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1

Foreword by the BSCB Vice Chair

As Vice Chair of the Bradford Safeguarding Children Board I welcome you to our 2014/15 Annual Report. Bradford is a diverse and vibrant city with a fast growing population. It also has its challenges: high levels of deprivation, child poverty, children with complex health and disabilities and the needs of newly arrived communities. Safeguarding children in the District is a high priority for front line staff in all agencies. I would like to thank them for the quality work that is undertaken with children and their families to keep them safe. There is also excellent engagement with the engine room of the Board – its sub-groups that drive the continuous improvement and practice development.

The Board and child protection services were inspected by Ofsted in 2014, the findings and areas for improvement are covered in this report. The Board was judged to be ‘Good’. Our focus has been on the core business of child protection which Ofsted said required improvement. We have seen an increase in the number of child protection investigations and the number of children on child protection plans has started to safely reduce with active work by the core groups working with the child and their family. Case conferences are being held in a timely way and we have taken opportunities to co-locate staff to improve the services to children.

There has been significant investment by the Council and West Yorkshire Police to increase capacity in social work teams and the child protection units. The oversight of missing children is organised and effective and staff are using intelligence and information-sharing to protect children at risk of child sexual exploitation (‘CSE’). Following the Rotherham enquiries, Bradford has strengthened its operational response to CSE and has been transparent and open investigating all historic concerns.

The Board promotes a learning culture across the partnership and has embedded the practice improvements following the Hamzah Khan serious case review. This includes a child focused single assessment for children and a non-engaging pathway to pick up families that may be falling through the net.
It has disseminated learning and improvement from the Ofsted inspection, internal reviews, challenge panels and the new continuous improvement tool – the Section 11 audit.

There has been a 12% increase in allegations against people who work with children, this shows increased awareness and twice as many referrals have been dealt with and closed compared to last year. Finally, this year the Board has invested in a safeguarding adviser to madrassahs and mosques and safeguarding children in all faith settings remains a high priority.

I hope you will better understand the complexity and quality of the safeguarding work in the District once you have read the rich detail in this report.

Julie Jenkins
Vice Chair of the Bradford Safeguarding Children Board

August 2015
2 The Safeguarding Children Context in the Bradford District

Bradford District has a diverse geography, with both rural and urban communities. The majority of the population live in the District's urban areas to the south of the District. The most recent Office of National Statistics population estimates for 2014 show that there are 528,155 residents in the District, of whom 152,592 (29%) are children and young people aged 0-19, making Bradford the youngest English city outside of London. Of these, 41,018 are aged 0-4 and 111,574 are aged 5-19 years.

The 2011 census showed that there had been an increase of over 20% in the number of 0-4 year olds since 2001. Over the next ten years the child population is projected to grow further. Most of the District's population growth is due to a high birth rate, with around 8,500 births annually in the District. This level of child population growth is having a profound impact on demands for education provision. Over the same period, the proportion of working age people is expected to decline slightly and the proportion of older people to grow to 19% compared to 16% at the moment, the England average is expected to be 25%.

Approximately a quarter of the District's citizens are from Black and Minority Ethnic (‘BME’) groups. However, amongst the 0-19 population BME children are just under half of the population and 39% of 0-19 year old children have a South Asian ethnicity. The majority of children with South Asian ethnicity are of Pakistani ethnicity (ONS, population projections 2011). The District has some newly establishing communities that are growing relatively quickly through inward migration. These communities are mostly of white ethnicities from Central or Eastern European countries, and include emerging Roma communities.
Parts of Bradford experience considerable deprivation, and Bradford is ranked as the 26th most deprived of 326 Local Authority Areas in England. The District has high levels of health and social inequality. Many inequalities show a link with deprivation, in general the worse the deprivation the worse the health outcomes for children, young people and families.

The 2012 child poverty rate (the most recently available) is 23.6%. This is 5 percentage points higher than the national average, meaning that just over 33,000 of the District's children live in relative poverty - that is, in households with less than 60% of average income. This is a level of income that creates difficulties in meeting unexpected costs or coping with emergencies. It is likely to be caused by a combination of low wages, higher than national levels of under-employment in many working households, and higher levels of unemployment.

Over half of children in poverty live in 8 out of 30 wards, concentrated in the inner city areas which have the highest and fastest growing child population. There are also pockets of deprivation in suburban and semi-rural wards. In 2012 the District’s child poverty rate was the third highest in the Yorkshire and Humber region, behind only Hull and North East Lincolnshire, and 4th highest in its ‘statistical neighbour’ group- a group of local authority areas with similar characteristics.

Between 2007 and 2012 the proportion of children in poverty in Bradford District who live in lone parent families increased from 48% to 60%. Children in poverty in the District are still more likely than children across the country to live in large families. In 2012, 29% (9,840) of children in poverty lived in families with 4 or more children compared to 21% nationally. In 2012, 20% of children lived in 'workless' households, compared to 15% of children nationally.

Service providers have reported that some migrants from Central and East European communities in particular are experiencing high levels of deprivation, with poor housing conditions, low-uptake of services and high levels of family and child poverty; the latter is unlikely to be fully represented in the child poverty statistics.

The District is forecast to have increasing numbers of children and young people with severe disabilities and long term health problems by 2018. In a January 2014 analysis, just under 20,000 children and
young people aged 0-25 with a disability or a Special Educational Need were known to services across the District. Of these, half (49%) have a White ethnicity and 43% have an Asian ethnicity. By type of Special Educational Need (‘SEN’), 70% had a learning need, 28% a social, emotional or behavioural need and 27% had communication needs (more than one type of need is recorded).

Half lived in high deprivation areas - specifically in 7 of the 8 wards with the highest levels of child poverty. The most recent 2013 Lifestyle survey of almost 10,000 pupils showed that more pupils who identified themselves as having SEN or a disability reported that they had experienced significantly more bullying and violence compared to the average for the District.

Approximately 500 young people are known to the District's young carers' support service. Of these, a third are caring for a parent with some form of mental illness (usually in a lone parent situation), a quarter care for a parent with a substance misuse problem, just under a third care for a parent with a physical impairment or a physical illness. Young carers are equally split by gender and are broadly representative of the ethnic makeup of the District.

The District has higher risk factors for babies both before and after birth than nationally. 15.8% of women smoke in pregnancy, and 8.5% of births are low birth weight (HSCIC, 2013) although this is in part due to the lower average birth weights for women from South Asian communities. Alcohol and substance misuse are more common in pregnant White women.

Bradford's infant mortality rate has reduced in recent years, but remains high, with 5.6 infant deaths per 1,000 live births in the three year period from 2011 to 2013, compared with 4.0 infant deaths per 1,000 live births across England. Encouragingly, the rate of infant mortality in the most deprived 20% of the population has reduced at a quicker rate, from 10.6 to 6.9 per 1,000 live births over the same period of time. Most deaths under 1 are due to perinatal/neonatal factors or chromosomal, genetic and congenital (inherited) anomalies.

Poor oral health is a problem for some children in Bradford, with the highest rate of child admissions to hospital for tooth decay in Yorkshire. Lack of dental care is recognised as a sign of neglect.
According to the 2013/14 National Child Measurement Programme, 21.6% of children in Reception year, and 36.4% of children in Year 6 are overweight or obese. More boys are overweight or obese, and the rates are higher in deprived areas.

There are 15,000 child admissions to hospital each year, of which 65% are emergency admissions. The District has a higher than regional and national rate of admissions to hospital for injury to children aged 0-14 in 2013-14.

Since 1998 Bradford's teenage conception rate has halved, and now stands slightly above the rate for England but slightly below the rate for Yorkshire and Humber.

Raising educational attainment remains a long-term priority for the District. The trend of slow improvement and narrowing the gaps with national attainment faltered in 2014 under the new system of reporting first rather than best results at GCSE, when GCSE results fell much more sharply in the District than nationally. Only 44% of pupils achieved 5 or more good GCSEs at grade A* to C including English and Maths, compared to 53% both nationally and for statistical neighbours.

In 2014, 55% of the District's 5 year olds were judged to have reached a 'Good Level of Development' in assessment at the end of their reception year in school compared to 49% in 2013, and compared to 60% nationally in 2014.

Approximately one fifth of school pupils are entitled to Free School Meals. At all stages of education the cohort of children who receive Free School Meals have on average lower levels of attainment than non-Free School Meal pupils. Attainment gaps between SEN pupils and their peers grow wider over their school career. There has been considerable progress to close educational gaps for children from many BME groups.

The Education Improvement Board coordinates school improvement activity, working closely with the Bradford schools partnerships for the primary and secondary sectors. The Health and Well-Being Board co-ordinates action through a Health and Well-Being Strategy that addresses six priorities for children and young people: infant
mortality; poverty; obesity and healthy eating; oral health; disabled children and parenting and early development.

The Children's Trust has an overall governance and co-ordination role for all the partnership activity across the District to improve outcomes for children. It is in this context that the local agencies work in partnership to provide services to safeguard the District's children and to promote their welfare. Each year, the Bradford Safeguarding Children Board produces detailed performance information and analysis which is summarised in section 3 of this annual report. This report contains management information and analysis about the partnership work of agencies in the District to keep vulnerable children safe and to address some of the factors that increase vulnerability within families.
3 Effectiveness of Safeguarding Children Performance Information

BSCB frequently monitors information and data regarding the performance of partner agencies in their work with the most vulnerable children in Bradford. This information is considered by the BSCB Performance Management, Audit and Evaluation Sub-group, which has a role in ensuring that BSCB has a thorough understanding of the effectiveness of services in keeping children safe in the Bradford District. This section of the annual report summarises the key performance information and analysis for the year 2014-15.

Any references made to national and regional comparator data is from 2013-14 as this remains the most recent available data. The Department for Education will produce a statistical release containing national and Local Authority level data for 2014-15 in Autumn 2015.

Performance Data Child Protection

Terminology

**Referral** - when a member of the public or a professional has concerns about the welfare of a child, a referral should be made to Local Authority Children’s Social Care Services, who have a duty to investigate any concerns.

**Section 47 (S47) Enquiry** – is a child protection investigation. Where a child is believed to have suffered or be at risk of significant harm, a strategy discussion takes place. Professionals from the relevant agencies will meet to decide whether to initiate a section 47 enquiry. This refers to an enquiry under section 47 of the Children Act 1989 and initiates further investigation. The social worker leads an assessment gathering more information from the child, parents, family members and other professionals in order to determine whether the child is in need or at risk of continuing harm. If the section 47 enquiries substantiate concerns about a child, a child protection case conference will then be convened.
Initial Child Protection Case Conference (ICPCC) - A child protection conference is held when a child is deemed to be at risk from significant harm following a section 47 enquiry to decide whether or not to make a child subject to a child protection plan. The conference should be attended by the child or the child's representative, child protection social workers, other relevant professionals who have been involved with the assessment process, and family members.

Child Protection Plan (CP Plan) - contains details of how Children's Social Care Services will check on the child's welfare, what changes are needed to reduce the risk to the child and what support will be offered to the family.

Child Protection Data – last 6 years

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>7547</td>
<td>5777</td>
<td>4712</td>
<td>4609</td>
<td>5246</td>
<td>5011</td>
</tr>
<tr>
<td>Section 47 Enquiries</td>
<td>1539</td>
<td>1534</td>
<td>1431</td>
<td>1844</td>
<td>1810</td>
<td>1938</td>
</tr>
<tr>
<td>Initial Child Protection Conferences</td>
<td>504</td>
<td>441</td>
<td>376</td>
<td>406</td>
<td>568</td>
<td>569</td>
</tr>
<tr>
<td>Child Protection Plans at year end</td>
<td>405</td>
<td>379</td>
<td>390</td>
<td>374</td>
<td>577</td>
<td>513</td>
</tr>
</tbody>
</table>

External factors and events in particular national and local serious case reviews (‘SCRs’) can influence the demands and pressures on Children’s Social Care Services. As with referral and child protection investigations, the number of initial child protection case conferences reached high levels in 2009 following the death of Baby Peter in Haringey. The numbers decreased during 2010-11 and 2011-12 but have risen significantly since then; during 2014-15 there were 569 children subject of an initial child protection case conference.
In 2014-15 there were 5011 referrals to Bradford Council’s Children’s Social Care Services (a decrease of 235 referrals compared to the previous year). This is a rate of 362.3 per 10,000 child population which is much lower than the national rate for 2013-14 (573 per 10,000). In November 2013, BSCB published the report of the Hamzah Khan SCR and this is likely to have contributed to the increase in referrals in 2013-14 compared to 2012-13.

When working with vulnerable children and families, it is important that professionals try to develop a prompt and accurate assessment of what help is required, from the start, at the point of referral to Children’s Social Care Services. One method of judging this is the number of children and families who needed to be helped repeatedly. The “re-referral rate” for Children’s Social Care Services in 2014-15 at 16.7% was very similar to 16.6% in the previous year and lower than the national average re-referral rate of 23.4% in 2013-14.

There has been a significant increase of an additional 128 children subject of Section 47 Enquiries in 2014-15 (1938 in total) compared to 1810 in the year before. Bradford’s rate of 140.1 per 10,000 child population is higher than the national rate of 124.1 in 2013-14. 29.4% of children subject of S47 Enquiries in the year were then progressed to initial child protection case conferences compared to 31.4% in the year before.

The number of children who were the subject of a CP plan in Bradford at 31 March 2015 was 513 (a decrease of 64 children compared to the previous year). Bradford’s rate per 10,000 child population was 37. This is lower than the national rate for 2013-14 (42.1).

The number of children who newly became subject of a CP plan during the year was 565, a decrease of 12 children compared to the previous year. Of these, 69 children (12.2%) became subject of a CP plan for a second time in their lifetime compared to 9.5% the year before. The national average in 2013-14 for this performance measure was 15.8%.

In the year, there were 618 children whose CP plans ended compared to 379 in 2013-14. Of these, the proportion that lasted over 2 years was 6.5%. This is compared to 5.1% in the previous year when the national average was 4.5%.
Neglect (48%) is the main CP category for children being subject of a CP plan at 31st March 2015. This is followed by emotional abuse (38%); physical abuse (9%); and sexual abuse (5%). There was almost an equal gender split amongst boys and girls.

Children from a black and minority ethnic (BME) background are under-represented in terms of being subject of a CP plan (32%), compared to 47% of BME children and young people in the District. However, this is still an increase compared to 30.5% from the previous year. There has been a decrease in the proportion of children from Eastern European countries subject of CP plans at 31 March 2015 (9.5%) compared to 15% at 31 March 2014.

The percentage of children subject of CP plans who had all their review meetings held within required timescales was 98.3%, up from 97.7% last year.
4 Safeguarding Children: Key Activity Areas

4.1 Children Who Go Missing

Annual Report on Children who go missing from Home or Care 2014 - 15

“Good, effective systems ensure that missing and trafficked children are identified and that risks become promptly understood and minimised….Children missing from home are routinely discussed at the CSE Hub and their situations assessed to identify their vulnerability to exploitation while they are missing.”

(Inspection of Bradford MDC services for children in need of help and protection, children looked after and care leavers, Ofsted 2014, para 44)

1) Introduction

There is now unequivocal evidence that children who go missing from home or care are at heightened risk: they face the possibility of becoming the victim of a range of crimes. There is also the danger that a young person who is missing can become involved in offending and become criminalised as a result of their experiences. The strong link between missing children and child sexual exploitation has been clearly established not least by enquiries following high profile prosecutions.

The reasons that children go missing are often complex and will involve a number of “push” or “pull” factors. That is why each missing incident needs to be understood within the context of a young person’s views, feelings and experiences.

This report will refer to the national guidance for agencies tasked to assist missing young people and then looks at the statistics around the performance of the multi-agency network that is responding to these children in Bradford.
2) **The National Context**

The national guidance for responding to missing children was updated and re-issued in January 2014. *“Statutory Guidance on Children who run away or go missing from home or care”* defines the roles and responsibilities of those agencies active in this field including Local Authorities, Local Safeguarding Children Boards, multi-agency partners (Police, Health etc) and the Voluntary Sector.

The guidance maintains that there are no reliable national figures for the number of children who go missing or run away, but estimates suggest that the figure is in the region of 100,000 per year. (Children’s Society, 2011). Children may run away from a problem, such as abuse or neglect at home, or to be somewhere they find more attractive than home or care for example contact with family or friends that they are not allowed to see. They may have been coerced to run away by peers or adults seeking to exploit them. Whatever the reason, it is estimated that approximately 25 per cent of children and young people who go missing are at risk of serious harm (ibid)

The national guidance is clear in its requirement that the response for children who go missing will be a significant component of future Ofsted inspection.

“... Section 13 of the Children Act 2004 requires local authorities and other named statutory partners to make arrangements to ensure that their functions are discharged with a view to safeguarding and promoting the welfare of children. This includes planning to prevent children from going missing and to protect them when they do. Through their inspections of local authority children’s services, Ofsted will include an assessment of measures with regard to missing children as part of their key judgement on the experiences and progress of children who need help and protection.”

According to the guidance, all local authorities must agree a protocol with the local Police service to determine the response to children who runaway or go missing from home or care (‘RMFHC’). This protocol should include neighbouring authorities to avoid boundary conflict as to who should respond to a child. Bradford has had a protocol in place for a considerable time and over the past year it has been revised and updated.
The new document is currently being launched and is in the process of being added to safeguarding procedures. It provides a clear definition of terms, details the risk assessment that is required should a child be RMFHC and what should be happening when a child returns having been away. It is a detailed and useful document.

There is a clear duty in the national guidance to actively listen to children’s experiences, to gain an understanding of their needs and understand the factors that made them go missing in order to prevent future missing episodes. Bradford’s professional network is set up to do this.

3) Missing in Bradford

The primary source of statistics for children who are missing is the Police. All children who are reported missing are included on a database that reflects the missing statistics for the whole year.

The well publicised child sexual abuse cases for example those in Rotherham, Rochdale and Sheffield have highlighted the vulnerability of missing children and this has led to a change in reporting practices. In the previous year’s children who were deemed to be unauthorised absent rather than missing did not feature in the return. This has now changed and even relatively short periods of absence are being included in the annual return. It therefore is a more accurate reflection of the missing situation in Bradford.

