 Thereafter, agencies should consider whether there are any lessons to be learned about the ways in which they work together to safeguard children.
- 14.4.7 When a child dies in the circumstances outlined in 14.4.5 above, Hertfordshire's SCB will always conduct a SCR into the involvement with the child and family of agencies and professionals.
- 14.4.8 Additionally the Board will consider carrying out a SCR in the following circumstances:
- A child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect
  - A child has been subjected to particularly serious sexual abuse,
  - A child is subject of a child protection plan and dies from any cause
  - A child's parent has been murdered and a homicide review is being initiated
  - A child has been killed by a parent with a mental illness, or
  - The case gives rise to concerns about inter-agency working to protect children from harm
- 14.4.9 SCRs are not enquiries into how a child died or who is culpable; that is a matter for Coroners and Criminal Courts respectively to determine. SCRs should therefore be conducted in such a way that the process is a learning exercise.
- 14.4.10 Equally, SCRs are not part of any disciplinary process, but may highlight information which may indicate that one or more agencies should consider disciplinary action within established procedures

## CRITERIA FOR CONVENING SCR

- 14.4.11 Hertfordshire's LSCB will always undertake a SCR when a child dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in the child's death (irrespective of whether Children's Social Care is or has been involved with child or family).
- 14.4.12 The Strategic Board should always consider whether to undertake an SCR when a child has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children. This includes situations where a parent has been killed in a domestic violence situation or where a child has been killed by a parent who has a mental illness.
- 14.4.13 The following questions may help in deciding whether a case should be the subject of a SCR in circumstances other than when a child dies. The answer 'yes' to several of these questions is likely to indicate that a review could yield useful lessons:
- Was there clear evidence of a risk of significant harm to a child, which was - not recognised by organisations or individuals in contact with the child or perpetrator or not shared with others or not acted upon appropriately?
  - Was the child killed by a mentally ill parent?
  - Was the child abused in an institutional setting e.g. school, nursery, family centre, YOI, STC, Children's Home or Armed Services training establishment ?
  - Did the child die in a custodial (prison, young offender institution or secure training centre) setting?
  - Was the child abused while being looked after by the local authority?
  - Did the child commit suicide, or die while absent having run away from home?
  - Does one or more agency or professionals consider that its concerns were not taken sufficiently seriously, or acted upon appropriately, by another?
  - Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures, which go beyond the handling of this case?
  - Was the child subject of a child protection plan or had it been previously the subject of a plan or on the child protection register?
  - Does the case appear to have implications for a range of agencies and/or professionals?

## STRATEGIC MANAGEMENT

- Does the case suggest that the HSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted upon?
- 14.4.14 When more than one LSCB has knowledge of a child, Hertfordshire LSCB will take lead responsibility for conducting the SCR when the child was 'ordinarily resident' in Hertfordshire. The question of ordinary residence should be addressed in discussion with the other authorities involved. Any other LSCBs that have an interest or involvement in the case should be included as partners in jointly planning and undertaking the SCR.
- 14.4.15 In the case of looked after children, Hertfordshire's LSCB will take lead responsibility where it is the responsible authority, again involving other LSCB's with an interest or involvement.
- 14.4.16 In addition, the Secretary of State for the Department for Education and Skills has powers to demand an inquiry be held under the Inquiries Act 2005.

## INSTIGATING A SCR

### Does the case meet SCR criteria?

- 14.4.17 A potential case may be identified in any agency. Each agency is required to have internal arrangements for reporting of cases which give rise to serious concern to senior managers, which must include children's cases that may need to be subject to a SCR. An agency which identifies a potential SCR will be asked by the HSCB manager to complete the 'initial referral form' with brief information regarding the case (see Practice Guidance appendix 3).
- 14.4.18 Within each member agency one named senior manager (or an agreed deputy), who is a member of the HSCB Strategic Board (therefore also a member of the serious case review panel (SCR panel), will be identified as having the responsibility to decide whether a case needs to be considered by the SCR panel, and will also be their agency representative on this panel. An up-to-date list of named panel members will be kept in the HSCB office.
- 14.4.19 In relation to any potential case, the named senior manager will provide a written brief on the referral form containing:
- Basic details of the case and the identity of all the children and adults known to be involved.
  - Relevant background
  - Information about other agencies known to be involved
  - Any specific concerns pointing to the need for consideration by HSCB

