

# LEICESTERSHIRE POLICE AUTHORITY



Meeting           **POLICE AUTHORITY**

Date               **TUESDAY 27 APRIL 2010 AT 2.00PM**

Report of         **CHIEF CONSTABLE**

Subject           **EVERY CHILD MATTERS UPDATE**

## **Purpose of the Report**

1. This report is submitted as a requested update on issues relating to the Every Child Matters and Child safeguarding within Leicester, Leicestershire and Rutland.

## **Background**

2. In 2003 as a response to the Victoria Climbié case The Government published Every Child Matters which together with supplementary documents, forms the Statutory Guidance issued by the Department for Children, Schools and Families (DCSF) for Safeguarding Children.
3. High profile cases including “Baby Peter” have resulted in a further review of Safeguarding by Lord Laming. He has reported back to government with 58 further recommendations. These recommendations were accepted by Rt Hon Ed Balls MP, Secretary of State for Children, Schools and Families. They formed the basis of a detailed government response issued in May 2009.
4. In March 2010 the DCSF published a revision of “Working Together To Safeguard Children”. This is the practitioners guidance that describes the interagency working required to safeguard children. This Guidance addresses 26 of the Laming recommendations and adjusts working practices accordingly.
5. The statutory guidance requires Leicestershire Constabulary to be a member and support the Local safeguarding Children’s Board (LSCB). This board provides the coordination which assists the various agencies responsible for safeguarding children, to work in partnership.
6. Government Policy changes have also created Children’s Trusts to coordinate the provision of services such as education and healthcare to children within a Local Government Area. There are now three Children’s Trust Boards covering Leicester, Leicestershire and Rutland respectively. These trust boards are the new forums for the coordination of provision and commissioning services to children. Safeguarding is one aspect of their wider remit. The LSCBs report on Safeguarding to the trusts on an annual basis. The LSCBs also hold the Trusts to account to ensure that Safeguarding is considered as general services are delivered.

7. One of the functions of my Detective Chief Inspectors post is to engage with the LSCBs and ensure that the police contribute effectively to child safeguarding. I also ensure that the Police perspective is appropriately recognised within the LSCB business plans.

### **Developments within Leicester, Leicestershire and Rutland**

8. The Safeguarding headline story for 2009 / 2010 has therefore been a period of unprecedented change and high profile. The Government requirements and standards have been updated and tightened and the delivery structures have significantly altered. The media and political debate continues to focus on Serious Case Reviews and wider safeguarding.

#### **Principal Areas of Development:**

9. In early 2009 the Leicester, Leicestershire and Rutland LSCB began a process of disaggregating into two new boards. There is now a Leicester LSCB and a Leicestershire and Rutland LSCB. Both boards have agreed to maintain common policies and working practices but are developing separate meeting structures and support functions. The majority of this structure is in place and functioning but some further implementation is still required.
10. The quality assurance information provision to both Boards has had to be revitalised. Both Boards have accepted the importance of this work and are developing improved performance / scrutiny functions. These are beginning to present data to the Boards for discussion and to lead decision making. Police information is included in the developing packages. The objective remains to provide regular and intrusive performance indicators which will allow the board and its partners to ensure that their safeguarding arrangements are effective.
11. The training provided by the Boards has been debated and a common strategy is currently in place until October 2010. Discussions about a common approach beyond October will create a strategy for future development. This will need to take account of the Children's trusts new roles and leadership in training provision.
12. The management of Serious Case Reviews has been tightened up nationally with local implications.
13. OFSTED review all completed reviews against a rigid marking scheme. They currently focus on the quality of the final report rather than the evidence of lessons being learnt. However a revised OFSTED scrutiny role has been drafted and will be released after the election process. The current system is time consuming and resource intensive. Considerable effort has to be expended to ensure that the report and its production process can withstand scrutiny. The Quality of the Police Independent Management Reports (IMR's) has shown a steady improvement over the year and the last report received the Highest "Outstanding" Grade.
14. The independence of all key roles in the reviewing process has been strengthened. Each review now has to have an independent panel chair and an independent author. Each IMR writer and panel member has to be independent of the management of the staff / units involved in the case under review. These rules preserve the integrity of the review process but add significantly to the complexity and cost. Each review takes 6 months to complete. The Review Process is described in Appendix 1 of this report.
15. At the time of my last update there were a number of legacy serious case reviews which have been delayed by criminal proceedings or other processes and were outside the new 6 month completion requirement. All have now been submitted to OFSTED for evaluation but some have not been published because there are still ongoing criminal or