The system for responding to missing children has not changed substantially in terms of the agencies involved and their professional linkages since last year but there have been developments and a growth in resources. Additional Police staff have been provided both to oversee missing cases and to work directly with children’s residential units. This arrangement has provided a significantly improved response. There have been good examples where Police officers involved with a Children’s Home have been able to identify a missing young person, having previously met and spoken with them, and used Police knowledge of the local area to determine where they might go missing and as a result been able to recover them.
The Police now have in place three Missing Persons Investigators who are tasked with overseeing all live missing person investigations and linking with the local Neighbourhood Policing Teams and Safer Schools Officers. Since April 2014 the Police have been more proactive in respect of missing referrals. This has led to an increase in the number of recorded incidents but does not indicate a worsening of the situation. The increased number of referrals reflects an increased level of scrutiny and monitoring around missing incidents.

No specific agency is tasked with an overall analysis of the cohort of children that go missing in Bradford. Missing incidents tend to be looked at on a case by case basis. This is a developing picture particularly around the CSE issue where there are much more proactive strategies being deployed against those who would seek to exploit missing children.

The filtering and processing of the missing referrals to the Police is carried out by Barnardo’s Turnaround service. There have been issues with interruptions in the sharing of data between the Police and Turnaround; these appear to be related to staff availability and work is being done to resolve them.

Barnardo’s filter the missing reports and check against available records to determine if there is already any Children’s Specialist Services (‘CSS’) involvement. Any acute safeguarding issues should already have been picked up by Police officers responding to the child or young person having returned, however if there are still such concerns then referral will be made to CSS.

Children will be referred on for appropriate follow up from a range of agencies including Prospects, The Hand in Hand Project (Children’s Society), and Turnaround Project itself. All of the children who appeared in the missing return from 2014/5 received follow up to establish the reason for them going missing and to try to prevent further episodes.
4) Missing Statistics 2014-15

Where children were previously deemed to be unauthorised absent there was no requirement for the Police to record these therefore the missing return was much lower for example in 2012/13 this totalled 232 referrals. When unauthorised absences were included the missing return at the end of 2013/14 rose to 435.

The current total includes for example referral for a 10 year old child who was missing for a total of 55 minutes or a 14 year old child missing from her adoptive home between 7:00 p.m. and 9:30 p.m. The growth in the number of referrals is an indication of the degree of vigilance.

Closer analysis of this year’s figures shows that the relatively small group of children who go missing on multiple occasions generate a large percentage of the referrals. For example in quarter 1, April to June, 23 children accounted for 45% of the referrals that is 21 children out of a total of 103, under a quarter of the children involved generating nearly half of the referrals. This pattern is repeated in the other quarters in Jul – Sep, 22 children generated 42% of the referrals, in quarter 3 25 children generated over half 51% of the referrals.

**Missing Statistics 2014-15**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Missing Referrals</th>
<th>Children Involved</th>
<th>No of Children in care(% of total referrals)</th>
<th>Children missing multiple times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-Jun</td>
<td>138</td>
<td>103</td>
<td>23 (22.3%)</td>
<td>21</td>
</tr>
<tr>
<td>Jul -Sep</td>
<td>168</td>
<td>108</td>
<td>28 (25.9%)</td>
<td>15</td>
</tr>
<tr>
<td>Oct - Dec</td>
<td>204</td>
<td>131</td>
<td>29 (14.2%)</td>
<td>24</td>
</tr>
<tr>
<td>Jan - Mar</td>
<td>199</td>
<td>185</td>
<td>53 (26.6%)</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>709</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Clearly effort needs to be focussed on looking at the repeat referrals especially where we have children running away from care placements on multiple occasions.

### Missing Statistics 2013-2014

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Missing Referrals</th>
<th>Children Involved</th>
<th>No of children in care (% of total referrals)</th>
<th>Children missing multiple times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr- Jun</td>
<td>77</td>
<td>60</td>
<td>11 (28.6%)</td>
<td>8</td>
</tr>
<tr>
<td>Jul - Sep</td>
<td>128</td>
<td>107</td>
<td>23 (33%)</td>
<td>13</td>
</tr>
<tr>
<td>Oct - Dec</td>
<td>75</td>
<td>52</td>
<td>13 (41.3%)</td>
<td>8</td>
</tr>
<tr>
<td>Jan-Mar</td>
<td>155</td>
<td>115</td>
<td>23 (36.1%)</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>435</strong></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

5) **Links to the Child Sexual Exploitation (CSE) Hub**

There is now considerable evidence that co-locating professionals from key-agencies is effective in sharing information, planning and acting to protect children and young people and in securing evidence to prosecute offenders. Bradford has learned from other authorities in the development of its own multi-agency co-located team.

The team, known as “the Hub” is a single point of contact for all agencies to refer concerns they have about children who may be at risk or to share information about potential offenders. The main focus of the team is to reduce the threat and risk to the victim. This is achieved by having a multi-agency personalised plan for every child at risk. The plans have a specific focus on safeguarding and promoting the welfare of the child or young person and supporting her or him through the criminal justice system. The plans will address the need for therapeutic and support services for children and young people, after the abuse has stopped.
The co-location of the key partners including the Police, Children’s Specialist Service, Voluntary Sector service (e.g. Barnardo’s, BLAST) and health allows for the flow of information to build up a comprehensive risk assessment of a child and the creation of a plan to safeguard them.

5) Honor & Ben: a good practice example

Honor and Ben are unrelated, live in different areas of Bradford and attend different schools. Turnaround received separate missing reports for both Honor and Ben. When the Turnaround Missing Persons Coordinator read the reports sent by the Police she identified that both children had gone to a flat where a woman who was known to the Hub and involved in CSE lived. Honor was visited by the Misper Coordinator and as a result, a safeguarding referral was made to Children’s Social Care (CSC). Honor was living at home with her mum and younger siblings but relationships had broken down. Honor had been arrested for assaulting her Mum when she returned from a missing incident. A Police Protection Order had been placed on Honor and Mum refused to allow her to return to the family home. Through CSC intervention Honor was placed with her Grandma and Turnaround initially supported her through 1-1 work. Honor then joined a group which was also attended by Ben. Both young people participated and fully engaged in the group and had no further missing incidents. Neither of the young people went to the woman’s flat again and Honor and her Mum received support from CSC Placement Support. Honor is now back in school and her relationship with Mum has greatly improved.

The example illustrates how a range of agencies working together sharing information and intervening in an integrated manner can obtain good outcomes for children.
6) Missing alerts from Bradford District Care Trust (BDCT)

The BDCT has a robust procedure for picking up on children who go missing from their service

Missing alerts between 01/04/14 - 23/03/15

33 missing alerts were circulated. 13 of these children/families have been found.

For children who are subject to a Child Protection Plan or for whom there is Children’s Social Care Services involvement, the named Social Worker will be contacted as soon as possible and the records and case responsibility will be maintained by the Health Professional until they are located. (Any national alert will be the responsibility of the Local Authority.)

For children and families who are missing from their last known address or children who have gone missing from school BDCT staff visit the last known address and try to make contact with family via any available phone numbers. Following this, liaison to take place with other appropriate professionals involved to check address/whereabouts for example: Health Visitors, School Nurses, GP’s, Paediatricians, Children Centre’s, Education and Safeguarding Children’s Team.

For children under school age the Health Visitor will retain the records and do three monthly checks for a period of twelve months. After the twelve month period the GP and appropriate professionals will be informed and Child Health notified. For school age children the School Nurse will retain the records and undertake three monthly checks for a period of twelve months. School Nursing Teams have robust working arrangements with the Educational Social Work Service to complete checks and a process for geographical cover is now in place for children who are Missing from Education, receiving Elective Home Education (parent/carer) or being Home Tutored.
After the twelve month period appropriate professionals will be informed and Child Health notified. Where there are Safeguarding concerns a Health Alert will be circulated by The Children’s Safeguarding Team (BDCT). This alert is recorded in SystmOne, to which all GP’s have access. Also the Named Nurses at Bradford and Airedale Hospitals, Paediatric A&E Liaison Nurses and Midwifery Services are alerted.

7) Children Missing Education

All Local Authorities have a statutory duty under Section 436A of the Education and Inspections Act 1996 to make arrangements to enable them to establish (so far as it is possible to do so) the identities of children residing in their area who are not receiving a suitable education.

These measures are also in place in order that children are safe from harm. Going missing from education for any reason is damaging to the well-being of a child/young person, but of even more concern is when the disappearance from school is an indication that a child/young person’s safety is at risk. The Local Authority also has a duty to have in place robust procedures to track and trace children who go missing with their families from Bradford schools.

Bradford Children Missing Education Procedures were devised to ensure that this responsibility is being robustly discharged. A detailed description of the system for recording and tracking this group of children is appended to this report.

The Out of School Register records the details of all known pupils missing from education in one of four referral categories until they have been introduced to an appropriate education provision.

The referral categories are:

- **Missing Children** – pupils who have gone missing, with their families, from Bradford Schools.
- **Not on Roll** – pupils who have been identified as living in Bradford but not on the roll of a school.
- **Removed from Roll** -having failed to return following a period of Leave of Absence or Extended Leave of Absence.
Other Local Authority referrals – The Education Social Work Service regularly receive referrals from other LAs informing them of pupils who have or may have moved into the Bradford area.

<table>
<thead>
<tr>
<th>Referral reason</th>
<th>No. of Referrals 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing Children</td>
<td>1080</td>
</tr>
<tr>
<td>Not on Roll</td>
<td>792</td>
</tr>
<tr>
<td>Removed from Roll</td>
<td>172</td>
</tr>
<tr>
<td>Other Local Authority referrals</td>
<td>82</td>
</tr>
</tbody>
</table>

8) Prospects/Connexions

The filtering system described above re-directs work for 13+ children where there is no immediate safeguarding issue and the children require follow up to Prospects (formerly known as Connexions). Prospects collect extensive service user data as part of their work and have provided a comprehensive breakdown of their cohort.

![MISPERs report by month from April 2014 to March 2015](image)

Prospects Personal Advisors are based in both mainstream school secondary schools and Pupil Referral Units. They offer both one-to-one support as well careers guidance to young people.

Personal advisors are able to follow up any missing person’s referral they receive and operate to a protocol of initial follow up within 5 working days. Prospects have advisors in outreach roles who are able to see young people at home during the day or evening.
Missing persons interviews highlight to the individual young person the risk factors that they face and where applicable are used to signpost them to additional support services.

**9) ‘Missing’ Group Quarterly Meetings**

The missing group quarterly meeting involves representatives from all of the key agencies working to safeguard missing children including Children’s Specialist Services, the Police, the Children’s Homes, Barnardo’s Turnaround Project, Education Social Work, the Children’s Society Hand in Hand Project and Prospects.

This meeting was held regularly throughout 2014/15 and was used to allow the agencies to raise issues around service delivery. It also has taken on the role of reviewing a sample of cases from the missing return to look at case management and the outcomes for children.

In the last quarter Turnaround project have designated specific staff to look at the overall missing return to analyse it for trends and indications as to how best to address the problem in future. It should also be noted that Missing figures will now be included in the Bradford Safeguarding Children Board’s Multi-agency Performance Dataset which will ensure that there is increased monitoring of this issue.

**Conclusion and Recommendations**

In summary, there is good evidence that the response to children who go missing in Bradford is organised, effective and focussed and there are sound links between the key agencies working to safeguard such children. The co-location of a number of services as part of the CSE Hub has had a major benefit in that it allows the agencies to pick up on children going missing and make a judgement early on as to whether there are child sexual exploitation issues that need a response. The concentration of staff at Sir Henry Mitchell House from the police, voluntary sector and children’s services will further strengthen this process.
All of the children who were reported as missing to the police in the year 2014-15 received a follow up response ranging from a letter to the family home offering support and advice to a full team around the child (TAC) planning process.

Changes in reporting practices and increased awareness of the significance of missing incidents have increased the number of children that are included in the missing return from the year with the reporting strategies agreed for children contributing to this increase.

Small numbers of young people who run away repeatedly generate a large percentage of the missing referrals.
Recommendations

The following will be reflected in the Missing Group’s work plan for 2015-16

1. To make more extensive enquiries regarding return interview to ensure that any relevant learning is picked up and communicated out to agencies working with missing children.

2. To ensure that the Missing Group continues to improve the professional links between the range of agencies working with these children.

3. That the Missing Group is involved in updating the e-learning package on missing children in the light of updated guidance and the new missing protocol and assists in the promotion of the package to all Children’s Services staff once it is completed.

4. To require the Missing Group to continue to regularly analyse random sample’s from the missing children cohort to determine that the response and follow up for such children is robust and to ensure that any learning is circulated out Children’s Services.

5. To develop best practice guidance and standards around CSE and missing children for LAC and YOT health teams. To ensure that these issues are included in the statutory health plans for these children.

Frank Hand
Service Manager
Safeguarding and Reviewing Unit
4.2 Safeguarding Looked After Children

Independent Reviewing Officer Annual Report April 2014 – March 2015

1. Purpose of Service and Legal Context

1.1 The appointment of an Independent Reviewing Officer (‘IRO’) for a child or young person looked after by a Local Authority is a legal requirement under s.118 of the Adoption and Children Act 2002.

1.2 The IRO Handbook, regulations and statutory guidance for IROs, came into force in 2011, to improve care planning and strengthen the role of the IRO. The responsibility of the IRO has changed from the management of the review process to a wider overview of the individual child’s care including regular monitoring and follow-up between looked after child reviews. This has increased the importance of mid review checks and processes. The IRO has a key role in relation to the improvement of Care Planning for Children Looked After and for challenging drift and delay.

1.3 There have been several research studies undertaken to look at whether the care planning and review system is effective and whether IROs make a useful contribution to bringing about positive change for children; change that secures the best possible outcomes for them.

1.4 The University of East Anglia (‘UEA’) undertook such research which included a study of case files on a total of 122 children, plus interviews and focus groups with social workers, IROs, parents and young people, and a national survey of IROs, social work managers and Cafcass children's guardians.
Key messages from the study regarding the IRO role:

- Review recommendations should be ‘SMART’ and followed-up.
- IROs have generally become more active and interventionist.
- Social workers and team managers usually valued the input of IROs, even when they found it challenging.
- Social workers generally welcomed informal advice and monitoring; most IROs thought that they were effective at working in these collaborative ways, to improve practice.
- Local authorities, and ultimately the children and young people in their care, will benefit if well-supported IROs have effective channels to feed in collective concerns and influence policy development.

1.5 Broadly, the results of independent audit by Ofsted and by independent research supported the view that the IRO service does not need to sit outside mainstream children’s services to operate in a truly independent capacity. The UEA research concluded that IROs can help to achieve positive change for children, sometimes through formal challenge, but more often in more subtle and collaborative ways.

1.6 In terms of changes in the legal framework with regards to the IRO role, the February 2012 Family Justice Review stated there should be reduced court scrutiny of care plans by the courts – linked to increase in the role of the IRO. Courts should refocus on the core issues of whether children can remain safely in the care of parents or whether alternative provisions are required. In determining whether a care order is needed or not the court should reduce its scrutiny of the detail of the care plan. This reduced role is mirrored by the enhanced role of the IRO. In Bradford we still operate our unique policy of ensuring every child’s proposed court care plan is ratified by the IRO at a decision making review before submitting to court.
The judiciary further identifies that to avoid drift the IRO should:

- Monitor child’s case rather than simply monitoring progress in relation to reviews
- Effective liaison with SW team and other key professionals, including Cafcass
- IROs need to have all relevant information in order to effectively manage a child’s case
- Speaking to the child or young person, where appropriate, and obtaining their views
- LAC care plan must include a plan for permanence from the second review onwards

2. Profile of the IRO Service in Bradford

2.1 Currently Bradford employs 13 IROs, 10 full-time and 4 part-time (11.2 FTE). The teams are all experienced practitioners with 5 years post qualification experience as required by the IRO Handbook.

2.2 A new IRO Manager was appointed on the 4th August 2014 to offer consistent support and management to the team through supervision, practice observation and yearly appraisals. This is to drive and achieve the same good performance and efficient service delivery the team has produced previously. They attend the divisional management meeting group which acts as a good interface between senior management and the IRO service.

2.3 A development day training workshop took place in October 2014. This included a tight focused agenda covering key priorities set by the team. The feedback has been very positive. (See under section 5 Supervision & Training in this annual report).

2.4 There have been some changes to the team over the year. One of the IROs was successfully appointed as a Team Manager in January and another retired.

2.5 The service undertook two IRO recruitments successfully appointing 2 Full Time and 1 Part Time workers to the team. There are now 7 females and 6 male IROs. The service has
appointed a south Asian female in the latest recruitment which adds to the diversity to the team.

2.6 In December 2014, the Safeguarding & Reviewing unit moved location to Sir Henry Mitchell House. This location change also involved moving onto flexible and new ways of working. All the team completed the relevant flexible working contract agreement and protecting information Level 1 data breach online training. The team has adjusted well to the new mobile arrangements. It has led to changes in diary management and IROs will use touch down points and increased working from home to undertake admin duties.

3. Quantitative Information about the IRO Service in Bradford

3.1 Looked After Children’s Population over 2014/15

<table>
<thead>
<tr>
<th>CARE STARTED / CEASED AT 31 MARCH 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Children who have Started to be Looked After</td>
</tr>
<tr>
<td>Total Number of Children who have Ceased Care</td>
</tr>
</tbody>
</table>

As we can see from the above figures, the number of children who have ceased to being looked after is almost the same as the number of children becoming looked after, a difference of 7. Children’s Services had 294 children becoming looked after where as in the previous year it was 318, a reduction of 7%. Children leaving care is 301, where as last year it was 327, a reduction of 8%.

3.2 In terms of the total number of LAC children, it is relatively constant throughout the year; 881 at the start and 878 at the end of the year. This reflects the consistency in thresholds, planning & review process throughout the year.
3.3 In comparison to the previous year, the number of LAC children stayed static, the same number as 31\textsuperscript{st} March 2014, 878. The number peaked around August and September with 909. In the previous year there was a peak in September 2013 with 895 LAC children. This seems to correlate with children returning back to school. It is common for contacts and referrals to increase at the beginning of the school year and often vulnerable children and families have reduced contact with agencies over the summer holiday period.