## STRATEGIC MANAGEMENT

- 14.4.20 Any referral will be made to the HSCB manager, or in her/his absence the Deputy Director (Social Care and Prevention), and the chair of the HSCB will be informed as soon as the referral is received. At this point, an initial letter will be sent by the HSCB manager requesting that organisations secure their files and provide brief information about their involvement (see Practice Guidance Appendix 3).
- 14.4.21 On receipt of a referral, the HSCB manager will communicate the referral to the members of the SCR panel.
- 14.4.22 At this stage the SCR panel may convene a meeting or communicate by other means in order to make a recommendation to the chair of the HSCB as to whether a SCR should be undertaken. Its deliberations must involve, as a minimum, representatives of Children's Social Care, health, education and the police and should happen as quickly as possible, once all the relevant information has been gathered.
- 14.4.23 In coming to a view in cases other than when a child dies, the questions outlined above may be helpful (see [14.4.13](#))
- 14.4.24 In some cases, the SCR panel may conclude that the criteria for a SCR are not met, but that it may be valuable for individual agencies to conduct management reviews, or smaller-scale audits of individual cases which give rise to concern, but which do not meet the criteria for a SCR. In such cases, relevant findings should be shared with the Operations Board. If a decision is made not to hold a SCR a further letter will be sent to agencies informing them of this decision (see Practice Guidance Appendix 3).
- 14.4.25 The decision of the SCR panel will be forwarded as a written recommendation, on the referral form, to the chair of HSCB who has ultimate responsibility for deciding whether to conduct the SCR. The recommendation is to include proposed terms of reference and scoping for the review (see 14.4.28 below) and to suggest possible members of the SCR working group. If the decision is to conduct a SCR, CSF should always inform the local region of the Commission for Social Care Inspection and Health Agencies will need to inform the Strategic Health Authority.
- 14.4.26 The chair of the HSCB should make a decision on whether a SCR should take place, following the recommendation of the SCR panel, within one month of the case coming to her/his attention. This decision, and the reasons for it should be recorded on the referral form, signed, and kept on file in the HSCB office.

## DETERMINING SCOPE OF REVIEW

- 14.4.27 The chair of the HSCB will nominate a chair to manage the SCR working group/ S/he will be a member of the Strategic Board whose organisation has had no involvement in the case, to oversee the process, convene the SCR working group, review the scoping document and to be responsible for the delivery of a report back to the HSCB. The chair of the SCR working group will nominate an independent report writer.
- 14.4.28 The HSCB manager will convene a meeting of the SCR working group who should meet within one month of the decision to conduct the case review and to review the draft scope and terms of reference. Relevant issues include:
- What appear to be the most important issues to address in trying to learn from this specific case? How can the relevant information best be obtained and analysed?
  - Who should be appointed as the independent author for the overview report?
  - Are there features of the case which indicate that any part of the SCR process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review?
  - Might it help the SCR working group to bring in an outside expert at any stage, to shed light on crucial aspects of the case?
  - Over what time period should events be reviewed, i.e. how far back enquiries should cover, and when should be the cut-off point?
  - What family history / background information will help better to understand the recent past and present?
  - Which organisations and professionals should contribute to the SCR, including, where appropriate, for example, the proprietor of independent school or playgroup leader should be asked to submit reports or otherwise contribute.
  - How should family members contribute to the SCR and who should be responsible for facilitating their involvement?
  - Will the case give rise to other parallel investigations of practice, e.g. independent health investigations or multi-disciplinary suicide reviews, a homicide review when a parent has been murdered, a Youth Justice Board (YJB) Serious Incident Review and a Prisons and Probation Ombudsman investigation where the child has died in a custodial setting? If so, how can a co-ordinated or jointly commissioned review process best address all the relevant questions which need to be asked, in the most economical way?

## STRATEGIC MANAGEMENT

- Is there a need to involve organisations / professionals in other LSCB areas and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- How should the SCR process take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case?
- How best to liaise with the Coroner and/or the Crown Prosecution Service?
- How should the SCR process fit in with the processes for other types of reviews e.g. for homicide, mental health or prisons?
- Who will make the link with relevant interests outside the main statutory organisations e.g. independent professionals, independent schools, voluntary organisations?
- When should the SCR process start and by what date should it be completed? – a draft timescale should be produced which should aim to complete the process within a further four months period (see Timing below)
- How should any public, family and media interest be managed, before, during, and after the SCR?
- Does the HSCB need to obtain independent legal advice about any aspect of the proposed SCR?

14.4.29 Some of these issues may need to be re-visited as the SCR progresses and new information emerges.

14.4.30 The first meeting of the SCR working group will be chaired by a member of the HSCB Strategic Board, (see 14.4.27). The HSCB manager holds responsibility for co-ordinating the continuing work on the SCR and will report back as required to the HSCB Strategic Board and the chair of the HSCB.

14.4.31 During the first meeting of the SCR working group dates should be set for further meetings, as appropriate to the complexity of the case, in order that SCRs can be completed within the prescribed timescales. This should include setting a date for a final meeting to conclude the SCR process and to agree the overview report and the executive summary.

## TIMING

14.4.32 SCRs will vary widely in breadth and complexity, but in all cases, lessons should be learned and acted upon as quickly as possible. For further details of timescales see attached flow chart (Practice Guidance Appendix 3).

14.4.33 SCRs should be completed within four months of the decision by the chair of the HSCB to conduct a SCR, unless an alternative timescale is agreed with CSCI at the outset. Sometimes the complexity of a

case does not become apparent until the SCR is in progress. As soon as it emerges that a SCR cannot be completed within four months of the decision of the chair of the HSCB to initiate it, there should be a discussion with CSCI to agree a timescale for completion.

- 14.4.34 In some cases, criminal proceedings may follow the death or serious injury of a child. Those co-ordinating the SCR should discuss with the relevant criminal justice agencies, at an early stage, how the SCR process should take account of such proceedings, for example how does this affect timing, the way in which the SCR is conducted (including interviews of relevant personnel), its potential impact on criminal investigations and who should contribute at what stage?
- 14.4.35 SCRs should normally not be delayed because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. Much useful work to understand and learn from the features of the case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases it may not be possible to complete or to publish a SCR until after Coroners or criminal proceedings have been concluded but this should not prevent early lessons learned from being implemented and consideration should be given as to the appropriateness of publishing the Executive Summary.