civil proceedings. There are also some new cases reaching a conclusion. It is therefore likely that a disproportionate number of cases will be published locally and nationally during the next 6 months. This may give a misleading impression about the frequency and seriousness of these cases. The heightened media interest in these cases is likely to build upon the national situation and presents a risk to the public confidence in the police and our partners. The LSCBs are coordinating the partnership activity to prepare for these releases.

16. The LSCBs have analysed the lessons learnt from the last 20 serious case reviews conducted. They have found that there are 7 key themes emerging which are broadly consistent with national learning. These themes are listed in Appendix 2 of this report.
17. The SCR process developed as a statutory requirement for child safeguarding is now spreading as best practice for other police business areas. The model is now part of guidance for MAPPA and YOS repeat offenders. Adult Safeguarding Boards have also adopted the same methodology. It is reasonable to expect that this trend will continue and the conduct of reviews will continue to become a more frequent requirement.
18. The increased media and professional focus on safeguarding children has caused an initial 50% increase in the number of concern referrals recorded by the police. This has remained at an elevated level since the Haringey case. Officers report that the increased caseload is made up of appropriate and genuine cases which we would encourage the public and our partners to refer. Other agencies report a similar increase. These increases are presenting challenges for all partners. The initial reports have now filtered through to ongoing partnership safeguarding work. The police have maintained their attendance at initial case conferences but inline with the national experience we are struggling to cope with the increase in ongoing case reviews. These case conferences are a vital part of the risk management of cases and we are currently reviewing our structure to respond to this challenge.
19. The 2008/9 precept funded growth to the Child Abuse Investigation Unit has been steadily implemented. An additional DCI managing the strategic relationships with statutory partners and overseeing the Constabulary's involvement in Serious Case Reviews has been just one of the essential improvements made in this area. Others include increased management and supervision on the CAIU; three BCU based officers coordinating police response to vulnerable victims; increased investigators in the CAIU and a specialist team focusing solely on the most serious child abuse investigations. Despite the investment and growth that has taken place, the pressure on the staff in CAIU continues to increase as public expectation, referrals and requirements for increased multi-agency solutions grow.
20. Information sharing between partners will be promoted by the introduction of ContactPoint latter this year. This national computer database project has suffered delays but will help professionals working with a young person to identify all other interested agencies. It will be particularly useful when families move between police areas.. The business processes and protocols to make use of this system are being developed by early adopter forces and Leicestershire will join the next phase of implementation. Our councils already have staff working on the data about every child under the age of 18 years, held in the system.
21. The introduction of the Police national Database will also ensure that safeguarding systems can make a step change in improvement. We can become more compliant with the Bichard enquiry recommendations, Currently Leicestershire Constabulary holds records of all the offenders and victims it has encountered however we do not have access to the information and intelligence held by other forces. We are therefore vulnerable when offenders and victims move between force areas. When risk

assessing situations as part of safeguarding procedures it is clearly important to have as complete a picture as possible.

## **Recommendations**

22. Members are asked to note the current developments outlined in this paper.

## **Implications**

Safeguarding children is a growing area of business for Leicestershire Constabulary. The current political and media focus shows no signs of abating and is likely to generate further legislation and statutory guidance. To date this has generated more referrals and more complex process requirements to respond to them. During the last financial year this has been contained within existing budgets however eventually this trend will have resource implications for the force. The media focus has created a high risk environment where all safeguarding agencies will face considerable pressure to invest appropriately in their safeguarding services despite current financial constraints.