3.4 Age and Gender of the Looked After Population

The gender split of the LAC population is fairly even at 460 boys and 418 girls. All young people cease to be looked after at 18. Our lowest number of LAC children age range is under 1 for both girls and boys. It can be seen below that the older children will remain in care longer where as permanency plans such as adoption and SGO are more achievable with younger children.
### AGE AT 31 MARCH 2015

<table>
<thead>
<tr>
<th>BOYS</th>
<th>GIRLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1: 23</td>
<td>Under 1: 22</td>
</tr>
<tr>
<td>1 - 4: 81</td>
<td>1 - 4: 70</td>
</tr>
<tr>
<td>5 - 9: 108</td>
<td>5 - 9: 91</td>
</tr>
<tr>
<td>10 - 15: 170</td>
<td>10 - 15: 170</td>
</tr>
<tr>
<td>16 - 17: 78</td>
<td>16 - 17: 65</td>
</tr>
<tr>
<td>18 &amp; over and placed in a community home: 0</td>
<td>18 &amp; over and placed in a community home: 0</td>
</tr>
<tr>
<td>TOTAL BOYS: 460</td>
<td>TOTAL GIRLS: 418</td>
</tr>
<tr>
<td>TOTAL ALL CHILDREN LOOKED AFTER AT 31 MARCH:</td>
<td>878</td>
</tr>
</tbody>
</table>

In the previous year the total number for boys was almost identical at 458 and 420 for girls. The most popular age range was also 10 – 15, slightly down from this year at 319. Under-1 was again the least number with very similar numbers, 42 and 45. The trends are very similar across the 2 years.

#### 3.5 Category of need for children looked after at 31 March 2015

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or neglect</td>
<td>747</td>
</tr>
<tr>
<td>Disability</td>
<td>18</td>
</tr>
<tr>
<td>Parental illness or disability</td>
<td>7</td>
</tr>
<tr>
<td>Family in acute stress</td>
<td>37</td>
</tr>
<tr>
<td>Family dysfunction</td>
<td>52</td>
</tr>
<tr>
<td>Socially unacceptable behaviour</td>
<td>5</td>
</tr>
<tr>
<td>Low income</td>
<td>0</td>
</tr>
<tr>
<td>Absent parenting</td>
<td>12</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>878</td>
</tr>
</tbody>
</table>
As can be seen from the above figures, abuse and neglect is still the main category of need and the reason for our initial involvement. It is actually 85%, a reduction of 2% from last year’s figure of 87%.

3.6 Legal Status of our LAC Population for 2013 - 2015

<table>
<thead>
<tr>
<th>LEGAL STATUS AT 31 MARCH  2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Orders:</td>
</tr>
<tr>
<td>Interim</td>
</tr>
<tr>
<td>Full</td>
</tr>
<tr>
<td>Voluntary agreements under S.20 (single period of accommodation)</td>
</tr>
<tr>
<td>Freed for adoption</td>
</tr>
<tr>
<td>Placement Order</td>
</tr>
<tr>
<td>On remand, committed for trial, or detained</td>
</tr>
<tr>
<td>Emergency orders or police protection</td>
</tr>
<tr>
<td>TOTAL:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEGAL STATUS AT 31 MARCH  2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Orders:</td>
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</tr>
<tr>
<td>On remand, committed for trial, or detained</td>
</tr>
<tr>
<td>Emergency orders or police protection</td>
</tr>
<tr>
<td>TOTAL:</td>
</tr>
</tbody>
</table>

The percentage of children with adoption being pursued as a permanency plan is 93 out of a total of 878, 10% at 31st March 2015. From the two tables we can see an increase of 33 in the children subject to Interim Care Order. This increase in proceedings will have
an impact on front line assessment and Children and Families teams. Placement orders have reduced over the two years which could be due to pursuing more options within the family and Special Guardianship Orders as a permanency plan.

3.7 Children Placed Outside of Local Authority Area

The number of children and young people being placed out of the district, in March 2014 was 182. The figure this year at 31st March 2015 is 191. It is a slight increase and Bradford has identified the need to recruit more in house foster carers. Children placed outside the area are entitled to and receive the same review service as all our LAC children. This includes an allocated IRO who will monitor the ongoing care planning arrangements for the child and the undertaking of formal review meetings within the statutory guidance as reported in the IRO handbook. This compares favourably with the statistical and England averages of 14.4% and 13%. Bradford is ranked 36th best performing Local Authority out of 152 Local Authorities.

4. Qualitative information regarding the IRO service.

4.1 IRO – Case loads / Review Process

![IRO Average Caseloads](image-url)
The average caseload range over the year was 80 per full time IRO on 1st April 2014 to 79.8 per full time IRO on 31st March 2015. The peak was in September at 82.6 cases with lowest being December 2014 at 79.4.

The average IRO caseload is still in the 80 – 90 range, which is still higher than the recommended number by the IRO handbook 50 - 70. The service has undertaken recruitments and increased the size of the team to address the volume of work. This has considerably reduced the average case load. We are confident that the changes in court time scales and better permanency planning for sibling groups will further have a positive impact on reducing our LAC population.

IROs do not currently have any other specialist role such as in other authorities in the region. The service is very confident that we can continue to deliver a quality service according to the regulations.

4.2 Timeliness - target performance achieved 97%

This year our performance for reviews on time is 97%. This has exceeded the performance target and is an improvement on last year which reflects the hard work undertaken by the team ensuring reviews are completed in the recommended time scale. A continuation of a high number of reviews being held on time indicates the quality of the service this team delivers. There were 2430 LAC Review meetings held in 2014-15 in respect of 1065 children, which give the 97% figure. This will include care proceedings, complex cases and adoptions where a child can have several reviews over the year.

To monitor and maintain good timeliness performance, IROs are instructed to continue adhering to the standards of practice guidance where review meetings are booked in at 2.5 and 5 month intervals. This will continue to give some flexibility to rearrange meetings at last minute cancellations. IROs report that the primary reason for missing time scales is due to the unavailability of social workers or carers.

4.3 Participation

The voice of the child should be central to the reviewing process and Ofsted inspection focuses specifically on how well this has been achieved. Good practice relies on the professional’s ability to engage children in the assessment, planning and review process. To
communicate effectively in a language that is child friendly. To explain the role of the IRO, the team have individual profile introduction sheets to give to the child. Our participation strategies include speaking to the child before the meeting, ensuring that not only does the child see the benefit of attending the review but they do grasp the concept of it being a meeting about them. Child centred practices such as consultation with the child on who should be invited and having an input in setting some of the agenda is also encouraged. Where possible, often the IRO will allow the child to co chair parts of the meeting.

The IRO Handbook states,

“The review is the child’s meeting (see paragraph 3.29) and discussion should take place between the social worker and the child at least 20 working days before the meeting about who the child would like to attend the meeting and about where the meeting will be held. This allows time for subsequent discussion about attendance and venue between the IRO and the social worker and for written invitations to be sent out.”

There are a number of different ways that a young person can participate in the review. Some will simply attend and give verbal feedback. There are situations where young people avoid meetings where they are faced with adults and professionals. They may nominate a person to advocate on there behalf or complete the online Viewpoint questionnaire.

Once again, the outcome for participation from last year has improved increasing from 85% to 89.6% this year.

4.4 Viewpoint

Viewpoint Interactive is a computer based consultation tool used for obtaining the views of children and young people in preparation for their Looked After Children reviews. Children and young people using Viewpoint can do so via the internet or a laptop computer using a unique login ID allocated to them. They complete an age appropriate questionnaire interactively and a report is then produced for their LAC review.
Viewpoint Performance

<table>
<thead>
<tr>
<th>Number of reminder letters sent for LAC Reviews (April 13 - Mar 14)</th>
<th>Number of Questionnaires completed</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1165</td>
<td>645</td>
<td>55%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of reminder letters sent for LAC Reviews (April 14 - Mar 15)</th>
<th>Number of Questionnaires completed</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1158</td>
<td>595</td>
<td>51%</td>
</tr>
</tbody>
</table>

Completion figures 2014-15

<table>
<thead>
<tr>
<th>Questionnaire Age Group</th>
<th>Questionnaires Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAC Review (Unaccompanied Minor)</td>
<td>1</td>
</tr>
<tr>
<td>LAC Review 10 to 15</td>
<td>329</td>
</tr>
<tr>
<td>LAC Review 16 plus</td>
<td>49</td>
</tr>
<tr>
<td>LAC Review 4 to 6</td>
<td>75</td>
</tr>
<tr>
<td>LAC Review 7 to 9</td>
<td>141</td>
</tr>
<tr>
<td>Total</td>
<td>595</td>
</tr>
</tbody>
</table>

The Viewpoint questionnaires have scaled questions to provide aggregated data regarding the effectiveness of the Looked After system. The IROs will have sight of these questionnaires before the review meeting. For example a child expressed a wish to be able to remain long term with current short term approved carers. The IRO opened this up for discussion at the meeting which eventually led to the carers being approved as a long term placement.
4.5 Viewpoint Evaluation

- The most successful return is from the 10-15 range which is also the largest category of our LAC children’s population. Questionnaire completion is slightly down from last year from 55 to 51%. We attribute this to problems in accessing the database over the summer & changes in the reminder process.
- Viewpoint is a good and effective tool when used appropriately. Most children and young people like using it and IROs found that it was effective in helping children and young people contribute to their LAC reviews.
- Viewpoint is a very cost effective and efficient means of consulting with children and young people.
- Viewpoint can provide aggregate data reports which can be used for service planning.
- Viewpoint Questionnaires have been regularly updated with input from the children in care council.
- There is a task & finish group to develop a young person’s app which will go on mobile platform with a reminder and link to viewpoint.

4.6 Quality Assurance of the IRO Service

The IRO has a statutory duty to monitor the performance of the local authority functions as a corporate parent for the children in looked after and to resolve problems arising out of the care planning process. Challenge and resolution are an integral part of the IRO role.

Ideally resolution processes are there to resolve any problems at the lowest level and as quickly as possible. Through the process the IRO should be able to demonstrate to children that they are taking action on their behalf and they should be able to evidence their own work in resolving the issue.
4.7 Aims of Quality Assurance

- Strengthening families & improved outcomes for children.
- Continuous service improvement.
- Evidence delay in timely outcomes for children subject to Child in Need, Child Protection or LAC plans.
- Identify trends and themes across teams.
- Improve performance & identify excellent practice

A challenge and dispute resolution process is included as a standard agenda item within supervision and the IROs appraisal over the course of the year.

The IRO Team Manager is to introduce a Quality Assurance process linked into the integrated children’s system which is the primary database for Children’s Specialist Services. This will enable our service to capture the effective subtle manner in which IROs achieve efficiency and better planning through collaboration, informal discussions which is often left unrecorded.

Using our regional partners agreed terms of reference for QA we have began to develop our own system. This will hopefully involve the implementation of a recording element within our own Liquid Logic database where IROs can raise challenge of good and bad practice. It will involve initiating a QA communication around issues of concern which can be automatically sent to social workers and managers with a set time scale for response.
Workflow Process of Quality Assurance

In essence it will enable a formal recording of the informal challenges IROs do regularly in there role which will sit on the child’s file. The system can then report on any of the following, challenging poor assessments, poor care plans, drift and delay, health and dentist appointments not within time scales, personal education plans not completed, social work visits not undertaken.

4.8 Over the course of the year all the IROs have been observed and assessed by their manager. IROs were all very familiar and efficient with there pre meeting processes. They adhered to the requirements of the handbook by checking the child’s file, speaking to the relevant social worker and professionals before the meeting, validating the accuracy and quality of the pre meeting report and checking all other important documents such as a completed Viewpoint questionnaire, placement reports etc. IROs also demonstrated a wide range of skills in the meetings. Good conflict resolution, active listening, child participation and good time management were observed. This will continue in 2015-16.
4.9 Problem Resolution and Escalation

The IRO Handbook requires that every Local Authority should have a dispute resolution process in place that encompasses informal and formal resolution which is accessible to children/families/staff. The dispute resolution process should offer a continuum for resolving issues through informal and formal resolution processes. IROs should feel supported and confident in challenging. In Bradford, the first stage of escalation is to issue an IRO alert. This is a formal document that requires a management response.

Outcomes from disputes should inform strategic planning with a clear view to improving service delivery. During the year the team has collectively issued 34 IRO alerts, this is an increase from last year where 28 alerts were issued.

These covered the following Alert code areas and some alerts covered more than one code:

<table>
<thead>
<tr>
<th>Alert Code</th>
<th>Definition</th>
<th>No of Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Preparation for Child Care Review</td>
<td>10</td>
</tr>
<tr>
<td>A2</td>
<td>Non-completion/failure to meet time scales in review decisions</td>
<td>8</td>
</tr>
<tr>
<td>A3</td>
<td>Assessment</td>
<td>3</td>
</tr>
<tr>
<td>A4</td>
<td>Lack of Comprehensive Care Plan by the 2nd Review</td>
<td>3</td>
</tr>
<tr>
<td>A5</td>
<td>Lack of Evidence of Corporate Parenting to meet the Care Plan</td>
<td>10</td>
</tr>
<tr>
<td>A6</td>
<td>Permanency Planning within timescales</td>
<td>3</td>
</tr>
<tr>
<td>A9</td>
<td>Education provision / PEP</td>
<td>5</td>
</tr>
<tr>
<td>A10</td>
<td>Placement choice and/or standard of care</td>
<td>1</td>
</tr>
<tr>
<td>A13</td>
<td>Safeguarding Concerns</td>
<td>1</td>
</tr>
<tr>
<td>A14</td>
<td>Lack of child/young persons participation</td>
<td>1</td>
</tr>
<tr>
<td>A15</td>
<td>Other</td>
<td>10</td>
</tr>
</tbody>
</table>
It shows that the 3 most significant areas for formal alerts have been A1 – preparation for child care review, A5 – Poor care plans and A15 other which included things such as poor communication, ICS records not updated, child’s views not obtained etc.

5. Supervision and Training

5.1 There is a supervision contract with all of the IROs before commencing formal supervision. This clarifies supervision arrangements, 6-weekly minimum schedules for full time IROs and the outline agenda that will be used. Challenge and complex case discussion is a set, regular agenda item as identified in the IRO handbook and National Children’s Bureau research.

5.2 The IROs performance around the Standards of Practice has been audited closely and performance is improving.

5.3 An IRO Development Day took place on 29th October 2014. The agenda included looking at a new Quality Assurance process and the impact on service delivery, legal implications and impact for the IRO, Pre meeting report criteria and Participation.

5.4 The Development Day has been instrumental in achieving the following work streams and areas of change for our service;

▪ Agreement to pursue the development & implementation of a QA process.
▪ Agreement to visit all new looked after children over the age of 7 before the second review.
▪ Task and finish group to look at relevant information required for the new Bradford single assessment pre meeting report.

5.5 The IRO team has contributed to the development of the single child assessment as a multi functional pre meeting template to inform LAC and CP reviews. The manager has been directly involved in its development and delivered training.

5.6 Following our last Ofsted inspection it was agreed that LAC and CP review timescales should be used as an automatic time frame to update children’s assessments and that these very same templates could be used as pre meeting reports.
Assessments have been modified to include sections for the sole purpose of our LAC reviews. Guidance notes to sit in the form to advise the allocated workers on what information is required for the meeting.

5.7 The IRO team has also contributed to other work streams through the year. The team also contributed to the placement stability action plan where we looked at ways to achieve better stability and less placement disruption for our LAC children. The team also contributed to the changes in the consultation forms for parents and carers. More recently a new member of the team has agreed to be a part of the task and finish group looking at changes in children’s residential setting inspections and the impact for practitioners and the wider services.

The IRO team had demonstrated over the year a willingness to contribute and get involved with other areas of the service alongside maintaining its independent identity.

6. Summary / Key Priorities for the Year

1. The service will continue providing the same high quality service with good performance on timeliness and participation of children and young people. This will be driven by consistent supervision and performance monitoring using collated data.

2. To continue to develop a Quality Assurance process in line with the agreed terms of reference set by our regional group to capture informal challenge within our database. This will hopefully then report on patterns and trends of challenge by specific IROs in relation to specific service areas, social workers and teams. This new reported information can then be used to improve service deliver and standards.

3. One of the key priorities identified in the appraisal of the IROs is to drive more placement visits. Even though the expectation of the handbook is that IROs speak to children before the review which our participation data evidences it is also recognised as good practice where possible to visit children in there placement. We have already begun to drive this for our most vulnerable children who are placed in residential homes.
A member of our team is on the task and finish group looking at the impact of the revised Ofsted inspections of our residential units on practitioners and residential staff.

Our database shows that in 2013/2014 IROs had seen the child 345 times and we are happy to present that the figure for this year’s recordings is 401. We want to continue improving this figure.

4. The Safeguarding and Reviewing Unit is planning to contribute to the Children’s Services improvement agenda. Our contribution will be to present collective performance data, update on Quality Assurance and also inform practitioners and managers of the expectations of a good review process. It will be very effective in demonstrating to newly qualified workers and reminding existing ones of their responsibilities and role. We will also cover the use and evaluation of the Bradford single child assessment as a pre-meeting report for our CP and LAC meetings.

5. Our Viewpoint system for child participation and consultation is under review. Alongside the user group another work stream has been organised to look at the functionality and capability of the system. This will hopefully enable more robust, streamlined reporting of trends associated with our LAC children.

6. We have a further IRO development day scheduled for October 2015. This will once again be a structured day set aside to address key priorities identified by the team.

7. The IROs are also committed to participating in the regional practitioner’s forums and it has been agreed that we will facilitate one of these meetings later on in the year.

8. The service will continue to work closely and effectively with our partner agencies, health, education, police, voluntary sector and Cafcass.
9. IROs contribution to reducing the number of LAC children will be to continue reviewing our children with a commitment to avoiding drift and delay, both in the formulating and implementation of appropriate plans. IROs will ensure that discharge plans and tasks are addressed within the necessary timescale. The IRO will ensure that permanency options within the family have been exhausted before considering long term local authority care.

Imran Cheema
IRO Team Manager
4.3 Allegations Against People Who Work With Children

Annual Report of Allegations Against Staff, Carers and Volunteers Working with Children

“Local authorities should have designated a particular officer, or team of officers (either as part of multi agency arrangements or otherwise), to be involved in the management and oversight of allegations against people that work with children. Any such officer, or team of officers, should be sufficiently qualified and experienced to be able to fulfil this role effectively, for example qualified social workers. Any new appointments to such a role, other than current or former designated officers moving between local authorities, should be qualified social workers. Arrangements should be put in place to ensure that any allegations about those who work with children are passed to the designated officer, or team of officers, without delay”.