### WHO SHOULD CONDUCT SCRS

- 14.4.36 The initial scoping of the SCR should identify those who should contribute, although it may emerge, as information becomes available, that the involvement of others would be useful. In particular, information may become available through criminal proceedings, which may be of relevance to the SCR.
- 14.4.37 The HSCB manager will write to individual agencies requesting that the service undertakes a separate management review of its involvement with the child and family, or submit a nil return (see Practice Guidance Appendix 3). This should begin as soon as the SCR working group has agreed on the scope of the process and drawn up clear terms of reference and even sooner if a case gives rise to concerns within the individual agency.
- 14.4.38 Voluntary agencies and others who are not members of any of the HSCB agencies should be asked and encouraged to contribute where relevant. It may be appropriate to ask one of the authors of an individual management review to act as a liaison point with such agencies.
- 14.4.39 The SCR working group chair will commission an overview report that brings together and analyses the findings of the various reports from organisations and others, and that makes recommendations for

future action. The overview report should be commissioned from a person who is independent of all the agencies / professionals involved.

- 14.4.40 Each agency should decide who will take the lead on conducting its management review, taking into account the nature of the case and the need to appoint someone with an appropriate level of seniority and professional background. Those conducting management reviews of individual services, or producing the overview report, should **not** have been directly concerned with the child or family, **nor** be the immediate line manager of the practitioner/s involved.

### INDIVIDUAL MANAGEMENT REVIEWS (IMRS)

- 14.4.41 The aim of management reviews should be to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about.
- 14.4.42 As far as possible, relevant staff should be involved in the management review process, although the conclusions will be those of the author. Before the management review report is completed there should be a process for feedback and de-briefing for staff involved, in advance of consideration of the report by the HSCB. Errors of fact identified at this stage should be corrected. There may also be a need for a follow-up feedback session if the HSCB overview report raises new issues for the agency and staff members.
- 14.4.43 SCRs are not a part of any disciplinary enquiry or process, but information that emerges in the course of management reviews may indicate that disciplinary action should be taken under established procedures. Alternatively, management reviews may be conducted concurrently with action made under disciplinary procedures e.g. suspension. In some cases e.g. alleged institutional abuse, disciplinary action may be needed urgently to safeguard other children.
- 14.4.44 SCRs should be conducted in a manner that facilitates learning and appropriate arrangements made for the support of those staff involved.
- 14.4.45 Management review reports should be accepted and endorsed by the senior officer in the agency who will be responsible for ensuring that recommendations are acted upon. This should take place before the report is submitted to the SCR working group. At this stage the agency should prepare a draft action in response to the management review finding and should act without delay on any urgent issues identified.

- 14.4.46 When a child dies in a custodial setting (prison, young offender institution or secure training centre) the Prisons and Probation Ombudsman investigates and reports on the circumstances surrounding the death of that child. The investigation examines the child's period in custody, including an assessment of the clinical care they received. The report would normally be made available to assist any SCR process.
- 14.4.47 The following outline format should guide the preparation of management reviews, to help ensure that the relevant questions are addressed, and to provide information to HSCB in a consistent format to help with preparing an overview report. The questions posed do not comprise a comprehensive check-list relevant to all situations. Each case may give rise to specific questions or issues which need to be explored, and each management review should consider carefully the circumstances of individual cases and how best to structure a management review in the light of those particular circumstances. Where staff or others are interviewed by those preparing management reviews, a written record of such interviews should be made and this should be shared with the relevant interviewee.
- 14.4.48 A template for completing written reports has been developed and is available via the HSCB office.
- 14.4.49 So as to address the issue of 'what was our involvement with this child and family':
- Construct a comprehensive chronology of involvement by the agency and/or professional/s in contact with the child and family over the period of time set out in the review's terms of reference. Briefly summarise decisions reached, the services offered and/or provided to the child/ren and family, and other action taken.

### Analysis of Involvement

- 14.4.50 The analysis should not consist of a rewording of the chronology. It is important for authors to critically analyse their agency's involvement.
- 14.4.51 Consider the events that occurred, the decisions made, and the actions taken or not. When judgements were made, or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. Consider specifically:
- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?

- Did the agency have in place policies and procedures for safeguarding children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/ provided, or relevant enquiries made, in the light of assessments?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- When, and in what way, were the child/ren's wishes and feelings ascertained and considered? Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- Were more senior managers, or other agencies and professionals, involved at points where they should have been?
- Was the work in this case consistent with agency and HSCB policy and procedures for safeguarding children, and wider professional standards?
- Did resource issues impact significantly on the services provided

### What Do We Learn From This Case?

- 14.4.52 Are there lessons from this case for the way in which this agency works to safeguard children and promote their welfare? Is there good practice to highlight, as well as ways in which practice can be improved? Are there implications for ways of working; training (single and interagency); management and supervision; working in partnership with other agencies; resources?

### Recommendations for Action

- 14.4.53 What action should be taken by whom, and by when? What outcomes should these actions bring about, and how will the agency review whether they have been achieved?