## **Background Papers**

Appendix 1 The Serious Case Review Process

Appendix 2 The Common Themes Emerging From Serious Case Reviews

## **Person to Contact**

DCI Peter Jackson. CAIU, Crime support. Tel. 0116 2485163

Email: [peter.jackson@leicestershire.pnn.police.uk](mailto:peter.jackson@leicestershire.pnn.police.uk)

**The Serious Case Review Process**

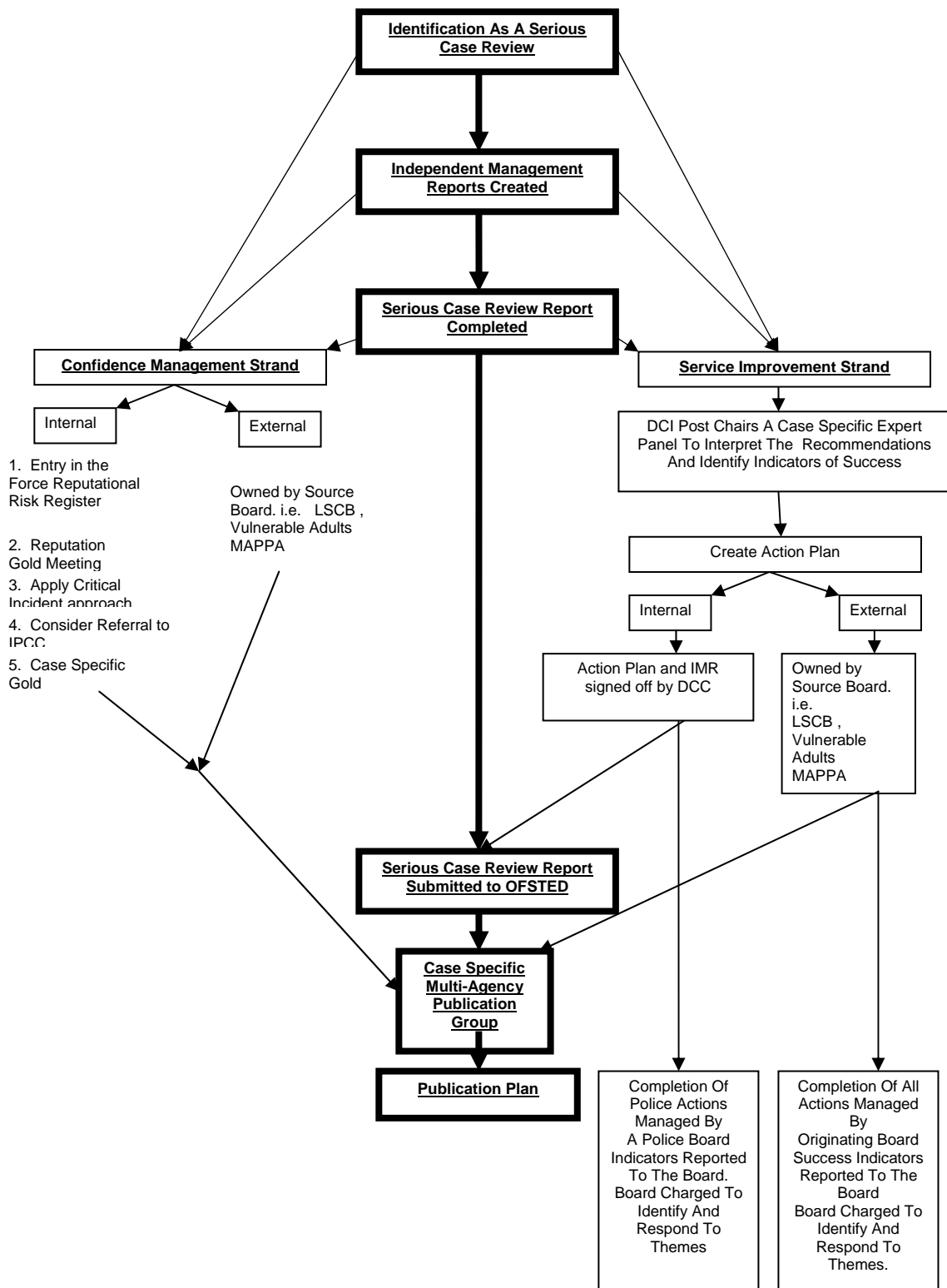
Each Serious Case Review(SCR) follows a standard approach.