Working Together 2015
(‘WT 2015’) Para 5, Page 54

1. Introduction

1) The role of the Local Authority Designated Officer (LADO) for allegations management referrals has become firmly embedded in the practice of this local authority since the requirement first came into regulation in 2006.

All local authorities are required to ensure that there is a prompt and thorough investigation whenever someone working with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
These criteria apply to paid, unpaid, volunteer, casual, agency or self-employed staff working with children.

These criteria have been confirmed in the latest guidance WT 2015 guidance.

2) In Bradford allegations are processed by the Child Protection Coordinator staff team. In practice one designated staff member covers this role for 3 days per week whilst the rest of the team (5.5 FTE) cover the other 2 days of the week on a rota basis. This has led to better oversight of the referrals in the system and more consistency in the response.

3) The designated managers for allegations also provide consultation and advice to the broad range of agencies involved with children across the Bradford District during office hours. The team are now more actively tracking these enquiries as they can consume considerable staff time without necessarily resulting in a referral being made.

4) The policies and procedures around the LADO function are easily accessed via the BSCB web pages:

http://westyorkscb.proceduresonline.com/index.htm

2. Summary of Key Performance Indicators

1. Number of Referrals for the Year 2014-15

This year has seen a 12% increase in allegations management referrals since the Child Protection Unit began collecting reliable figures in 2008. Checks with regional colleagues suggests that they too have seen significant increases of between 2 and 20%
During this year there has been an increase in calls to the unit where an employer is uncertain whether a matter falls within the allegations management procedure. A number of these did not meet the criteria from WT 2015 and whilst unit staff may well have offered advice and consultation the matters were dealt with within an employer’s management procedures. We have taken this as a positive indication that a range of agencies are more aware of the allegations management requirements and are seeking guidance to work out what are their responsibilities. A check of these referrals suggests that the most common misconception is that the allegations management procedures apply to those who do not work with children. These are not reported in the figures above.

2. There have been a number of historical referrals which have probably been encouraged by a number of high profile national cases of historical abuse.

3. Number of referrals by referring agency

Children’s Social Care Services has been the largest referrer over the past year. Usually Education Department is the largest referrer. Education Department has consistently provided a substantial portion of the referrals in any one year and there is a well developed allegations management system as would be expected of an organisation that comes into contact with children in such large numbers. The Police have doubled the amount of referrals they submitted compared to last year further evidencing how well allegations management cases are embedded in their practice. This relationship will be reinforced with police officers being co-located at Sir Henry Mitchell House, the Children’s Services building, allowing for more direct consultation.
<table>
<thead>
<tr>
<th>Agency</th>
<th>Number 2013-14</th>
<th>Number 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care</td>
<td>46</td>
<td>66</td>
</tr>
<tr>
<td>Health</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Education</td>
<td>56</td>
<td>59</td>
</tr>
<tr>
<td>Foster Carers</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Connexions</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Police</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>YOT</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Probation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CAFCASS</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Secure Estate</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NSPCC</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Voluntary Youth Organisation</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Faith Group</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Armed forces</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Immigration/Asylum support services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ofsted</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>44</td>
<td>28</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>184</strong></td>
<td><strong>209</strong></td>
</tr>
</tbody>
</table>

2 referrals have been from faith groups this year compared to none in 2013/14. However there is still considerable work underway to raise awareness in mosques, madrassahs and small independent churches. Whilst the low numbers are of concern, it should also be noted that there are a range of religious settings that display excellent practice in their safeguarding with clear policies and thorough vetting of all staff.

The settings where this is less well developed or ignored, present an ongoing challenge for those responsible for safeguarding children that needs to be addressed in the work plan for the coming year.
4. Referrals by category

The primary category for referrals remains physical. This category is broad and includes allegations of direct physical assault, and other issues around physically touching children. There were 3 referrals of physical assault connected to restraints of children in care, 2 in children’s homes and a further one connected to transport a looked after child to school. All 3 were fully investigated and found to be unsubstantiated. As can be seen from the table below, physical assault has been the prevalent category for the past 3 years.

<table>
<thead>
<tr>
<th>Referral category</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>61.37%</td>
<td>58.7%</td>
<td>54.00%</td>
</tr>
<tr>
<td>Sexual</td>
<td>18.51%</td>
<td>15.7%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Neglect</td>
<td>2.64%</td>
<td>12.5%</td>
<td>3.35%</td>
</tr>
<tr>
<td>Emotional</td>
<td>9.52%</td>
<td>4.9%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Other</td>
<td>5.82%</td>
<td>7.0%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Not specified</td>
<td>2.11%</td>
<td>1.08%</td>
<td>0.48%</td>
</tr>
</tbody>
</table>

2014/15 has seen a rise in referrals for sexual abuse whilst there has been a significant reduction in referrals for neglect.

5. Number of referrals by employment sector and primary abuse category

This return supplies data on the number of referrals that occur within each employment sector. As would be expected Education Department have more allegations referrals in respect of their staff given the high numbers that they have in direct contact with children.
Referrals concerning Foster Carers are up from 24 last year, to 29. Several of these refer to placements with independent fostering agencies. Generally the response from these organisations has been good with prompt, appropriate referrals. The local authority Fostering Service has always discharged its responsibility for allegations management appropriately.

6. Overall outcomes for referrals closed in year

<table>
<thead>
<tr>
<th>Employment Sector</th>
<th>Physical</th>
<th>Emotional</th>
<th>Sexual</th>
<th>Neglect</th>
<th>Other</th>
<th>Not Specified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Social Care</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Connexions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education</td>
<td>56</td>
<td>5</td>
<td>19</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>92</td>
</tr>
<tr>
<td>Faith Setting</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Foster Care</td>
<td>21</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>29</td>
</tr>
<tr>
<td>Health</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>NOT SPECIFIED</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>3</td>
<td>16</td>
<td>4</td>
<td>13</td>
<td>1</td>
<td>55</td>
</tr>
<tr>
<td>Police</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Voluntary</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>YOT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total for each type of abuse:</strong></td>
<td>113</td>
<td>14</td>
<td>47</td>
<td>7</td>
<td>27</td>
<td>1</td>
<td>209</td>
</tr>
</tbody>
</table>

Referrals concerning Foster Carers are up from 24 last year, to 29. Several of these refer to placements with independent fostering agencies. Generally the response from these organisations has been good with prompt, appropriate referrals. The local authority Fostering Service has always discharged its responsibility for allegations management appropriately.

6. Overall outcomes for referrals closed in year

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number 2013-14</th>
<th>Number 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Only</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Malicious</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Substantiated</td>
<td>41</td>
<td>79</td>
</tr>
<tr>
<td>Unfounded</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Unsubstantiated</td>
<td>41</td>
<td>118</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>110</td>
<td>260</td>
</tr>
</tbody>
</table>
This represents an area of major improvement in performance with more than twice the number of referrals concluded during this year compared to 2013/14. It is attributable to extra staff resources being provided to help support the allegations management functions plus a business process review and a re-focussing of effort on referrals open on the system that needed to be moved more proactively to a conclusion. It has been possible to review each individual Coordinator’s caseload and pick out specific referrals that needed to be concluded. This activity has made a major contribution to making the allegations management process in Bradford more robust and timely.

7. Timescales

The improvement in the timeliness of handling referrals is positive progress. Although WT 2015 contains no practice advice regarding timescales it has always been the goal to conclude referrals in a timely fashion consistent with appropriate and full investigation. The improvement of 52 referrals concluded in under a month represents the best performance the unit has achieved in this respect. Across all the timescales the improved performance reflects the impact of additional resources and improved processes.

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 month:</td>
<td>19</td>
<td>27</td>
<td>16</td>
<td>52</td>
</tr>
<tr>
<td>Between 1 and less than 3 Months:</td>
<td>32</td>
<td>36</td>
<td>37</td>
<td>49</td>
</tr>
<tr>
<td>Between 3 months and less than 12 months:</td>
<td>44</td>
<td>32</td>
<td>25</td>
<td>82</td>
</tr>
<tr>
<td>12 months and More:</td>
<td>40</td>
<td>30</td>
<td>32</td>
<td>79</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>135</td>
<td>125</td>
<td>110</td>
<td>262</td>
</tr>
</tbody>
</table>

The challenge in the 2015-16 will be to improve on this performance to ensure that an increasing number of referrals can be managed within the first month however this does depend on whether an allegations management referral is linked to a criminal investigation. Criminal investigations, particularly those linked to historical allegations or complex situations involving multiple victims, can be protracted and affect the length of time a referral is open on the system.
3. Additional Activities.

1. Training

The Designated Officer has remained involved with delivering training around allegations management and the linked safer recruitment workshop. These courses are delivered as part of the BSCB’s multi agency training programme so they involve staff drawn from the agencies that make up the Board as well as the voluntary and private sector.

This year 55 staff attended the allegations management training, which is a considerable improvement on last year's figure of 24 staff trained. A breakdown of agencies and numbers attended is included as Appendix 1 attached to this report. With respect to Safer Recruitment 37 staff attended the training again an improvement on the 22 who attended last year.

Whilst the overall increase in the numbers trained there is still work to be done promoting the training to organisations that are consistently not sending staff to this training. It should be emphasised that the training is a 3 hour interactive presentation which is felt to be accessible and can be fitted into a working day.

2. Regional LADO Group

The regional group is a voluntary body put in place to provide a forum to discuss wider service issues and to foster consistency in decision making in applying the criteria from WT 2015. The network provided by this group has proved particularly valuable in sharing information and providing consultation which has become increasingly important in the light of limited guidance from central government as to the role and responsibility of designated officers for allegations. There is still no movement to establish any national standards or linkage to central government for LADOs like those in place for Independent Reviewing Officers and this is reflected in the most recent guidance.
3. Second National local Authority Designated Officer Conference

The Second National Conference was held at Kensington Town Hall, London on Friday 13th March 2015. The conference heard five high quality research based presentations on a range of subjects including “Creating safer Organisations: Practical implications of research about abuse in professional settings,” presented by nationally recognised researcher Marcus Erooga and a detailed overview of the development of the LADO function delivered by Caroline Rhodes former regional government Allegations Management Advisor. This was a high quality event delivered by the London Wide LADO group. Sadly it was not possible to have any officials from the DFE to provide any insight into how the LADO function should be delivered or developed nationally.

4) Conclusions and Work Plan for 2015/16

The key elements for last year’s work plan were to ensure that the required improvements set out by the Ofsted inspection were completed. A review of the business process was carried out and to ensure that there was sufficient management oversight of the work. Additional staff were recruited and are now contributing to the allegations management work. Performance in terms of the number of referrals completed in a year and the time taken to process them has improved significantly. The service is ready for a future inspection and will improve it’s readiness as the changes instituted become further embedded. The following elements need to be addressed in the coming year:

1. There needs to be continued monitoring of performance to ensure that all allegations continue to be handled efficiently. This will be reflected in the date return for outcomes and timescales.

2. The information in respect of the agencies not sending representatives to the BSCB sponsored training for allegations management and safer recruitment needs to be used to provide targeted publicity and other promotion to ensure that the all sectors send staff to the workshops. To embed knowledge of the procedure and the responsibilities of employers more thoroughly across Bradford.
3. The LADO service needs to work closely with Bradford Safeguarding Children Board on more efficient ways to make links with faith settings to promote wider knowledge and use of the allegations management procedure.

4. To use the regional LADO groups expertise in devising a means of conducting peer audits of the Bradford LADO service, especially where there has been recent experience of Ofsted inspection, to further promote the adoption of good practice where that has been recognised as part of inspection.

Frank Hand
Service Manager
Safeguarding and Reviewing Unit
# Appendix 1

## Allegations Management training 2014-15

<table>
<thead>
<tr>
<th>Service/Agency</th>
<th>Allegations Management 20/05/14 AM</th>
<th>Allegations Management (AM) 16/10/14</th>
<th>Allegations Management (AM) 04/11/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults Services</td>
<td>0</td>
<td>0</td>
<td>0 (1 ap)</td>
</tr>
<tr>
<td>Airedale Hospitals</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BDCT</td>
<td>0</td>
<td>0</td>
<td>1 (1 non attendee)</td>
</tr>
<tr>
<td>Bradford MDC Other</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Bradford Youth Service</td>
<td>0 (1 ap)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BSCB</td>
<td>1</td>
<td>0 (2 ap)</td>
<td>2</td>
</tr>
<tr>
<td>CAFCASS</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CCG's</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Children's Social Care (Including YOT/Families First)</td>
<td>8 (1 non attendee)</td>
<td>6 (3 ap)</td>
<td>7 (1 ap)</td>
</tr>
<tr>
<td>Connexions Bradford (Prospects)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Early Years, Childcare &amp; Play</td>
<td>6 (1 non attendee)</td>
<td>0 (2 ap, 1 non attendee)</td>
<td>4</td>
</tr>
<tr>
<td>Education Bfd (now part of CBMDC)</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Education - School &amp; Ch's Centre based</td>
<td>2</td>
<td>0 (1 non attendee)</td>
<td>1</td>
</tr>
<tr>
<td>Education Other (Colleges/City Training/FE)</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Housing</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Private/Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Probation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Voluntary/Not for profit/Charity</td>
<td>2 (1 ap)</td>
<td>1</td>
<td>1 (1 ap)</td>
</tr>
<tr>
<td>West Yorkshire Fire Service</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>West Yorkshire Police</td>
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<td>0</td>
</tr>
<tr>
<td>Yorkshire Ambulance Service</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total no. of places offered</strong></td>
<td><strong>25</strong></td>
<td><strong>22</strong></td>
<td><strong>25</strong></td>
</tr>
<tr>
<td><strong>Total no. of apologies</strong></td>
<td><strong>2</strong></td>
<td><strong>7</strong></td>
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<td><strong>21</strong></td>
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- **Total**: 55
## Safer Recruitment training 2014-15

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<th>Services</th>
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<tr>
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<td>Children's Social Care (Including YOT/Families First)</td>
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4.4 Private Fostering

1. Introduction

1.1 The Local Authority reports annually to the Chair of the Local Safeguarding Children Board on how it satisfies itself that the welfare of privately fostered children in its area is satisfactorily safeguarded and promoted, including how it co-operates with other agencies in this connection.

1.2 This section sets out the report on Private Fostering for Children’s Specialist Services, Bradford Metropolitan Council to the Bradford Safeguarding Children Board (‘BSCB’) and outlines activity and progress on Privately Fostered Children within the Bradford District over the last two years, plus identifies areas that need to be improved along with plans to achieve improvement.

1.3 Definition - a private fostering arrangement is one made privately by a parent or person who has a Residence Order for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more.

2. Improving Notification

2.1 The Children’s Initial Contact Point receives all enquiries and notifications regarding proposed or existing private fostering arrangements. All publicity states this service as the contact point.

2.2 These arrangements ensure there is an assured response to all notifications made to the Local Authority. Initial enquiries are screened by the relevant Assessment Team and passed to the social work team to undertake an assessment to ascertain that this child is privately fostered. If the arrangement is confirmed as within the definition for private fostering then a suitability assessment is carried out by the Lead Practitioner who then holds the case in the Child and Family Team to carry out the required ongoing welfare visits to see the child and provide support and advice to the private foster carers.
2.3 In 2012-14 initiatives were undertaken to highlight the notification arrangements to existing and potential private foster carers, voluntary and statutory agencies, and members of the public. However, this has been limited mainly to publicity during Private Fostering Weeks which has been promoted and advised in both years and the Lead Practitioner has liaised with the Communications Unit in Bradford Council to ensure that relevant publicity has gone to promote awareness and understanding of the issue. Dedicated WebPages are available to the public and are up to date. The Lead Professional advises other agencies and staff on whether a situation is private fostering and the actions that need to be taken.

2.3 BSCB currently has responsibility for training other agencies and internal staff on Private Fostering and publicity. Currently that training is captured in the ongoing courses rather than focused specifically on Private Fostering; there is an awareness of the issue in each course around safeguarding children. Clearly this needs to improve and will be covered by the newly formed Steering Group so that the training strategy is more comprehensively addressed internally and at an interagency level.

3. **Safeguarding and Promoting Welfare**

3.1 The Private Fostering procedures were last reviewed in March 2015.

3.2 The number of privately fostered children is constantly changing as new arrangements are referred and children move on - sometimes back to their parents - or when they reach 16 years (or 18 years if disabled). During 2014 - 15 there were 13 new notifications and 11 Private Fostering arrangements that ceased, with a total of 11 ongoing arrangements at the end of the year.

3.3 All new notifications in the year 2012 - 13 received an initial visit, with 100 % taking place within 7 working days in the year 2012 - 13. The England average for 2013 - 14 is 80%. In the year 2013 - 14 this average dipped to 83.3 % and 2014 – 15, 84.6 %
This needs improving to 100% and under the new arrangements with the assessments of both the child’s circumstances and the Private Foster Carers taking place within the Integrated Assessment Team, we envisage increased timeliness on this indicator to 100%.

4. **Improvement Plans for 2015 - 16**

4.1 Private Fostering Assessments will be undertaken in the Integrated Assessment Team at Sir Henry Mitchell House. There will be a lead Team Manager who will oversee this work and raise awareness of Private Fostering within their service. This is a model that most Local Authorities have adopted as it helps promote awareness with the public, other professionals and social work practitioners about Private Fostering and promotes timely and effective assessments. The assessments will also have advice and input from the lead Fostering Manager who will arrange for consultancy and advice from a fostering worker to thoroughly assess the Private Foster Carers abilities and support needs. Once the Assessment is completed the case will transfer to the long term Child and Family Team who also have Lead Team Managers who will offer oversight and guidance to the allocated Social Worker and their Team Manager about the Private Fostering regulations and practice standards. This will also mean that knowledge and awareness of Private Fostering will become embedded across the service.