## OVERVIEW REPORT

- 14.4.54 The HSCB will commission an overview report which brings together and analyses the findings of the various reports from agencies and others, and which makes recommendations for future action. The chair of HSCB, advised by the chair of the SCR working group, will commission the overview report from an appropriate report writer.

- 14.4.55 On receipt of the individual agency management reviews, the SCR working group will ensure that a composite chronology of events is prepared and notify the appropriate agencies of any discrepancies or other issues requiring immediate attention. The authors of individual reviews may be asked to attend one or more meetings of the SCR working group to present their findings and contribute to the discussion. When necessary, the SCR working group may request additional information not provided through the management review.
- 14.4.56 The SCR working group will prepare an overview report which should bring together and relate the information and analysis contained in the individual management reviews, together with reports commissioned from any other relevant interests. Overview reports should be produced according to the following outline format although, as with management reviews, the precise format will depend upon the features of the case. This outline will be most relevant to abuse or neglect which has taken place in a family setting, and may need to be modified in other situations such as institutional abuse.

### OVERVIEW REPORT OUTLINE FORMAT

#### Introduction

- Summarise the circumstances that led to the SCR
- State terms of reference of SCR
- List contributors and nature of contributions e.g. management review by local authority, report from adult mental health service
- List SCR working group members and author of overview report

#### The facts

- Prepare a genogram showing membership of family, extended family and household
- Compile an integrated chronology of involvement with the child and family on the part of all relevant agencies, professionals and others who have contributed to the SCR process -note specifically in the chronology each occasion on which the child was seen and the child's views and wishes sought or expressed
- Prepare an overview which summarises what relevant information was known to the agencies and professionals involved, about the parents / carers, any perpetrator, and the home circumstances of the children

#### Analysis

- How and why events occurred, decisions were made, actions taken or not - this is the part of the report in which reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events -the

analysis section is also where any examples of good practice should be highlighted.

### Conclusions & recommendations

- A summary of what, in the opinion of the SCR working group, are the lessons to be drawn from the case and how those lessons should be translated into recommendations for action
- Recommendations should highlight any specific gaps in current arrangements in relation to policy / procedures; training; practice; management/ supervision; and audit / clinical governance. This should include lessons for national, as well as local, policy and practice.
- Recommendations should include, but not be limited to, the recommendations made in individual agency reports which have been endorsed by the working group
- Recommendations should be few in number, focused and specific, and capable of being implemented.

14.4.57 The completed overview report will be forwarded by the SCR working group to the SCR panel who, once they are satisfied with the contents of the report, will then make a recommendation to the Chair of the HSCB and the Strategic Board. The report, and its recommendations, will be signed off by the Strategic Board with the Operational Board having responsibility for ensuring that individual agencies prepare and forward action plans in relation to the recommendations.

### EXECUTIVE SUMMARY

14.4.58 The chair of the SCR working group will ensure that the content of the executive summary is agreed and cleared for public and media release.

14.4.59 The primary purpose of the Executive Summary is to inform a wider public of the key elements in the SCR,, namely:

- The purpose and scope of the SCR
- An outline of the SCR process including the agencies involved in providing information
- A brief outline of the circumstances which led to the SCR
- A succinct account of inter-agency practice issues identified
- Key recommendations and plans for future action

14.4.60 The Executive Summary can be used to:

- Demonstrate how the HSCB has exercised its responsibilities in relation to death or injury to a child / ren

## STRATEGIC MANAGEMENT

- Provide a basis for press briefings should the SCR process attract active media attention
- Provide an efficient means of informing Chief Officers and the inter-agency practice community of key learning issues arising from the review of practice
- Provide information upon which to build further case specific training materials

## REPORTING THE OUTCOME

14.4.61 The findings and recommendations of the SCR will be reported to the HSCB Strategic Board for consideration. The role of the chair of the HSCB is to:

- Monitor the SCR and ensure that all aspects of the SCR process are satisfactory and completed in accordance with the relevant guidance
- Ensure that the HSCB Strategic Board discusses any recommendations made, agrees them if appropriate and implements an action plan

14.4.62 On receiving an overview report the HSCB will therefore:

- Ensure via senior named officers that contributing agencies and individuals are satisfied that their information is fully and fairly represented in the overview report
- Translate recommendations into an action plan which should be signed up to at a senior level by each of the organisations that need to be involved -the plan should set out who will do what, by when, and with what intended outcome - the plan should set out by what means improvements in practice/systems will be monitored and reviewed
- Clarify to whom the report, or any part of it, should be made available
- Disseminate report or key findings to interests as agreed, make arrangements to provide feedback and de-briefing to staff, family members of the subject child, and the media, as appropriate
- Provide a copy of the overview report, action plan and individual management reports to the CSCI and DfES.

14.4.63 Agency action plans, and any HSCB action plan, will be endorsed by HSCB and then monitored by the Operational Board until all recommendations have been actioned.

## REVIEWING INSTITUTIONAL ABUSE

14.4.64 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of SCR apply. However, they are

likely to be more complex, on a larger scale, and may require more time.