- There is an initial phase where a case is highlighted by any agency and all LSCB partners compare information to determine if a SCR is mandatory or appropriate. This decision is made with reference to the statutory guidance set out in “Working Together” for child cases.

The decision is made by the chair of the appropriate safeguarding Board following formal recorded consultation with all agencies involved. The Decision process is subject to scrutiny by GOEM.

- Once a decision to proceed has been reached, each agency involved submits a Independent Management Report (IMR) to a panel created to review them.
- The panel is chaired by an independent chairperson appointed by the appropriate safeguarding board. An independent author is also appointed to combine the IMR's into a composite SCR report and make recommendations.
- The report is submitted to OFSTED for evaluation. This process assesses the quality of the report but does not focus on the causes or of the serious case which caused its creation. Developing guidance is beginning to show that the focus will soon switch to implementation of the recommendations.
- The SCR report created is potentially discloseable to Coroners and Courts. There is a national unresolved tension between preserving the openness and improvement motivated ethos of the review process and the requirements of the courts and Coroner to take account of all available information.
- The IPCC have begun to enquire into cases involving serious case reviews. Other inspection bodies such as the HMIC and NPIA also use the findings to judge the health of forces. This introduces further tensions and challenges to the openness of the review process.
- There is then a requirement to publish the reports. The main review is not disclosed however an executive summary is made available. This is released following multi-agency preparation. This includes completion of a check list of issues which should ensure that the family and effected practitioners are given advanced disclosure and media interest is anticipated. Reviews are not normally published until other criminal , civil or coroners court processes are complete to ensure they do not interfere.

The Serious Case Review process and the service improvement and confidence work which supports it, is illustrated in the following diagram.



The Common Themes Emerging From Serious Case Reviews

The LSCB has analysed the last 20 serious case reviews it has completed. These have resulted in approximately 63 recommendations to agencies. Many of these apply to the police force and are mirrored by national findings.

Seven common themes have emerged from this work:-

- **Theme 1: Parents, Carers and Children's Mental Health / Vulnerability Issues.**  
*Including learning disability, alcohol and substance misuse, domestic abuse, divorce and suicidal tendencies.*
- **Theme 2: Thresholds for referral, assessment and intervention across agencies.**  
*Including the understanding and use of thresholds by staff and ensuring clarity regarding which families require universal, targeted, preventative and specialist services.*
- **Theme 3: Case Management Issues.**  
*Including issues relating to the shortfall in practice and intervention by agencies.*
- **Theme 4: Information Systems.**  
*Including ensuring that the systems are in place within and between all agencies involved in safeguarding for the effective recording, storing, retrieval, consideration, scrutiny and sharing of significant information.*
- **Theme 5: Inter agency working.**  
*Including ensuring that communication and constructive challenge is effective between agencies and there are clear processes for resolving conflict.*
- **Theme 6: Use of CAF and the framework for the Assessment of Children in Need.**  
*Including ensuring all agencies make active contributions to assessments.*
- **Theme 7: Children and Young People - Self Harm and Suicide**

Development work based on these themes will for the focus of the LSCB's business plans.