4.2 A Steering Group will meet regularly to ensure that practice standards are maintained and improved on. The performance and work will be reported back to BSCB and to the Performance Management, Audit & Evaluation Sub-group on a quarterly basis and in the next Annual Report.
5 Judging the Effectiveness of the Local Response to Child Sexual Exploitation

National Context

Professional and public awareness of child sexual exploitation (‘CSE’) has grown significantly in the 14 years since the publication of the first dedicated national guidance for dealing with this form of child sexual abuse, which was entitled: “Safeguarding children involved in prostitution”. Changes in legislation and guidance culminated in the publication of the national “Tackling Child Sexual Exploitation Action Plan” which was published in 2011, and this plan has itself been significantly strengthened by the government response to CSE published in March 2015. This response consisted of 3 key documents setting out expectations regarding information sharing arrangements, assessments and accountability and leadership.

In drawing up this response to CSE, the government particularly considered the findings of 3 key reports regarding CSE that were published in the course of 2014-15:

- “Real Voices: Child sexual exploitation in Greater Manchester” (An independent report by Ann Coffey, MP); and

Together, these reports raised concerns about the effectiveness of statutory organisations to address CSE in terms of strategic and political leadership, recognition of the issue, willingness to focus on children’s needs and wishes, and capacity to develop a sophisticated response to this complex issue. Briefings regarding each of these reports and the government response can be found at:

http://www.bradford-scb.org.uk/cse_reports.htm
In Autumn 2014 Ofsted undertook inspections of local responses to CSE in eight local authority areas. The final thematic report: “The sexual exploitation of children: it couldn’t happen here, could it?” was published in November 2014.

The report considered evidence from 36 inspections of children’s services that had already been published and inspections of 38 children’s homes, in addition to the eight specific CSE inspections.

This detailed report has produced 25 recommendations for local authorities (‘LA’), partner organisations, Local Safeguarding Children Boards (‘LSCB’), national government and Ofsted itself. Overarching themes in the findings and recommendations are: the need for strong strategic leadership; the need to develop effective local performance arrangements (informed by consistent crime recording); the need to prioritise awareness raising; the importance of police and LA using all powers to disrupt and prosecute offenders; and the need to ensure that all missing children have an independent return interview and that intelligence about missing episodes is collated to identify patterns and risks.

The Ofsted report, together with other recent publications, is of assistance in developing understanding of the complexity of CSE and of the necessity to develop a sophisticated “whole system” response to this form of abuse. It is possible to bench mark planning and activity in Bradford against some good practice identified in the report. The key findings and recommendations of this report are being considered by the CSE sub group of Bradford Safeguarding Children Board (‘BSCB’) and where appropriate are incorporated into the plan under-pinning the 9 Point Strategic Response to CSE.

**Local Context**

Partnership working to address CSE in the Bradford District dates from 1995. In October 2011, the independent chair of BSCB sought assurance as to the effectiveness of the multi-agency response to CSE. In common with other organisations nationally, it is now recognised that West Yorkshire Police and Bradford Council did not have the same rigorous and coordinated approach to dealing with allegations of child sexual exploitation that have subsequently been developed.
The key outcomes of a “structured challenge” to partners were:

- BSCB “Champion for CSE” identified: a Police Superintendent;
- A multi-agency co-located service, known as “The CSE Hub” was established in January 2012;
- BSCB to be responsible for the District’s strategic response to CSE.

These three outcomes remain central to the approach taken in the Bradford District to address CSE. They provide the basis on which strategies for awareness raising, training and preventative work, the operational response, governance and accountability are based.

In the course 2014 – 15 the Local Authority took steps to develop further its leadership role in responding to CSE in the District and to scrutinise the arrangements within the District. Reports drafted by BSCB staff were taken by the Council’s Senior Leadership Team, the Council Executive, Children’s Overview & Scrutiny Committee and each of the District’s Area Committees. BSCB offered Elected Members awareness raising and training opportunities regarding CSE, which many Members have taken up.

Beginning in March 2014 and concluding in July 2014, BSCB conducted a review of the effectiveness of the multi-agency, co-located CSE Hub. This review was chaired by the BSCB Independent Chair, Nick Frost. It was supported by the BSCB manager. The process was steered by representatives of the following key partner agencies:

- Bradford Children’s Services
- NSPCC
- NHS Clinical Commissioning Groups
- West Yorkshire Police
- Hand in Hand Project (Children’s Society).
The review considered a number of sources of information including:

- Operational data provided by the Hub;
- CSE case file audits undertaken on behalf of BSCB by managers from West Yorkshire Police and Specialist Children’s Services;
- A Bradford University research project into the experiences of young people affected by CSE, facilitated by Barnardo’s Turnaround and Hand in Hand and supported by the British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN);
- A self assessment of CSE partnership working against standards developed by the University of Bedfordshire;
- Home Office Innovation Fund evaluation of parental support work undertaken in the Bradford District by Parents against Child Exploitation (PACE);
- Information from external scrutiny of the Hub by Ofsted and the National college of Policing.

Key members of BSCB and the Independent Chair presented the findings of this review to the Council Chief Executive and the Director of Children’s Services (DCS) during July 2014. Key issues identified by the Review were:

- Since the Hub was established in January 2012 operational pressures had resulted in increased dedicated staffing resources from both LA Children’s Specialist Services and West Yorkshire Police. Increases had been primarily in management and administrative capacity;
- Audit of practice showed that cases were generally well managed within the Hub. The presence of a social work team manager in the Hub strengthened joint working between the police and social workers. Revised referral pathways for CSE cases were implemented as a result of learning from audit;
- The Hub had been externally scrutinised by both Ofsted (as part of the 2014 inspection of Local Authority Children’s Services) and the National College of Policing. Ofsted found that: “The co-location of police, social care and Barnardo’s within the CSE Hub is a particular strength. It promotes effective and early information sharing across agencies where children and young people are at risk of or are suffering sexual exploitation.
Timely and robust multi-agency involvement ensures that risks of CSE are identified and plans put in place to reduce these risks”. The National College of Policing awarded the Hub “Gold Standard” and has encouraged other police forces to adopt this operational approach as best practice.

- The review concluded that, working with the "Hub” model, partners had shown themselves responsive to increasing demand and complexity of cases and working arrangements. The review noted that it is likely that demand will continue to increase, at least in the medium term.

**Governance Arrangements**

Bradford Safeguarding Children Board has a CSE “Champion” who is currently a West Yorkshire Police Superintendent. This Champion ensures that BSCB and partners have a strategic approach to CSE and that the issue is addressed in the BSCB annual business plan. The Champion also chairs the BSCB CSE Sub-group.

The CSE Sub-group Terms of Reference are summarised in section 8.1 of this annual report. The key responsibility of the group is to oversee the delivery of the BSCB 9 Point Strategic Response to CSE. This document was adopted in December 2014 and builds on the previous 7 Point Strategic Response to CSE. The document can be viewed here:


The 9 Point response contains the following key points:

- Our partnership response to CSE is child, young person and victim focused;
- A multi-agency co-located team which will work together to reduce the risk to victims and bring offenders to justice;
- A bespoke training plan will be developed for schools to identify to pupils and teachers the signs of being groomed for CSE;
- A plan will be developed for all faith and community leaders to support communities through the damage caused by CSE;
- A support network will be developed focusing on women and mothers;
• A specific direct work plan will be developed aimed at boys between 14 yrs and 17yrs to tackle any unacceptable attitudes regarding the sexual abuse of any person;
• A specific product will be developed for the Pakistani origin community which addresses child sexual exploitation and explores the harm that this offence can cause to individuals and communities;
• A partnership response will be developed to reduce the opportunities for perpetrators of CSE to traffick and abuse children and young people through the use of all regulatory functions of the Council and its partners;
• Our partnership response includes undertaking multi-agency historic investigations into CSE.

BSCB has taken responsibility for reporting to the Council and where appropriate, bringing a positive challenge regarding CSE through the Executive, Scrutiny and Area Committee arrangements.

BSCB and Bradford Council Children’s Services also play a full role in the West Yorkshire CSE Strategic Group which meets bi-monthly to ensure an appropriately coordinated response to CSE and to seek sub regional efficiencies to the delivery of specialist services for children and families affected by CSE. This group includes each of the 5 West Yorkshire LSCBs, the 5 West Yorkshire Children’s Services Authorities, West Yorkshire Police and the Office of the West Yorkshire Police and Crime Commissioner.

**The Operational Response to CSE**

When there is a concern that a child or young person is at risk of CSE a professional is required to complete a multi-agency CSE referral and risk assessment form and forward this to the multi-agency CSE Hub. Each morning, representatives of all of the services co-located in or working closely with the Hub meet to discuss all new referrals and to share information and update risk assessments of cases already known to the Hub.

A shared assessment of risk is made on each case, which can be rated as low (preventative services to be provided by a single agency), medium (individual and family work to be offered which is likely to involve more than one agency) or high (a child has been abused or is
at significant risk of being abused through CSE and requires a multi-agency plan and an active criminal investigation is required). As cases are reviewed the assessment of risk may go up or down.

At present, the Council has a team manager and a social worker located in the Hub. The role of these staff is to ensure that appropriate risk assessments are completed and multi-agency child protection procedures are carried out on children that are referred to the Hub. These staff also ensure appropriate information sharing and joint planning takes place between the Hub and the LA social workers that are allocated to children at risk of CSE. This often involves supporting joint work with children and undertaking, with police colleagues, evidential interviews of child witnesses.

A police inspector, a sergeant and four dedicated police officers are located in the Hub. These colleagues are responsible for supporting the criminal investigations of alleged CSE. This group of police officers are supported by a police researcher and clerk. Within the district’s crime team and specialist teams such as the Homicide and Major Enquiries Team there are considerable numbers of officers focusing specifically on CSE investigations. The police officers within the CSE Hub are also responsible for making enquiries about children who go missing from home or care and for gathering and monitoring information about missing episodes. A detailed report regarding arrangements for children who go missing can be found in section 4.1 of this annual report.

A specialist police officer in the Hub focuses on supporting joint initiatives to disrupt CSE and to develop targeted action to ensure that operators of licensed services and key operators in the night time economy are aware of CSE and taking steps to minimise the risk of their businesses being used by perpetrators to facilitate CSE.

In addition to undertaking regular visits to businesses with relevant colleagues from the Council’s Licensing and Environmental Health Services, this officer, with support from other police colleagues, has also worked with 2 businesses to amend practices that caused concern and has developed an arrangement for daily police attendance at locations identified as being potentially associated with CSE, with 25 such locations initially identified.
The Barnardo’s Turnaround Service is located at the Hub which works with girls and boys to provide preventative inputs and to work directly with children, alongside partner services. A protocol with the Bradford District Care Trust ensures that an identified, consistent sexual health nurse works with the Hub to support children, either at the Hub, in NHS premises or in the community. BSCB is supporting the development of a business case for the commissioning of a health practitioner to be based as a permanent part of the Hub team, ensuring holistic health assessment, signposting to appropriate services and more effective information sharing across all health trusts. The activity of the Hub is supported by a police analyst and an admin support worker.

Other key partner agencies have a daily or regular presence at the Hub. These include: the Hand in Hand Project (Children’s Society), Parents Against Child Exploitation (PACE), BLAST (Bradford & Leeds Against the Sex Trade) and Bradford District Care Trust. Partners from other NHS Trusts, Education Support Services and the Youth Offending Team attend weekly meetings at the Hub.

In common with other children and adults who have been abused or are victims of violent crime, those who have experienced CSE are likely to require on-going therapeutic support to assist them in recovery. BSCB is working with partners in health trusts and the clinical commissioning groups to map current provision against a likely increase in demand. The outcome of this process may be that it is necessary to adjust current commissioning arrangements to ensure that CSE survivors have sufficient priority access to relevant services.
Prosecution and Disruption

Major Investigations

The majority of CSE criminal investigations for the Bradford District are managed within the co-located Hub at Sir Henry Mitchell House, Bradford.

However, particularly complex and resource intensive investigations have been managed within the Homicide and Major Enquiries Team (‘HMET’) of West Yorkshire Police and Protective Services Crime.

Operation Kellerabbey is currently HMET managed and currently has 14 men and a 16 year old male charged with numerous offences of rape and unlawful sexual activity against primarily one female child who was aged under 16 at the time. One of the allegations relates to a second victim who was also under 16 at the time of the offence in 2009. These charges have resulted in Court appearances and trials are set for the forthcoming months at Bradford Crown Court.

Operation Oakberry was a Protective Services lead investigation in relation to sexual grooming and unlawful sexual activity against a male child in his early teens. Males have been charged with a range sexual offences and a number have pleaded guilty and sentenced at Court. Those convicted of the lesser offences have been sentenced to community based orders; there are a number of trials scheduled for future hearings for more serious offences.

Operation Dalesway relates to a series of Historic CSE investigations within the Bradford district and is resourced by a dedicated team of Detectives and Police Staff investigators working alongside Social Care staff.

These enquires are complex, historic in nature and resource intensive, the likelihood of charges and prosecutions unlikely to be realised until 2017.
Ongoing District Investigations

The CSE team based at the Hub is currently undertaking 129 separate investigations. These investigations include situations where there is evidence of CSE and grooming taking place using the internet and social media, as well as “street grooming”. The markings for CSE related cases have been placed on offences up to April 2014 so accurate recording of these offences can take place. There are currently 183 individuals linked to these offences as a subject of interest or suspect (A suspect could be linked to more than one offence and some offences have more than one suspect shown attached to the crime). Of these 66 are showing as having been arrested.

Outcomes / Prosecutions

As CSE crimes have only been linked from the 1st April 2014 there may have been various trials and convictions since that date which would have been from previous years (as charging a person and finally getting a conviction in court may take 18-months to 2 years).

If we look at sexual offences over the last 5 years against a victim who was under 18 there are 178 suspects which have been charged for these offences.

A review of these charges has been undertaken and there are 56 of these offences which are considered to be of a CSE type.

Of the 56 suspects charged for the offences 45 have resulted in convictions. 6 were found not guilty, 2 are on file, 1 was NFA and 2 are still pending trial.

The range of sentences are appropriate to the seriousness of the offences and range from Community-based sentences to significant terms of imprisonment.
Historic Concerns

As a result of increasing public awareness of CSE, particularly following the publication of the Jay report there has been a national increase in members of the public contacting local authorities and the police raising concerns about their own previous experiences of CSE, or about possible incidents of CSE that they may have witnessed in the past. Some members of the public have made contact with Bradford Council or West Yorkshire Police regarding potential historic CSE incidents in the Bradford area.

West Yorkshire Police and Bradford Council have developed a partnership response to the issue of historic CSE concerns. A specialist team has been established. Currently this consists of a Detective Sergeant, 6 Constables, a police analyst, a police researcher, 2 social workers and a council researcher. Staffing levels for this service are being kept under review. The service has clear terms of reference which have been agreed by partner organisations.

During the period 1/4/2014 – 31/3/2015, 6 investigations into historical concerns of CSE were initiated by this specialist team. Between 1/4/2014 to 31/7/2015 a further 3 investigations commenced. All 9 investigations are still on-going.

What is the Extent and Profile of CSE in our Local Area?

In order to more clearly identify and understand incidence of CSE in the District, the Council has made a significant investment in developing the functionality of the Integrated Children’s System to allow children’s services staff to “flag” cases of children at risk of CSE, to record information about individuals and premises that may present a risk of CSE in a way that complies with Data Protection requirements and facilitates the production of regular detailed reports about this activity. Prior to April 2014 it was not possible to produce detailed data reports other than by time-consuming manual processes.

West Yorkshire Police has developed a similar “flagging” system which identifies for all officers and relevant police staff cases where there is a risk of CSE. The NHS “SystmOne” on-line records system is being gradually rolled out nationally. This already provides for
enhanced information sharing about child safeguarding matters within and between NHS Trusts. At present this system does not have the facility to “flag” CSE concerns as distinct from other safeguarding concerns. Discussions are currently underway with local Trust officers to establish whether it is possible to put such an arrangement in place.

Between April 1st 2014 – March 31st 2015, 431 children were referred to the Hub as being at risk of CSE. Of these children, 16 were under the age of 12, 73 were aged 12 – 13, 179 were 14 – 15 and 163 were over 16. 366 of the children were female and 65 were male. The ethnic breakdown of the group is: 273 white British, 24 Other white backgrounds; 24 Gypsy or Roma; 53 Asian; 4 Black British; 27 mixed heritage. In 26 instances the ethnicity of the child was not recorded.

Learning and Awareness Raising for Professionals

In the course of 2014/15, BSCB undertook a full review of its CSE training programme. This review was informed by government guidance, national reports and the learning from a BSCB Learning Lessons Review (see section 7.3 of this report for more details) and a BSCB challenge panel regarding CSE assessment arrangements (more details in section 7.2 of this report).

As a result of this review BSCB launched a new online training course: “Safeguarding Children from Sexual Exploitation”. This course is aimed at all staff and volunteers who work with young people who may be at risk of being abused through sexual exploitation or who work with adults/families where this issue is of relevance, including local authority elected members. This course has now been successfully completed by more than 2000 professional learners in the Bradford District.

The course covers:

- What is sexual exploitation?
- Legislation, guidance and interagency procedures.
- Indicator behaviours and vulnerability factors.
- Assessing risk.
- Understanding roles and responsibilities.
In partnership with Barnardo’s, BSCB has also developed a new face to face training course which will be launched in 2015, replacing the previous face to face CSE course. This course is aimed at staff who work directly with children and young people at risk of CSE, or those who have specific safeguarding responsibilities, e.g. named persons in schools. Further information about this and other BSCB training course can be accessed here:

http://www.bradford-scb.org.uk/training/training.htm

Preventative Work

In the course of 2014-15 an ambitious programme of preventative work was commissioned and delivered using additional one-off funding provided by Bradford Council. The specific initiatives funded were:

- Every Year 10 student in Bradford can attend a CSE drama performed by GW Theatre which is reinforced by pre and post performance lesson plans for schools to deliver.
- Work in Keighley by the Hand in Hand project has been boosted to provide more skilled volunteers to deliver preventative work for young people and to train young people as peer mentors.
- Barnardo’s has been commissioned to expand its work to support more boys and young men to supplement the important work of BLAST in the District.
- PACE (Parents against Child Exploitation) has been commissioned to provide intensive support to the parents of children who are known to be experiencing CSE and from January 2015 to train local practitioners to deliver specific support materials developed by PACE to parents and carers whose children may be at risk from CSE.
- Barnardo’s has been commissioned to deliver preventative group work sessions to parents and carers and to use the lessons from these sessions to develop a practitioner tool kit to provide a more consistent and evidence based approach to supporting whole families when children are at risk of CSE. This tool kit will be evaluated by the University of Bradford.
It was a condition of the commissioning of Hand in Hand, Barnardo’s and PACE that they should seek ways to sustain these service developments at the conclusion of the commissions and current indications are that this will be the case. It is also noteworthy that a number of schools have commissioned additional performances by GW theatre which they have themselves funded. By March 2015, more than 3500 students had seen the performance and completed the associated programme of work. It is expected that over 4500 will have seen the play by the end of the tour in December 2015.