- 14.4.65 Terms of reference need to be carefully constructed to explore the issues relevant to the specific case. For example, if children had been abused in a residential school, it would be important to explore whether and how the school had taken steps to create a safe environment for children, and to respond to specific concerns raised.
- 14.4.66 There needs to be clarity over the interface between the different processes of investigation (including criminal investigations); case management, including help for abused children and immediate measures to ensure that other children are safe; and review, i.e. learning lessons from the case to lessen the likelihood of such events happening again.
- 14.4.67 The different processes should inform each other. Any proposals for SCR should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

## ACCOUNTABILITY & DISCLOSURE OF SCR

- 14.4.68 HSCB should consider carefully who might have an interest in SCRs e.g. elected and appointed members of authorities, staff, members of the child's family, the public, the media - and what information should be made available to each of these interests. There are difficult interests to balance, among them:
- The need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others
  - Accountability of public services and the importance of maintaining public confidence in the process of internal review
  - The need to secure full and open participation from the different agencies and professionals involved
  - The responsibility to provide relevant information to those with a legitimate interest
  - Constraints on sharing information when criminal proceedings are outstanding, in that access to the contents of information may not be within the control of the HSCB
- 14.4.69 It is important to anticipate requests for information and plan in advance how they should be met, e.g. a lead agency may take responsibility for de-briefing family or for responding to media interest in liaison with contributing agencies and professionals.
- 14.4.70 In all cases, the HSCB overview report should contain an executive summary that will be made public including at a minimum, information about the SCR process, key issues arising from the case

and the recommendations made. Examples of both good practice and areas where change is required should be included.

- 14.4.71 Such publication will need to be timed in accordance with the conclusion of any related court proceedings. The content will need to be suitably anonymised in order to protect the confidentiality of relevant family members and others.
- 14.4.72 The HSCB should ensure the SHA and CSCI are briefed, so that they can work jointly to ensure the DH and DfES respectively are fully briefed in advance about publication of the executive summary.

### LEARNING LESSONS LOCALLY

- 14.4.73 SCRs are of little value unless lessons are learned. At least as much effort should be spent on acting upon recommendations as on conducting the SCR. The following may help in getting maximum benefit from the SCR process:
- As far as possible, conduct the SCR in such a way that the process is a learning exercise in itself, rather than a trial or ordeal
  - Consider what information needs to be disseminated, how, and to whom, in the light of a SCR -be prepared to communicate both examples of good practice and areas where change is required
  - Focus recommendations on a small number of key areas, with specific and achievable proposals for change and intended outcomes - PCTs should seek feedback from SHAs who should use it to inform their performance management role
  - The Operations Board of the HSCB will be the agreed forum for auditing action against recommendations and intended outcomes
  - Seek feedback on SCR reports from CSCI who should use reports to inform inspections and performance management
- 14.4.74 Day to day good practice can help ensure SCRs are conducted successfully and in a way most likely to maximise learning:
- Establish a culture of audit and review and ensure that tragedies are not the only reason inter-agency working is reviewed
  - Have in place clear, systematic case recording and record keeping systems
  - Develop good communication and mutual understanding between different disciplines and different HSCB members
  - Communicate with the local community and media to raise awareness of the positive and 'helping' work of statutory services with children, so that attention is not focused disproportionately on tragedies
  - Ensure staff and their representatives understand what can be expected in the event of a child death / SCR

## LEARNING LESSONS NATIONALLY

- 14.4.75 Taken together at a national level, child death and SCRs should be an important source of information to inform national policy and practice.
- 14.4.76 The DfES is responsible for identifying and disseminating common themes and trends across SCR reports, and acting on lessons for policy and practice.
- 14.4.77 The DfES will commission overview reports at least every two years, drawing out key findings of SCRs and their implications for policy and practice.
- 14.4.78 The HSCB will consider this report to explore opportunities for learning lessons nationally.

## 14.5 CHILD DEATH REVIEWS

- 14.5.1 One of the LSCB functions in relation to the deaths of any children in its area will be (with effect from 01.04.08):
- Collating and analysing information about each death with a view to identifying any case that requires a serious case review; any matters of concern affecting the safety and welfare of children in the area and any wider public health or safety concerns arising from a particular death or pattern of deaths
  - Putting in place procedures for ensuring that there is a co-ordinated response by the authority, its LSCB partners and other relevant persons to an unexpected death

### OVERVIEW PANEL FOR ALL CHILD DEATHS

- 14.5.2 An overview panel of each LSCB should be responsible for reviewing information on all child deaths and be accountable to the LSCB chair. The LSCB should use the aggregated findings from all such deaths, collected according to a nationally agreed minimum data set (currently being developed by the 'Confidential Enquiry into Maternal and Child Health CEMACH at [www.cemach.org.uk/child\\_health\\_enquiry1.htm](http://www.cemach.org.uk/child_health_enquiry1.htm)
- 14.5.3 Hertfordshire LSCB will be discussing and developing their approach to these new responsibilities in the course of the next year and some or all may initiate the required service in advance of the 01.04.08 deadline. Details will be published in the next edition of these procedures scheduled for 2008.
- 14.5.4 The LSCB should be informed of all deaths of children, normally resident in its geographical area. The LSCB chair should decide who will be the designated person to whom the death notification and

other data on each death should be sent. The chair of the 'overview panel' will be responsible for ensuring that this process operates effectively.