Regular dialogue with a wide range of faith groups has played a significant role in opening up an honest dialogue about the incidence and impact of CSE in the District. Specific faith based events are planned for 2015/16.

**The Future**

Through the CSE sub group, BSCB will continue to monitor the implementation of the 9 point strategy to tackle CSE. Improved management information from all partners is essential in judging the effectiveness of this.

During 2015/16 a number of positive developments are anticipated:

- The CSE Hub will move to be co-located with Specialist Children’s Services Assessment Team and other services which will provide additional efficiencies and opportunities for joint working.
- The current West Yorkshire Assessment tool for CSE will be reviewed and revised to ensure that it is compliant with new expectations and under-pinned by up to date and robust research.
- Work in the night time economy to address CSE will be strengthened by the appointment by Barnardo’s of a night time economy worker to operate alongside the existing Council and Police staff working in this area.
- BSCB will be seeking funding to launch “Families and Communities against CSE” (‘FCASE’) a programme piloted and successfully evaluated in 3 areas of England. This programme would provide a significant boost to community focused preventative work in the District.
All partners are also aware that the nature of CSE is that there will be challenging developments that require continued strong working arrangements and positive communication and dialogue with communities. Whilst continuing high profile prosecutions are evidence of effective joint working they can also contribute to increased media interest and challenges for the District in terms of negative perceptions and community anxieties. Tested mechanisms will continue to be used to address the potential for concerns of CSE to hard community relations.
6
Priorities during 2014-15

6.1 Mosques and Madrassahs

The work on safeguarding in mosques and madrassahs has continued to progress in 2014 – 15, building on the achievements from the previous year. This has been made possible by the continued appointment of the Safeguarding Advisor for madrassahs. The Safeguarding Advisor has a social work background and also has an understanding of the Islamic faith, culture, local networks and knowledge of the local area.

In 2012 – 2013, 5 trailblazer madrassahs were identified to pilot safeguarding work with the Safeguarding Advisor. By March 2014, the Safeguarding Advisor had visited a further 39 mosques and madrassahs across the Bradford District. Visits had increased to 60 by March 2015. Bradford has approximately 80 established masaajids and madrassahs within the district. Since the launch of a self-assessment toolkit in March 2013, in excess of 200 copies have been distributed to mosques and madrassahs.

The Safeguarding Advisor uses the toolkit as a basis for engaging with mosques and madrassahs. It contains policy and practice guidance on safeguarding, including: referral procedure, the importance of having a named safeguarding person, information sharing, safe recruitment and suggested templates.

In many of the madrassah visits, but specifically the home madrassahs, the concerns have highlighted:

- Tutors not having DBS checks
- Lack of awareness of safeguarding matters
- Increasing number of children attending classes
- Noise pollution
- Road traffic congestion
- Fire and health and safety being compromised
- Unclear with regards to lone working policy.
Each madrassah has been provided the following documents and support:

- Madrassahs toolkit
- Road safety kit
- Risk assessment
- Working in partnership
- Whistle blowing
- Lone working policy
- Fire brigade visit at places of worship
- Anti-bullying policy
- Public liability insurance guidance
- Citizenship guidance
- Code of conduct
- Pupil accident book
- First Aid
- Parenting in Islam
- Madrassah excellence DVD

A significant part of the project was building the capacity of custodians, imaams, parents and the wider Muslim community with regard to safeguarding and other issues. The project work has led to closer working between mosques and madrassahs with the Road Safety Team and the West Yorkshire Fire and Rescue Service. The BSCB, together with the Council for Mosques, is also strengthening links with the Yorkshire Ambulance Service on first aid training. Various other local organisations have been approached and responded positively to providing support.

There is further work to be done, including:

1. Further strengthening of a multi-agency **infrastructure** to support Islamic institutions.
2. Increasing partner agencies **awareness** and understanding of Islamic institutions.
3. Increased **engagement** activity with parents and community members to encourage the reporting of abuse.
4. Further work to be undertaken to increase the accessibility of Islamic institutions for children with **additional needs**.

5. Development of **training courses** or modules appropriate for imaams and mosque leaders, including teacher training and community leadership.

### 6.2 Learning from Hamzah Khan: Further Progress

On 13\textsuperscript{th} November 2013, Bradford Safeguarding Children Board (‘BSCB’) published the Serious Case Review (‘SCR’) that was commissioned into the death of Hamzah Khan. Also published that day was an executive summary and a learning and improvement report. All of these documents can be accessed at the BSCB website:

[http://www.bradford-scb.org.uk/hamzah_khan_scr.htm](http://www.bradford-scb.org.uk/hamzah_khan_scr.htm)

The serious case review examined, for the purpose of professional learning and service improvement, the involvement of agencies with Hamzah Khan who died as a result of the criminal neglect by his mother, Amanda Hutton who was convicted of manslaughter and child cruelty in October 2013. The full extent of his treatment was not known about until the evidence was laid before a judge and jury in the autumn of 2013 following an extensive criminal investigation.

The SCR reached key conclusions which raised significant issues for all agencies that had tried to work with Hamzah and his family:

- Hamzah’s death was not predictable.
- He died because of his mother’s neglect.
- To a large extent, Hamzah and some of his siblings were invisible to professionals.

The SCR identified considerable learning for agencies and professionals, which are encompassed in the following themes:

- Professionals need to be supported to keep an open mind and understand the significance of risky adult behaviour.
• Managers and systems must help professionals to keep their focus on children’s needs and to overcome barriers and obstacles to helping vulnerable parents care safely for their children.
• Professionals must not view incidents or crises in isolation.
• Systems that rely on parents doing the right thing might not be enough to keep children safe in a small number of families. Professionals who work together to keep children safe need a shared understanding of what constitutes good enough parenting.
• Professionals need good tools to help them share and analyse information and to recognise underlying concerns, such as neglect.
• Professionals in all services, need clear local arrangements to help them use information about vulnerable children, especially pre-school children, and to develop models of help and support for families which can escalate to more assertive forms of help when necessary.

BSCB and each of the agencies involved in this SCR produced detailed plans setting out the actions that would be taken to disseminate learning and improve services. These action plans are monitored by the BSCB Serious Case Review Sub-group at its bi-monthly meetings. The progress made to implement changes is tested through audit and challenge panel activity.

In the Annual Report 2013 – 14, BSCB published examples of actions taken by the agencies involved. The Ofsted evaluation of BSCB published in May 2014, provided rigorous external scrutiny of the conduct of the SCR and subsequent learning. The report found that performance was ‘good’ in the effectiveness of BSCB. Ofsted concluded that:

“The Serious Case Review in respect of HK has had a significant and positive impact on BSCB’s work to improve front line practice, particularly in terms of early recognition of, and responses to, neglect. The action plan provides a clear assessment of good progress against actions. Social workers and other staff are clear about how learning from the review has changed the way they work.
Procedures and practice have improved in respect of home visits and staff now routinely see where all children in a household live and sleep. Good new guidance is in place on families who are not engaging with services or are failing to attend appointments. Further improvements include an effective protocol between health trusts and education services over children who do not have a school place, and improved screening of domestic abuse.” (para 130)

Due to the significance of the Hamzah Khan SCR, it is important to summarise further progress on actions by BSCB and local agencies.

Here are some of the actions:

**Children’s Social Care Services**

- The Bradford Single Child Assessment is now embedded in practice, and is more child focussed, less bureaucratic, with a more in-depth analysis of neglect. It also captures the views of the child and child’s ‘journey’. The Board has received progress reports.
- Families First project is well established and now based at Sir Henry Mitchell House along with the social work teams.

**Health**

- Records of non-engaging families continue to be reviewed every 6-months and risk assessments undertaken.
- Training events promote GP practices in the District holding regular multi-disciplinary primary care meetings, to discuss vulnerable families and share information using specific electronic safeguarding systems.
- GPs have guidelines with practice standards for making 3 attempts to contact families, if children fail to attend for appointments or immunisations.
Health and Early Years

- An Integrated Care Pathway well established for children’s centres, midwifery and health visiting services across the District, i.e. where an infant or unborn child’s needs are being overlooked through the parents’ failure to engage.
- Work has been carried out within maternity services on understanding why women choose not to book for antenatal care.

Education

- Children missing from education procedures have been strengthened to include pre-school children in the term before they are due to start school.
- Improved inter-agency communication relating to vulnerable pre-school children to help identify such families via children’s centres, Community Health Service and Early Years Service.

BSCB

- The Safeguarding children procedures were reviewed following this SCR, and continue to be reviewed regularly.
- A new Non Engaging Pathway has been developed. This is widely available to agencies through the BSCB website and a link in the online Safeguarding procedures.
- Established courses, following this SCR, including working with hostile and uncooperative families; and multi-agency assessment training.
6.3 Actions from Ofsted Inspection

Bradford Children’s Services were inspected by six of Her Majesty’s Inspectors (‘HMIs’) and one additional inspector between the 18th February and 12th March 2014. This was under a new inspection framework focused on the work of the Local Authorities children’s services. It brought together previously separate inspection frameworks for Adoption and Fostering services and included an evaluation of the Local Safeguarding Children Board.

Ofsted Evaluation of Bradford Safeguarding Children Board

The Ofsted inspection report rated the effectiveness of Bradford Safeguarding Children Board (BSCB) as “good”. We reported on the details of the findings in our Annual Report 2013-14.

Summary of BSCB’s Strengths

In summary, Ofsted reported good leadership of BSCB; clear governance arrangements; a strong commitment from partner agencies; challenge panels are effective; the Hamzah Khan serious case review has had a positive impact on BSCB’s work; the Child Death Overview Panel report provides a good analysis; safeguarding procedures are comprehensive and up-to-date; BSCB delivers a comprehensive multi-agency training programme; BSCB has a good understanding of children missing from home or care and in improving inter-agency responses to child sexual exploitation; BSCB is successful in increasing the participation of children and young people; and the Annual Report is comprehensive.

Progress on Areas for Improvement and Actions

1. Implement routine oversight of arrangements for safeguarding and promoting the welfare of privately fostered children including work aimed at raising professional and public awareness of children who may be privately fostered.

Information about private fostering has been incorporated in to BSCB’s multi-agency data-set. Promotional materials have been prepared for publicity and briefings planned in July 2015.
2. The BSCB should accelerate development of a multi-agency data set and clearly record any challenge to areas of poor performance and the impact of this challenge.

A multi-agency data set has been developed and will be monitored through BSCB Performance Management, Audit and Evaluation Sub-group. Work is ongoing to place this within a performance management framework, which will further focus on improving performance.

3. The BSCB should review the engagement of schools and FE colleges to ensure that they are fully represented on the Board.

BSCB has well established engagement by primary and secondary school head teachers, and there is now representation on the Board. It is planned for FE college representation from May 2015.

4. The BSCB should complete the implementation of a comprehensive local learning and improvement framework.

A comprehensive Learning and Improvement Framework has been in place since June 2014, and covers the various methods of learning. This will be reviewed by December 2015.

5. The BSCB should evaluate the impact of safeguarding training on the quality of frontline practice and outcomes for children as part of a comprehensive training needs analysis.

A revised Learning and Development Strategy, Training and Delivery Plan 2014 – 17 sets out the mechanisms and measures for evaluating training. BSCB is overseeing and collating organisations’ self –analysis of the impact of training on staff as part of a comprehensive training needs analysis.
Ofsted Inspection of Early Help Services, Child Protection, Looked After Children, Adoption and Care Leavers in Bradford

The overall finding was that:

“There are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. However, the authority is not yet delivering good protection and help for children, young people and families. It is Ofsted’s expectation that, as a minimum, all children and young people receive good help, care and protection”.

The key judgements were:

- Children who need help and protection – Requires Improvement
- Children looked after and achieving permanence – Good
- Adoption performance – Good
- Experience and progress of care leavers - Good
- Leadership, management and governance – Good

Ofsted found that the Local Authority has the following strengths:

- Stable, consistent leadership has resulted in good outcomes for children and high standards of practice in the vast majority of service areas.
- Children are at the centre of social work and early help practice. Children’s voices and opinions are clearly evident and taken account of. Direct work with children is of good quality and routinely undertaken by social workers who know the children they work with very well.
- A good range of appropriately targeted early help services, including Families First, are having a positive impact for children, helping to address concerns and support families well. Partners are fully engaged and contribute to improving outcomes for children.
• The Integrated Assessment Team (IAT) is an effective front door to children’s social care and ensures shared understanding and implementation of thresholds. Referrals are dealt with in a timely way and good account is taken of family history. Decision making is good and there is effective screening of domestic violence notifications.

• The co-location of police, social care and Barnardo’s within the Child Sexual Exploitation (‘CSE’) hub is a particular strength. It promotes effective and early information sharing across agencies where children and young people are at risk of or are suffering sexual exploitation. Timely and robust multi-agency involvement ensures that risks of CSE are identified and plans put in place to reduce these risks.

• Social workers have well managed workloads, so they have time to see children often and build meaningful relationships that are long lasting. The workforce is stable and well qualified, with over half of social workers at an advanced level of professional development.

Summary of the action taken to improve

Recommendations from Ofsted:

1. Ensure that all strategy discussions include the police as a minimum standard. The outcome of the discussion and agreed actions must be clearly recorded in a child’s case file.

Strategy discussions with the Police were not taking place on every case before the social worker went out to see the child and family. This was immediately remedied during the inspection by locating a police officer authorised to hold strategy discussions in the integrated assessment team. The assessment team and the Police Child Protection Unit are now co-located in Bradford City Centre.

2. Take actions to increase and sustain sufficient capacity in the child protection conference service to meet service demands. Ensure that initial child protection conferences are held in a timely way that minimises risks to children and meets statutory guidance.
The Council invested £900,000 to increase the capacity in the social work teams, the child protection co-ordinators and case conference minute takers. Over 80% of case conferences now take place within the expected 15-day timescale.

3. Ensure sufficient capacity within the LADO service, so that allegations against professionals progress in a timely way and there is management oversight of all cases.

There is additional capacity in the child protection unit to rigorously manage the allegations made in the district to ensure that enquiries are concluded in a timely way and recorded on the database.

4. Ensure all children identified as requiring statutory assessment are visited swiftly following receipt of the referral which identifies the concern.

The Council has invested in three additional social workers in the assessment teams to ensure that the timeliness of the Bradford Single Child Assessment is good. There is daily oversight of all referrals in the city in the co-located assessment team and quick decisions are made regarding allocation and investigation if required.

5. Where plans to reduce the impact of chronic neglect are not progressing sufficiently swiftly, ensure that assertive action is taken to escalate all such cases to a higher level of intervention.

Neglect refresher training has been delivered by the safeguarding children board and practice guidance issued to all staff. The Family Justice Review expected timescales are good; cases are dealt with in 26 weeks. An additional Case Manager was appointed to track and quality assure plans and feedback on any undue delay.

6. Ensure that social workers and workers across all teams, particularly referral and assessment teams, receive regular supervision to support the complex work they are undertaking.
Children’s Services have invested in the Tony Morrison 4x4 reflective supervision model. Refresher training has been undertaken with all front line managers. There is an agreed recording template to cover case issues as well as the development needs of front line staff. This is regularly audited by service managers.
7
Scrubtny, Challenge and Response

7.1 Section 11 Audit

Section 11 Children Act 2004 places duties on a range of organisations and individuals to ensure that their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. Working Together 2015 requires LSCBs to gather data to assess whether partners are fulfilling their statutory obligations; this includes compliance with Section 11. Since October 2014, Bradford has been using an electronic on-line toolkit with a ‘R.A.G.’ self-rating system to record progress in compliance with the requirements of Section 11. The toolkit is supported by a local organisation Virtual College.

The contents of the toolkit have been devised by BSCB to comply with statutory and local requirements. The 9 standards used in the toolkit are:

**Standard 1** Senior management leadership and accountability

**Standard 2** Policies and procedures

**Standard 3** Safer recruitment and selection

**Standard 4** Supervision, support and training

**Standard 5** Complaints, allegations and whistle-blowing

**Standard 6** Interagency working, information sharing, communication and confidentiality

**Standard 7** Culture of listening to children, individual decisions and development of services

**Standard 8** Diversity

**Standard 9** Early Help offer
In the Bradford District, BSCB set an initial 2-stage completion process for organisations to complete various sections of the audit along with action plan points, within prescribed timescales. The rationale behind an online system is for organisations to approach Section 11 as a continuous process, enabling updating of evidence to be made. Ongoing training is given in order to ensure organisations can access and use the online tool effectively, and for new or additional staff who may be new to Section 11 auditing.

There have been some initial issues associated with the online toolkit, mainly its technical construction. BSCB has been instrumental in highlighting these problems with Virtual College, which will result in an improved redesign in April 2015.

Governance of Section 11 is through BSCB Performance Management, Audit and Evaluation Sub-group (‘PMAE Sub-group’). Various reviews of Section 11 have been undertaken by BSCB Safeguarding Team. This has enabled feedback to be given to each organisation, compliance to be followed up, training to be given and technical problems to be corrected. The reviewing facility is one of the advantages of an online system.

**Plans for 2015-16**

- The PMAE Sub-group plans to conduct interactive auditing within sub-group meetings.
- Further refinements to the online toolkit will be negotiated as and when appropriate in order to meet the requirements of both organisations and BSCB as ‘reviewers’.
7.2 Challenge Panels

Challenge Panel 1: Child Sexual Exploitation – Risk Assessments

Introduction

BSCB has a well established process of multi-agency challenge panels in Bradford. The Performance Management, Audit and Evaluation Sub-group (‘PMAE Sub-group’) commissioned a challenge panel focusing specifically on child sexual exploitation (‘CSE’) risk assessments. The all day panel took place in December 2014.