- 14.5.5 Deaths should be notified by the professional confirming the fact of the child's death. For unexpected deaths this will be at the same time as s/he informs the Coroner and Safeguarding Manager to be notified of all children's deaths in the area in which the child's death occurred.
- 14.5.6 If this is not the area in which the child is normally resident, the designated person should inform her/his opposite number in the area where the child normally resides. It should be decided on a case-by-case basis which panel should take responsibility for gathering the necessary information for a panel's consideration. In some cases this may be done jointly.
- 14.5.7 The Registrar and ONS respectively send a notification of each death to the local PCT and this will provide a check to ensure that all child deaths have been notified to the LSCB chair. Any professional (or member of the public) hearing of a local child death in circumstances e.g., while abroad, which means it may not yet be known about, can inform the chair of the LSCB.
- 14.5.8 The 'child death overview panel' will have a permanent core membership drawn from the key organisations represented on the LSCB although not all core members will necessarily be involved in discussing all cases. It should include a professional from public health as well as child health.
- 14.5.9 Other members may be co-opted either as permanent members to reflect the characteristics of the local population, e.g. a representative of a large local ethnic or religious community to provide a perspective from the independent or voluntary sector or to contribute to the discussion of certain types of death when they occur, e.g fire fighters for house fires. The overview panel will be chaired by the LSCB chair or her/his representative. The chair of the overview panel will be a member of the LSCB.
- 14.5.10 There should be a clear relationship and agreed channels of communication with the local Coronial Service.
- 14.5.11 The functions of the child death overview panel will include:
- Implementing, in consultation with the local Coroner, local procedures and protocols which are in line with this guidance on enquiring into unexpected deaths and evaluating these together with information about all deaths in childhood

- Collecting and collating an agreed minimum data set and where relevant seeking information from professionals and family members
- Meeting frequently to evaluate the routinely collected data on the deaths of all children and thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children;
- Having a mechanism to evaluate specific cases in depth, where necessary, at subsequent meetings
- Monitoring the appropriateness of the response of professionals to an unexpected death of a child, reviewing the reports produced by the rapid response team on each unexpected death of a child and providing them with feedback on their work. Where there is an ongoing criminal investigation, the CPS must be consulted as to what it is appropriate for the panel to be considering and what actions it might take in order not to prejudice any criminal proceedings
- Referring to the chair of the LSCB any deaths where, on evaluating the available information, the panel considers there may be grounds to undertake further enquiries, investigations or a SCR and explore why this had not previously been recognised
- Informing the chair of the LSCB where specific new information should be passed to the Coroner or other appropriate authorities
- Providing relevant information to those professionals involved with the child's family, so that they in turn can convey this information in a sensitive and timely manner to the family
- Monitoring the support and assessment services offered to families of children who have died
- Monitoring and advising the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths
- Organising and monitoring the collection of data for the nationally agreed minimum data set and make recommendations (to be approved by LSCBs) for any additional data to be collected locally
- Identifying any public health issues and considering with the Director/s of Public Health how best to address these and their implications for both the provision of services and for training
- Co-operating with regional and national initiatives e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH) to identify lessons on the prevention of unexpected child deaths

14.5.12 The child death overview panel will be responsible for developing their work plan, which should be approved by the LSCB. It will prepare an annual report for the LSCB, which will have responsibility for publishing relevant, anonymised information.

## STRATEGIC MANAGEMENT

- 14.5.13 The LSCB will take responsibility for disseminating the lessons to be learnt to all relevant organisations and acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

## 14.6 WHISTLE BLOWING

- 14.6.1 Staff, through fears about repercussions, may find it difficult to raise child protection concerns about colleagues or managers.
- 14.6.2 Senior managers should ensure provision of a well-publicised 'whistle blowing' or 'speak out' procedure that provides alternative methods of reporting concerns, using a direct specialist telephone line.
- 14.6.3 A leaflet should be available to publicise the whistle blowing procedure and should provide information about 'Public Concern At Work', an independent charity whose lawyers can give free confidential advice about how to raise a concern about malpractice at work (see appendix 1 for contact numbers).
- 14.6.4 The LSCB should ensure that each agency has an effective whistle blowing procedure for use by staff.

## 14.7 RECRUITMENT, SELECTION, SUPERVISION & TRAINING

### GENERAL RECRUITMENT PROCESSES

- 14.7.1 All partner organisations should make arrangements for ensuring that their functions, including safer recruitment are discharged with regard to the need to safeguard and promote the welfare of children in line with s.11 Children 2004 and s.175 and s.157 Education Act 2002.
- 14.7.2 So as to minimise the risk of employing or engaging an individual who poses a predictable risk to them, all LSCB agencies should consider, with respect to candidates who will be working with children (and in addition to personal interviews):
- Methodically applying techniques e.g. psychometric testing if satisfied that they can contribute to the identification of unsuitable individuals
  - Analysing rigorously all the information which is available about the candidate
  - Facilitating the involvement of children / young people in the selection process (A Warner report recommendation)

## STRATEGIC MANAGEMENT

- 14.7.3 To ensure that selectors of staff are able to successfully test candidates' ability and experience against a clearly defined person specification each agency must offer them:
- Specific training (the 'Getting it Right' policy requires anyone sitting on an interview panel to have received relevant training)
  - Supervised / supported experience of recruitment
  - Periodic evaluation of performance

## CHOICE OF CANDIDATE

### Quality of Job Description & Person Specification

- 14.7.4 LSCB partner agencies should develop detailed internal procedures which clarify allocation of 'human resource' tasks outlined below.
- 14.7.5 Job descriptions (J.D.s) and person specifications should reflect professional practice requirements.
- 14.7.6 All stated requirements must be expressed in terms sufficiently explicit to allow a candidate's experience, achievements or capabilities to be evidenced.