In the Bradford District, BSCB is the lead strategic body for the development and implementation of the District’s response to CSE. The Bradford multi-agency CSE Hub has been operational since 2012.

At a national level in 2014, child sexual exploitation (CSE) continued to be given prominence both amongst the general public and in the professional arena, with the publication of Professor Alexis Jay’s report into CSE in Rotherham (August 2014). Ofsted published a thematic inspection report (November 2014) and among it’s findings, highlighted the need for local authorities to prioritise awareness raising and ensure management oversight of practice.

It was recognised in Bradford that a challenge panel should look at the quality of CSE risk assessments in order to continue improving quality of practice.

Details about the Panel

The multi-agency panel consisted of:

- BSCB Safeguarding Manager (Panel Chair)
- BSCB Development Officer
- Service Manager, Safeguarding and Reviewing Unit
- Principal Education Social Worker
- Children’s Service Manager, Barnardo’s Turnaround
- Designated Nurse, Bradford District Clinical Commissioning Groups
- Interim Service Manager, Children’s Specialist Services
- CSE Hub Manager
• Police Constable, West Yorkshire Police
• Detective Inspector, West Yorkshire Police
• Designated Doctor, NHS Airedale, Bradford and Leeds

A stratified random sample of cases open to the CSE Hub was selected, comprising:

1 x Child in Need case
2 x Child Protection cases
2 x Looked After Children cases

Current allocated social workers were each given a one hour slot for panel attendance, and asked to complete a specifically designed summary sheet plus supplying the latest version of a CSE risk assessment, along with minutes of the most recent multi-agency meeting, for example, child protection review conference minutes. Panel members were given recording sheets which were designed to focus discussion and recording in the most effective way.

Summary

Panel members engaged the social workers in discussion, drawing out points about practice, suggestions for follow up, policies, and points for agencies. By the nature of the cases involving CSE, the degree of risk varied. Social workers were asked about their level of awareness of the CSE Hub. Awareness was informed in varying degrees and ways. Some workers had knowledge of the Hub, partly because of the request from the Hub Manager for updated CSE risk assessments to be provided. In another case, the social workers informed the panel of their contact with the Hub, and that they had in turn disseminated information about the Hub to fellow team members.

Generally, given the variety of the panel members’ professional backgrounds and roles, discussion took place around focused areas such as attendance at school, health concerns, criminal offending, and risk of CSE. Several of the panel members had first hand knowledge of the cases. During each case discussion, the experience of the social worker was established, e.g. newly qualified, very experienced etc. This assisted in adding context to social work practice with the cases.
Main Conclusions and Recommendations

1. The quality of CSE risk assessments varied considerably in detail, that is, some sections were completed better than others, such as recording of health information. The ‘RAG’ rating was not always completed, although there was descriptive text and discussion about risk.
2. The CSE risk assessment itself should be reviewed in relation to whether it is capturing the right information and whether other sections could be included, for example, a chronology of significant events.
3. CSE risk assessments should be quality assured both before and after being received by the Hub.
4. Hub managed cases should be reviewed – this was already in train at the time of the panel.
5. The Hub should offer support for agencies completing CSE risk assessments.
6. Staff inductions should include the role of the Hub.
7. Further promotion of the Hub is required.
8. It is important that any siblings at risk should be referred to the Hub.
9. All agencies to promote the importance of health information including STI/sexual health assessments.
10. All relevant agencies should further focus on internet safety for vulnerable children (there are already arrangements in place across schools).

Action Plan

Learning from the panel has been discussed at both the PMAE Sub-group and the CSE Sub-group, where the conclusions and recommendations have formed detailed discussions and actions progressed.
Challenge Panel 2: Safeguarding Disabled Children

Introduction

Challenge panels and multi-agency workshops in respect of disabled children have been delivered in the Bradford District since 2013, as a response to Protecting Disabled Children: Thematic Inspection (Ofsted 2012). The Ofsted findings pointed to disabled children being at increased risk of abuse and neglect, but less likely to have child protection plans, and concerns about the review and monitoring of child in need plans. Ofsted recommended robust monitoring of referrals and thresholds for disabled children. It was therefore decided that challenge panels should be developed in the Bradford District. The panel held in November 2014 was the third such challenge panel.

Details about the Panel

The multi-agency panel consisted of:

- Service Manager, Family Support & Services to Children with Complex Needs (Panel Chair)
- Representatives from Children’s Social Care
- Representatives from Adults Social Care
- A Special School Headteacher
- Safeguarding Specialist Practitioner, Bradford District Care NHS Foundation Trust
- Consultant Paediatrician, Bradford Teaching Hospitals Foundation Trust

A sample of 4 currently allocated cases was selected by the Chair. Frontline practitioners from school, social care, school nursing and therapy services, attended to present the cases and take part in a discussion with the panel.
Summary

4 pre-set questions were used by the panel as a framework to examine the cases:

- Do plans or reviews address the outcomes areas of preparing for adulthood (health, employment, community inclusion and living independence)?
- Is decision making about ongoing plans made in a timely and clear way for young people and their families?
- Is the young person involved in their planning?
- Are safeguarding issues appropriately addressed?

The panel and attending frontline practitioners engaged in detailed discussion and analysis, which led to a number of overarching themes in the process of developing a shared understanding and thresholds, together with the child’s ‘journey’ in case planning.

Six Overarching Themes Emerging from the Panel (and Previous Two Panels)

Theme 1 – Disability Equality

- Professionals need same safeguarding expectations for disabled children as non disabled children
- Equitable and achievable expectations and aspirations for disabled children (should be same as for non-disabled children)
- Importance of reinforcing high expectations for school attendance for children with complex health/life limiting conditions but who are still well enough to attend school

Theme 2 – Quality of Assessments

- Need for high quality referral information
- Importance of good quality and appropriately detailed initial assessments (including children being seen)
- Assessments should be revisited / reviewed, e.g. following a significant life events such as relationship breakdown of parents
Theme 3 – Universal Services and Early Help

- Need for on-going training to reinforce CAF/Early Support
- CAF should not be used as ‘tick box’ for referral to Social Care
- CAF following the child from one setting to another, avoiding a ‘Start Again’ approach
- Clear and honest discussion with families at Early Help stages

Theme 4 – Voice of the Child

- Carer’s voice clearly heard but young person’s not as obvious.
- Child’s aspirations or family’s aspirations not always clear or the same as one another
- Need to look at Child’s aspirations and Preparation for Adulthood outcomes from aged 14 years old

Theme 5 – ‘Think Family Approach’

- Need full and open sharing of all concerns and information at review meetings
- Regular reassessment of information which might impact on parenting capacity
- Non-engagement / disguised compliance evident

Theme 6 – Systems and Process Issues

- Definition of Learning Disability and Learning Difficulties – causes confusion
- Access to resources for families such as behaviour support for parents
- Need for greater clarity around transitions between Children’s to Adult Services
- Role of Adult Services when there are emerging safeguarding risks to children under aged 18 years in the family

Follow-up

The panel followed up general themes across organisations and reported back its findings to both the Pro-active and Responsive Safeguarding Sub-group and Learning and Development Sub-group.
Individual recommendations for practice were followed up by the case holders. Learning was also disseminated through workshops in Safeguarding Week.

7.3 Learning Lessons Reviews

Introduction

BSCB has a Learning and Improvement Framework (‘LIF’), as a requirement of Working Together 2013 (‘WT 2013’) (later revised in 2015). Learning Lessons Case Reviews are an example of a type of learning model contained in the LIF, where a case is reviewed, but does not meet the criteria for a Serious Case Review. Learning Lessons Reviews (‘LLR’) ‘can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children’ (‘WT 2015’, p.72).

Background

Bradford Safeguarding Children Board (BSCB) commissioned a LLR to consider the level of support offered to a 14 year old ‘child M’, who had been the subject of child sexual exploitation (‘CSE’) and then subsequently placed in care. Prior to being identified as a victim of grooming, child M was known to various local services and Children’s Social Care Services. The work of these services focussed on supporting school attendance and keeping her safe through statutory child protection processes.

Following an anonymous call, the police subsequently arrested the adult perpetrator. M was made the subject of police protection and then accommodated, due to being considered at high risk of CSE. Her case was discussed at the multi-agency CSE Hub daily meeting.

During the day of the trial, child M ran from court, was apprehended and detained in police cells overnight due to an arrest warrant being issued for her arrest. She later went on to successfully give evidence at the perpetrator’s trial.
Process

A multi-agency steering group was set with representatives from West Yorkshire Police, Children's Social Care Services managers, BSCB Safeguarding Team and Barnardo’s managers. The steering group was chaired by a local Police Superintendent. Challenge and independent scrutiny to the Review was provided by a safeguarding manager from the NSPCC (London). The LLR ensured that M’s views were heard as part of the process of learning lessons.

The aims of the LLR were to:

- Identify an excellent standard, victim centred, multi agency response to supporting vulnerable young victims through the criminal justice system. This support must start from the date of the arrest of the offender and extend beyond the end of the court case.

- Establish a minimum standard product for dealing with community issues relating to court cases involving allegations of CSE.

Terms of reference ensured that an evaluation of the multi-agency response, safety and support offered, were central to the LLR, both leading up to and during the trial of the perpetrator.

Summary of Learning

1. The Bradford District partnership has developed a robust process to effectively identify and safeguard children at risk of sexual exploitation.

2. The number of ongoing investigations is constantly increasing and successful outcomes have been achieved, such as the 7-year sentence in this case.

3. Although M lived an extremely chaotic life and denied that any offences had taken place, she did co-operate with much of the police investigation, and eventually gave evidence during the trial.
4. The planning and co-ordination between agencies prior to the trial was thorough.

Recommendations

1. Whenever a looked after child is arrested, a suitable appropriate adult should attend the police station and be present for the child’s rights, rather than just telephone contact.

2. The Bradford District currently has no secure PACE bed facility. Therefore, there remains a risk that the child may be detained for court the next day and will spend a night in police custody. In such situations staff need to ensure that senior managers are aware, and able to explore with partners, alternative arrangements to custody. Discussions are taking place between Children’s Social Care Services and Police about this.

3. In a situation where a child witness who is in care, has left the court before giving evidence, the court should consider hearing evidence from care or social workers and police officers in order to inform any decision about the most appropriate way to secure attendance.

4. Even though M was supported in court, the staff supporting on the day, had little experience of the court system and were not well prepared to deal with issues as they arose. Therefore, staff supporting vulnerable young people should have an understanding of how the process works.

5. For each CSE trial, a multi-agency plan must be put in place to support the victim and key witnesses through the court process. Part of this must be to accurately monitor the willingness of the victim and witnesses to give evidence in court and to ensure they have a good understanding of what to expect and are thoroughly prepared.

6. No CSE trials should be floating cases at court.

7. Key witnesses in CSE trials should be allocated specific timeslots for giving evidence, and be housed in a more comfortable environment and be brought to court at the appointed time.
8. CSE Hub processes are consistent with WT 2013 guidance (now WT 2015). Strategy discussions which take place within the Hub daily meetings, should be followed up with a further strategy discussion involving the allocated social worker and investigating police officer, should a section 47 enquiry be required.

9. At the conclusion of each CSE trial, the CSE Hub will review the investigation to identify learning.

10. Every CSE investigation and subsequent trial has the potential to have an adverse effect on community cohesion and tension in the district, so it is important that statutory partners are aware of all upcoming CSE trials. A proportionate partnership response should be implemented to mitigate any foreseen rise in tension.

The above recommendations have been addressed, and a result, this LLR has influenced practice around supporting child victims as witnesses in criminal proceedings. The LLR was reported back to the Serious Case Review Sub-group (see also section 8.2 of this report).
8
How the BSCB Sub-groups and Other Panels Worked on the Safeguarding Agenda during 2014-15

Summaries from Chairs of:

8.1 Child Sexual Exploitation

Chair’s name: Superintendent Vince Firth, West Yorkshire Police (CSE Champion)

Terms of reference

The sub group is responsible for overseeing the implementation of the 9 point strategic response, the key components of which are:

- Our partnership response to CSE is child, young person and victim focused;
- A multi-agency co-located team which will work together to reduce the risk to victims and bring offenders to justice;
- A bespoke training plan will be developed for schools to identify to pupils and teachers the signs of being groomed for CSE;
- A plan will be developed for all faith and community leaders to support communities through the damage caused by CSE;
- A support network will be developed focusing on women and mothers;
- A specific direct work plan will be developed aimed at boys between 14 years and 17 years to tackle any unacceptable attitudes regarding the sexual abuse of any person;
- A specific product will be developed for the Pakistani origin community which addresses CSE and explores the harm that this offence can cause to individuals and communities;
- A partnership response will be developed to reduce the opportunities for perpetrators of CSE to traffick and abuse children and young people through the use of all regulatory functions of the Council and its partners;
- Our partnership response includes undertaking multi-agency historic investigations into CSE.
The sub group is also:

- Monitoring a detailed action plan which sits under each of these points;
- Monitoring take up and quality of training;
- Working to ensure that professional and community awareness events take place.

The CSE Sub-group is attended by 25 partner representatives. The details of CSE work in the Bradford District is covered in section 5 of this report.
8.2 Serious Case Review

Chair’s name: Dr Kate Ward

Terms of reference

To make recommendations to the Chair of the BSCB for abuse or neglect of a child is known or suspected and either:

1. The child has died
2. The child has been seriously harmed and there is cause for concern as to the way in which the authority, its partners or other partners have worked together to safeguard the child.

To make recommendations to the Chair of the BSCB about conducting reviews (learning lessons) on cases which do not meet the SCR criteria.

Monitoring progress of action plans for all BSCB and formulated in response to recommendations to SCR and learning lessons reports.

To make recommendations about the dissemination of learning from reports.

Contextual information

Attendance at meetings is good; there have been some changes to personnel due to retirement and change of roles; inclusion of deputies at an appropriate level of seniority ensures representation by the agencies required to make recommendations and monitor progress and action plans.

A consultant from the NSPCC has been recruited to provide objectivity and academic viewpoints for the subgroup. Representation from probation has been sought.

No meetings have been cancelled. An extraordinary meeting was held in March 2015 to consider several cases.
Main issues covered and analysis of sub-group’s effectiveness

Two serious case reviews were commissioned at the end of 2014 – 15; both have been challenging and work continues with overviews, authors and panels.

The first has required close working with agencies from another area and the panel has included representatives from Bradford and that area. The overview panel has met twice and additional representation has been sought in the light of information shared with panel. The draft plan and timetable has been produced up to the expected consideration at BSCB meeting in December. The panel has sought to involve the parents in this case. The father has consented to engage in this process but the mother due to difficult circumstances does not wish to engage.

The second is an extremely complex case. Planning of the review has required careful consideration of the young person/subject who is extremely vulnerable. However, she and her family members are willing to engage in the review process after careful consultation and discussion. Chronologies have been received and frame of reference has been developed with a view to a first learning event later in the year. The aim is to complete the review by December 2015, though publication will depend on the progress of complex criminal proceedings.

The SCR Sub-group (‘SCR Sub-group’) reviewed a Learning Lessons Review (‘LLR’) on child M, led by West Yorkshire Police. The purpose of the LLR was to consider the level of support offered to a 14 year old child, who had been the subject of child sexual exploitation (‘CSE’) and then subsequently placed in care. The case went to trial and child M gave evidence which helped to bring a conviction against the adult perpetrator.

The District partnership has developed a robust process to effectively identify and safeguard children at risk of sexual exploitation through the CSE Hub and CSE meetings. The LLR did however raise a number of learning points and made several recommendations (see section 7.3 of this report for more detail).
Four serious incident reports from the Youth Offending Team (‘YOT’) were considered. Two related to alleged rape in vulnerable young people.

In one case the young person left herself vulnerable to risks due to chaotic behaviour and poor choice of acquaintances. She moved between areas. Clear guidance was issued with regard to communication between YOT including meeting with originating case workers when applicable. In the other cases there was discussion about the timing of informing YOT; no factors were identified, which suggested it would have been possible for YOT to prevent the incidence from occurring.

Cases have been considered which were neither considered to reach the threshold for a SCR or LLR, but themes were identified, including children who had suffered significant harm having been subject of a child protection plan or a pre-birth assessment.

Issues have been identified in terms of notification and gathering information for decision making regarding SCR and LLR.

It is planned to review systems used by other SCR sub-groups in conjunction with the NSPCC representative.

A review of the Working SCR Sub-group is to be commissioned by BSCB.

**Links to other sub-groups**

The SCR Sub-group has close links to all of the other sub-groups through the Business Planning Group. Links with the Child Death Overview Panel (‘CDOP’) are strengthened as the Chair of the SCR Sub-group sits on CDOP.

The Chair of the Learning and Development Sub-group is also a member of the SCR Sub-group which facilitates learning from reviews. This was particularly important in the case of Hamzah Khan, as several learning events were presented across Bradford to ensure that learning was disseminated.
Close links with the Domestic Homicide Review panels have been established. Where appropriate, a representative of the SCR Sub-group attends Domestic Homicide panel to ensure that learning in relation to safeguarding of children and young people is embedded in learning and business planning.

Action Plans are discussed at the Business Planning Group to enable effective development of policies, audit and learning.

**Demonstrate how the sub-group’s work has fed into the BSCB’s business**

- BSCB embeds learning from SCRs and LLRs using themes identified and matrix produced for the SCR Sub-group
- Identification of an excellent standard victim centred multi-agency response to supporting vulnerable young victims through the criminal justice system
- Establishment of a minimum standard product for dealing with community issues relating to court cases involving allegations of CSE
- Improved understanding and use of the CSE Hub

**Priority issues for 2015 - 16**

- Work on 2 serious commissioned case reviews to continue
- Work to continue on a further case which has been under consideration and recommendation made for a SCR
- SCR to set the priorities and outcomes according to the new BSCB proforma
- To review processes for collecting information and decision making regarding SCRs and LLRs
- To participate in the review of the SCR Sub-group and its resources commissioned by the BSCB
- The SCR Sub-group will continue to consider potential SCRs and reviews and to work with BSCB and to decide the formulation of action
8.3 Learning and Development

Chair’s name: Sue Thompson

Terms of reference

On behalf of the BSCB, to coordinate and evaluate the effectiveness of safeguarding children learning and development activity in the Bradford District so that those working with children, young people and families are appropriately skilled and competent.