### References from previous substantive employers

- 14.7.7 A previous employer (and reasonable steps should be taken to verify that status) who is asked for a reference, should be advised in the request to take reasonable care to ensure her/his statement:
- Is reliable and comprehensive - e.g. accurate dates of employment, CRB checks, any periods of sick leave
  - Is based upon an accurate assessment of an individual's qualities e.g. any disciplinary action, known convictions or other grounds for concern
  - Focuses on the key criteria for effective performance in the specified post and
  - Offers a full and frank disclosure of all matters considered relevant by the author - e.g. candidate's reason for planning to or actually leaving her/his post
- 14.7.8 A comparable reference should also be obtained from her/his line manager in respect of internal candidates for posts involving direct contact with children.
- 14.7.9 Following initial selection, references on the short-listed / preferred candidate/s should be obtained prior to final selection.

- 14.7.10 All agencies committed to these procedures should have explicit arrangements for provision within reasonable time-scales, of properly structured references which should ordinarily be issued in the name of the head of service (though they may be drafted by a more junior member of staff who has the necessary knowledge and experience).

### References with respect to agency staff

- 14.7.11 Given the proportion of staff currently engaged via specialist employment agencies, it is important that there are systems in place e.g. via contacts with recruitment centres, to ensure only those which can offer safe selection processes are used by those organisations committed to these procedures.

- 14.7.12 References from any previous substantive employers should be sought as above and requests to agencies seek confirmation of:

- The individual's registration with the agency in period/s claimed
- All assignments including dates, roles and name and address of all work places
- The quantity and pattern of any absences from their assignments
- Any cause for concern within the agency including any request by a client for the person to be withdrawn from an assignment which upon investigation was found to be justified

- 14.7.13 The agency should also be asked to confirm:

- That it carries out appraisals of its workers and be invited to describe the most recent relevant to the role which is to be filled
- The date of the last criminal records check it sought on the individual in question, its result, and to forward a copy of it
- From which previous employers references were obtained and whether or not these expressed any reservations about the individual in question
- If its overall selection procedures comply with the recommendations in the Warner report '*Choosing with Care*'

### Selection methods

- 14.7.14 Interviews may usefully be underpinned by practical exercises to simulate the working environment e.g. anonymised situations (with precautions taken to ensure no unfair advantage to internal candidates).

- 14.7.15 Such practical exercises may include:

- 'A situation exercise' which tests declared responses to events relevant to the post in question

## STRATEGIC MANAGEMENT

- 'Submission of a prepared written exercise' to allow a panel to prepare and deliver questions at an interview
- A 'presentation exercise' to test an individual's ability to research, prepare and present a topic relevant to the post in question
- 'Psychometric tests' - e.g. personality and/or skills based
- A group exercise which simulates a relevant forum and allows observation of interaction

14.7.16 Final interview panels should be balanced wherever possible by gender and race and may benefit from the inclusion of independent person/s as well as immediate line managers and more senior staff.

## CRIMINAL RECORD CHECKS

14.7.17 The Protection of Children Act 1999 (POCA) checks and referrals are handled by the 'disclosure service' of the Criminal Records Bureau (CRB) which provides two sorts of certificates of relevance to employers (standard and enhanced disclosures). One or other **must** be sought with respect to all candidates who seek to work with children and the current policy of CSF is that an enhanced check is completed on all those proposing to work with children.

### Standard disclosure

14.7.18 A standard disclosure is available for posts involving regular contact with children (and vulnerable adults), certain professions in health, pharmacy and the law.

14.7.19 Standard disclosures indicate if there is nothing on record or show details drawn from the Police national computer of:

- Spent and unspent convictions
- Cautions
- Formal reprimands and
- Final warnings

14.7.20 Standard disclosures are issued to the individual and copied to the body registered to seek them.

### Enhanced disclosures

14.7.21 Enhanced disclosures, in addition to information provided by a standard disclosure may contain non-conviction information from local Police records, which a chief Police officer thinks, may be relevant to the position sought.

- 14.7.22 Enhanced disclosures are available for positions involving regular caring for, training, supervision or being in sole charge of children (or vulnerable adults).

### Persons prohibited from working or seeking work with under eighteens

- 14.7.23 Both standard and enhanced disclosures will show whether under schedule 4 Criminal Justice and Courts Act 2000, the person is prohibited from working or seeking work with individuals under the age of 18

### Seeking disclosures from CRB

- 14.7.24 For organisations registered with the CRB applications by potential employers who can provide a reference number may be made by phone on 0870 90 90 844.
- 14.7.25 Registered organisations with 'payment on account status' can order paper disclosure application forms through the registration line on 0870 90 90 822 (also available for general enquiries).
- 14.7.26 Requests must include name, address and date of birth of the applicant.
- 14.7.27 If a disclosure reveals that an applicant is prohibited from seeking or working with under eighteens, it is an offence to employ her/him and the CPU must be informed without delay of the individual's attempt to seek employment.
- 14.7.28 Further information of how to apply for disclosures is available at [www.crb.uk](http://www.crb.uk)

### Limitations of disclosures

- 14.7.29 Checks should always be undertaken when employing from overseas. The local Police authority may be asked to provide relevant information including any criminal record. Whilst responses vary across countries, some e.g. Canada operate similar systems to the UK CRB.
- 14.7.30 The CRB may be able to advise about criminal record checking overseas.
- 14.7.31 Occasionally, an enhanced disclosure check may result in the local Police disclosing non-conviction information to the registered body only and not to the applicant e.g. a current investigation about the individual. Such information must **not** be passed on to her/him.

### **Police / CPS investigation of current employee**

- 14.7.32 For procedures relevant to a situation in which Police are investigating a current employee with respect to any behaviour that suggests harm to / offence against or related to / unsuitability to work with, a child see [module 10](#).

### **INDUCTION & REVIEW**

- 14.7.33 For those joining an organisation, an induction programme should be provided and there should be a minimum of six months supplementary supervision, training and appraisal with respect to their new role so as to identify any further training or personal or management development need.
- 14.7.34 Regular review meetings between the appointee and responsible manager should be convened by the manager throughout the induction period to address areas where further support, guidance and training may be required.
- 14.7.35 Induction for all new staff should include Local Safeguarding Children Board training requirements appropriate to their position.

### **SUPERVISION & SUPPORT**

- 14.7.36 Senior managers in all agencies for which this manual is relevant have a duty to ensure the provision of:
- Adequate training
  - Clear and up to date procedures to follow
  - Ready access to advice, expertise and management support (including recognition of need for additional support in particular cases or circumstances)
  - Systems to protect staff from violence, bullying and harassment including racial harassment
  - Systems to recognise and respond to poor practice e.g. regular audits of cases which involve children, including those in adult and mental health teams
  - Complaints and whistle-blowing procedures to allow service users and staff to highlight issues for consideration and resolution
  - Effective staff appraisal and personal development planning
  - Collated information for the local Safeguarding Children Board about issues arising from local operational experience of child protection

## STRATEGIC MANAGEMENT

- 14.7.37 Within all agencies which have operational responsibility for child protection services, there should be an agency policy, which defines minimum levels of formal supervision of those staff who are accountable for child protection cases and reflecting the need to offer a higher level of supervision for the least experienced.
- 14.7.38 Such supervision must ensure that **all** child protection cases are regularly discussed in supervision.
- 14.7.39 On some occasions – e.g. enquiries about complex abuse or allegations against colleagues, agencies should consider the provision of additional individual or group staff support.
- 14.7.40 Managers should develop local policies and systems to maximise staff safety and remain alert to the possibility some staff may be anxious about personal safety yet reluctant to acknowledge their concern.

## CHILD PROTECTION TRAINING

- 14.7.41 **All** professionals including staff in the private and voluntary sectors, require a general awareness of known indicators and pre-disposing factors of abuse as well as (role specific) detailed knowledge of agreed policies and procedures.
- 14.7.42 All **front line staff** must be trained to pass calls about the safety of children to the appropriate professional staff. This includes reception and switchboard operators and administrative staff.
- 14.7.43 LSCB training for staff engaged in child protection work must include:
- The Assessment Framework
  - Basic and advanced inputs on all forms of abuse and neglect
  - Targeted joint training – e.g. Achieving Best Evidence
- 14.7.44 For staff working with adults, sufficient training to inform and enable recognition of concerns about any dependent children which require referral to Children's Social Care (Social Care ) or Police.
- 14.7.45 The Local Safeguarding Children Board (LSCB) is accountable for:
- Ensuring provision of sufficient general and specialised training
  - Clarifying the specialist training required for different staff e.g. those undertaking s.47 enquiries, GPs etc
  - Monitoring take-up amongst those offered training
  - Routine evaluation of perceived effectiveness of training

## **STRATEGIC MANAGEMENT**

- 14.7.46 GPs are expected to participate in child protection training and are also responsible, as employers, for ensuring their staff are provided with opportunities to attend relevant training.
- 14.7.47 All staff who have any contact with children must be included in their agency's training programme on child protection at basic or more advanced level according to their role.

## **EQUALITY & DIVERSITY TRAINING**

- 14.7.48 All operational staff must routinely be provided with opportunities for basic and comprehensive anti-discriminatory training.
- 14.7.49 Such training must be rooted in recognition of the diversity of families and communities and respect for the differing approaches to child rearing this diversity represents.
- 14.7.50 Such training must also ensure that respect for difference is not confused with acceptance of any form of abuse or neglect.
- 14.7.51 Equality and diversity issues must be integrated within all child protection training provided to staff.

## **REPORTING SYSTEMS FOR UNSUITABLE STAFF**

- 14.7.52 Each agency must have a nominated 'HR' or Service Manager whose responsibilities include reporting, to the 'disclosure service' of the CRB / relevant professional body, any member of staff who (following an enquiry) it concludes to be unsuitable to work with children.