Contextual information

Sue Thompson has continued in the role of Chair of the sub-group throughout the year.

There have been a lot of changes in agency membership including the retirement of Jenni Whitehead, who was the Education representative and a longstanding member of the group. Farah Husain a Service Manager from Children’s Social Care Services has joined the group. The representative for Bradford MDC Workforce Development changed from Tina Lafferty to Gill Ward. The Police and Probation Service have not had a representative on a regular basis.

Main issues covered and analysis of sub-group’s effectiveness

During 2014-15, a variety of learning experiences was offered on a multiagency basis including:

1165 places on our annual training schedule;
288 participants attended learning and development events (professional practice forum, learning lessons briefings);
6808 professionals registered for e-learning courses.

Approximately 1700 local workers attended events, lectures and workshops during 'Safeguarding Week 2014' – which is a practice-focused collaboration between BSCB, Bradford Safeguarding Adults Board and the Domestic Abuse Partnership.

A key development this year has been the introduction of courses focussed on neglect. They include “Keeping the Child at the Centre”,
“Young People and Neglect” and “Managing Neglect”. These were based on Child and Family Training and Department for Education materials. A multi-agency pool of trainers was developed and supported to deliver the courses.

Another significant development was completion of the review and update of the E-Learning Programme “Safeguarding Children from Sexual Exploitation” which means that all workers in the District now have access to quality basic level training.

The introduction of “Self Registration” for the range of online learning packages we provide means that learners have easier and quicker access to E-Learning. This is reflected in the significant increase in numbers of learners who have registered for E-Learning during the year from 4,267 last year to 6808 this year.

A report covering evaluation of training was undertaken and presented to the Learning and Development Sub-group. This shows that the evaluation of the learning programme has included telephone follow ups for a sample of participants on specific courses. This has provided some specific examples of how learning from courses has been incorporated into the workplace.

The sub-group recognises how resource-intensive telephone follow-up is, which means that only a small sample can be included. However, the sub-group does consider it is an important part of the evaluation process. The recommendations in the report have been accepted. One of these is to consider an online follow-up evaluation to capture data from all courses and participants on a self-report basis, at specified intervals after the training.

**Links to other sub-groups**

The Learning and Improvement Framework has been re written and as part of this process it was reviewed by the sub-group. There continues to be the need for strong links between the Serious Case Review group and the Performance Management, Audit and Evaluation Sub-group. An example of this is the development and delivery of a briefing session from a case which was a serious incident.
Demonstrate how the sub-group’s work has fed into the BSCB’s business

The Learning and Development Strategy 2014-2017 was finalised after consultation with the Board.

Priority issues for 2015-16

- To collate a comprehensive training needs analysis through information from partners.
- Evaluate impact of safeguarding training and quality of frontline practice and outcomes for children, including consideration of development of an electronic evaluation process.
- Review Learning and Improvement Framework and its comprehensiveness with particular focus on identified learning needs emerging from the work of all the sub-groups.
8.4 Performance Management, Audit and Evaluation

Chair’s name: Julie Jenkins

Terms of reference

The terms of reference were reviewed and revised in 2014. The main purpose of the sub-group is:

- to ensure the provision of effective quality assurance and performance management data/systems as regards safeguarding; promote good practice by monitoring the effectiveness of local, inter-agency safeguarding arrangements and identifying and reporting on examples of good practice and areas for improvement.
- To provide regular reports to BSCB regarding the effectiveness of BSCB in co-ordinating local work and also the work of each Board partner in relation to safeguarding and promoting the welfare of children.

Contextual information

There were no cancelled meetings in 2014-15. There was generally good attendance from the core workforce in child protection including Children’s Social Care Services and Health partners (both commissioners and providers). The West Yorkshire Police representative changed during the year. The Police and Education Services have not been present at every meeting. The sub-group has benefited from the addition of Adult Services’ contribution since September 2014.

Main issues covered and analysis of sub-group’s effectiveness

- The group has overseen the post Ofsted single inspection framework and BSCB inspection improvement plan and ensured that actions to improve are delivered
- Section 11 Audit – embedding, training and use of the new online toolkit
• BSCB performance report – incorporating wider multi-agency data, reporting to BSCB, picking up areas of improvement as identified by Ofsted
• Analysis of the rise in child protection activity – there has been ‘Task and Finish’ work to address demand led to significant additional resources being allocated and a fast track pathway for families from new communities
• Learning from Challenge Panel and audits across the partnership
• Consideration of the Learning and Improvement Framework

Links to other sub-groups

• Focusing on Child Sexual Exploitation following publication of the Jay report, Casey report and government response. Specific consideration of CSE challenge panel findings and learning
• Consideration of BSCB Learning and Improvement framework to inform the Learning and Development Sub-group

Demonstrate how the sub-group’s work has fed into the BSCB’s business

There has been focused improvement on delivering the improvement actions from the Ofsted Inspection in March 2014. The inspection identified the need for a full multi-agency performance report that includes a broader range of performance from the Council as well as partners e.g. of performance information regarding Private Fostering arrangements; Looked After Children who are placed outside of the local authority; timeliness of Initial Case Conferences.

The Section 11 Audit is now undertaken across all partners, apart from newly created organisations who will have completed the audit by July 2015. This has included training on the electronic online toolkit. The toolkit provides visible evidence of the Board in areas of compliance and actions to improve. The aim is to use this as a dynamic, continuous improvement tool rather than a snap shot at a given time.

A task and finish group has considered Child Protection demand and pressures following a steep rise in numbers with a plan. The Council
has invested in 13 additional social work posts, additional chairs of case conferences and minute takers.

The task and finish group agreed with all partners a fast track pathway to wrap round immediate resource to families newly arrived in Bradford from central and eastern Europe.

There has been shared learning from challenge panels and audit work with other sub-groups e.g. CSE challenge panels.

**Priority issues for 2015-16**

Performance improvement is one of the four key priorities for BSCB in the 2015-16 year – ‘*Performance information system that gives an overview of the effectiveness of the safeguarding system*’.

This includes:

- The BSCB performance data set to be expanded and analysed to identify areas of declining effectiveness and also to include performance information on priority vulnerable groups.
- A performance framework is to be developed.
- Section 11 Audit review with progress reports to the sub-group and BSCB and for BSCB to use the tool as an improvement mechanism and to hold partners to account
- Early Help Board report to PMAE Sub-group on performance indicators and outcome measures evidencing impact and areas of strength and development
8.5 Universal Safeguarding

Chair's name: Jenny Cryer

Terms of reference

The Universal Safeguarding Sub-group's main purpose is to ensure effective Universal safeguarding is in place with a focus in the following areas:

- participation for children and young people, safeguarding in faith settings
- Unintentional accident prevention, bullying, safe recruitment and management of allegations and safeguarding awareness

Contextual information

The group has met throughout the year although, due to two changes of Chair, there have been some cancelled meetings. When the group has met it has had good attendance from partners. There have been some significant changes with the 2013/14 Chair changing from George McQueen to Shirley Brierley. Shirley remains as the CDOP Chair. George McQueen, Assistant Director for Access and Inclusion was appointed as the new Chair and chaired the sub-group until November 2014.

In February 2015 Jenny Cryer, Regional Director for Prospects Services took over Chairing of the group. Graham Hutton continued as the Vice Chair, throughout this period, offering continuity. There were a number of new members invited to the group including representatives from neighbourhoods, Inclusion, behaviour and Attendance Collaboratives, Young Lives Bradford, the Prevent Team and School Nursing.
Main issues covered and analysis of sub-group’s effectiveness

Throughout the year, reports and presentations were received via the sub-group on a number of key areas including:

- accident prevention updates including the securing of home safety equipment funding;
- the Madrassah safeguarding toolkit and launch
- the Early Help Board and threshold of need
- an update on the coping with Crying (NSPCC project)
- a presentation about the Lifestyles Survey
- a presentation on the NSPCC Thriving Families project
- a review and discussion around the Allegations Management report
- discussion around Bradford’s response to the Prevent Consultation
- a number of discussion around bullying which was identified as a key strand of work

The progress of the group was slowed as a result of there being three Chairs within the twelve month period of the report. Core business around accident prevention and the Madrassahs project continued, and a new stream of work around Prevent was identified. The membership of the group was reviewed and additional key stakeholders invited to the group, which has enhanced the expertise and representation. Young people were involved in the recruitment processes for the Independent Chair of the Board, where their contribution was noted as impressive.

Links to other sub-groups

Close links are established with chairs of all the other sub-groups, including attendance at the Business Planning Group meetings.

Demonstrate how the sub-group’s work has fed into the BSCB’s business

Along with the other-sub-groups, the Universal Safeguarding Sub-group has reported to every BSCB meeting over the last year,
providing the minutes and brief report by the Chair, including presentation of specific items as they are required.

**Priority issues for 2015-16**

- To progress the anti bullying work
- Inclusion of the Prevent on the agenda
- The link between on line grooming inherent in bullying, CSE and Prevent
- Developing participation of children and young people, in alignment with participation work going on around with other Boards, including the Children’s Trust Board and the Early Help Board
- The Terms of Reference for the Group will also be reviewed in 2015-16
8.6  Pro-active and Responsive Safeguarding

Chair’s name: Sharda Parthasarathi

Terms of reference

On behalf of the Bradford Safeguarding Children Board (‘BSCB’) to be responsible for proactive work that aims to target particular groups of children and young people including:

- Developing, and evaluating thresholds and procedures for work with children and families where a child has been identified as “in need”, but where the child is not suffering or likely to suffer significant harm.

- Work to safeguard and promote the welfare of children and young who are potentially more vulnerable than the general population for example children living away from home; children who have runaway; are missing from school or child care; children in the youth justice system including custody; disabled children and young people and those affected by gangs.

It is also responsible for responsive work to protect children who are suffering or likely to suffer significant harm, including children abused and neglected within families by adults known to them; by professionals and carers; strangers; and other young people.

Contextual information

The sub-group has always had excellent representation from a range of agencies across the district including the voluntary and community sector with a representative of Young Lives Bradford. There have been some changes in individual members during the year.

Main issues covered and analysis of sub-group’s effectiveness

During the early part of 2014 - 15, the substantive work of the sub-group was to support the work of the Bradford Child Sexual Exploitation (‘CSE’) Hub. A separate task group was formed to lead on this work. It soon became apparent that the local and national
prominence of the work meant that a CSE Sub-group in its own right should report directly to BSCB.

The PaRS Sub-group has continued to take briefings from the CSE Sub-group offering any support, advice and professional challenge where appropriate.

The sub-group also considered reports on:

- Children who go missing
- Allegations against people who work with children

Priority issues for 2014-15

- Improved protocols and guidance in “Working with Uncooperative or Hostile families”

This was an extensive piece of work completed within a task group to consider a multi-agency response to working with uncooperative families or those families who fail to engage in services particularly when there is little known about the family. It is sometimes this missing information that may lead to concerns or emerging risk.

The Non-Engaging Pathway was developed in response to a Bradford Serious Case Review, building on good practice guidance already existing, supporting a multi-agency response and decision making for children and young people for who risk is unable to be assessed by a single agency approach. The success of this protocol and additional guidance has been its simplicity to follow. In addition to the documents produced there was also an extensive training schedule to ensure professionals across the Bradford District were fully informed about the processes.

- Improved protocols and guidance in “Working with Children who present problematic and/or harmful sexual behaviour (HSB)”

Members of a task group have worked with colleagues in Leeds to influence the review of the West Yorkshire Consortium Safeguarding Procedures for “Abuse by Children and Young People who Display Sexually Harmful Behaviour”. This work will continue into 2015/16 and the task group will produce additional guidance to run alongside the
procedures that will help professionals when working with children who present HSB.

- Improved protocols and guidance in working with children at risk of Female Genital Mutilation (FGM)

This has been a significantly bigger piece of work than had first been anticipated and the sub-group has made significant progress in this area. All of the work will be carried forward into 2015 with plans for this to be completed in November 2015.

- Improved protocols and guidance in working with newly-arrived communities. This will include helping agencies better engage with these communities

This has been a less significant piece of work for the PaRS sub group, as this became a wider issue for BSCB. The sub-group has contributed more distantly with this work in relation to the conference and a coherent response to ensuring this community were able to better access the universal and targeted services that support children and their families.

**Links to other sub-groups**

The PaRS Sub-group Chair has liaised with the chairs of all the BSCB sub-groups to ensure that the work is co-ordinated. The Chair of the Learning and Development Sub-group is also a member of PaRS and this has brought particularly good transitional arrangements, ensuring that the communication of new or reviewed protocols and guidance in communicated well across the district with briefings and workshops arranged where necessary. The BSCB Performance Officer is also a member of the PaRS Sub-group and this also contributes to excellent linkage between the two sub-groups. The substantial communication between sub-groups takes place within the Business Planning Group where all chairs are members.
Demonstrate how the sub-group's work has fed into the BSCB’s business

The work has always followed the guidance from Working Together 2013 and 2015. We have influenced the content of the BSCB Business Plan 2015 – 16 in relation to priority areas.

Priority issues for 2015-16

- Improved protocols and guidance in working with children at risk of Female Genital Mutilation (FGM)

- Further improved protocols and guidance in “Working with Children who present problematic and/or harmful sexual behaviour (HSB)”

- To produce and review the strategy for Neglect
8.7 Child Death Overview Panel

Chair’s name: Shirley Brierley

Terms of reference

In April 2008, the Bradford Safeguarding Children Board (‘BSCB’) established the Child Death Overview Panel (‘CDOP’) in response to the statutory requirement set out in Working Together to Safeguard Children. The aim of the CDOP is to systematically analyse all child deaths from in order to try to prevent deaths in the future. CDOP reviews all deaths in children under 18 years of age in the Bradford District using an agreed national template and also reports key data to the Department for Education as required.

CDOP has a key role in identifying modifiable factors which may have contributed to an individual child’s death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. When a modifiable death is identified, recommendations are made to organisations and agencies and assurance is sought that these recommendations have been implemented. CDOP collates the data and understanding of why children die in the District and key issues are identified during analysis of the deaths, which although may not have contributed to that individual child’s death, are important and again specific recommendations are made.

Contextual information

CDOP has met monthly to review all deaths throughout the year and in addition have an Away Day every summer to look at the CDOP data in detail and invite key speakers. Attendance at the meetings has been good overall of key members of the panel and there is a wide representation from different organisations. We also now have regular attendance from an Airedale paediatrician. We are in the process of reappointing a vice-chair due to changes in membership to add resilience to the panel. The data for 2014-15 will be reviewed in detail at the Away Day in June 2015 alongside the summary of the data and understanding of why children die from 2008-09 to 2014-15 overall.
Main issues covered and analysis of sub-group’s effectiveness

During the year April 2014 – March 2015, 68 child deaths were reviewed by the Bradford CDOP. This brings the total number of deaths reviewed by the Bradford CDOP to 528 since April 2008. Overall, 90% of the 586 cases reported to CDOP from April 2008 - March 2015 have now been reviewed which is above national levels.

The majority of these deaths were in infants under 1 year of age (70 %) and 30% were aged over 1 year of age. Overall, the vast majority of deaths were in Categories 7 (chromosomal, genetic and congenital anomalies) 41% and Category 8 (perinatal/neonatal events) 33 %. There were significantly more children dying in Category 7 in Bradford district when compared to national CDOP data and South Asian children were over-represented in the deaths (63%).

The 8 modifiable deaths identified were in Category 3 (trauma and external factors), Category 4 (malignancy), Category 8 (perinatal/neonatal), and Category 10 (sudden unexpected and unexplained death) and this was 12% of the total deaths compared to 22% nationally.

The key recommendations from the 8 modifiable deaths reviewed in 2014 - 15 were to:

- Raise public awareness of the risks of leaving children bathing alone/supervised by another young child
- Raise awareness of safety around fireguards in fireplaces as part of Child Safety Week and raise the specific issue with Trading Standards
- Reduce risks of future specific clinical incidents by changing policies and practice at Bradford Teaching Hospitals Foundation Trust (BTHFT)
- Increased awareness to avoid co-sleeping with babies especially when risk factors are present such as alcohol

A detailed Action Plan for Modifiable causes identified is in place to audit the response to the recommendations and ensure all organisations have completed their actions. Further to these recommendations, the panel records an issues log.
The key issues identified in 2014 – 15 included smoking and obesity in pregnancy, the need for appropriate and timely bereavement support and access to chaplaincy services, neonatal cot capacity and a range of issues related to genetically inherited diseases including genetic counselling and increased risks for siblings.

Overall infant and child mortality rates in Bradford District are higher than national and regional averages. However, both rates have been falling in recent years and infant mortality rates have been falling faster than regionally and nationally especially in more deprived areas. Work is on-going in many forums to reduce the risk factors which contribute to the high infant and childhood mortality rate in Bradford District; the Every Baby Matters Steering Group leads the partnership working to reduce infant mortality rates. Specific strategies and actions plans such as the Road Safety Strategy and Accident Prevention in Children Strategy for the District aim to reduce risk of death and morbidity in the future for all the children in Bradford District.

Where themes emerge in specific areas over the years, e.g. drowning in baths, co-sleeping with risk factors, then these areas are highlighted by CDOP with key organisations and assurance is sought that staff are providing appropriate advice and support for parents, carers and their families. All these actions together contribute to reducing the risk of deaths in children from the same or similar causes in the future.

**Links to other sub-groups**

CDOP works with a wide range groups and leads including the sub-groups of BSCB and other groups such as the Maternity and Children’s Network, Every Baby Matters Steering Group, Road Safety Team, Accident Prevention Lead and other key groups and organisations as required. In addition, CDOP members participate in regional and national CDOP events and Safeguarding Week.

**Demonstrate how the sub-group’s work has fed into the BSCB’s business**

CDOP is an agenda item on every BSCB meeting with a detailed Annual Report produced and included as an appendix in the BSCB Annual Report.
Priority issues for 2015-16

Recommendations identified in the 8 deaths with modifiable factors from 2014 - 2015 covered the following areas:

Drowning in baths:

- To raise public awareness of the risks of leaving children bathing alone/supervised by another young child – a drowning alert was devised and circulated via Public Health and BSCB.

Fireguards:

- West Yorkshire Fire and Rescue Service to liaise with Trading Standards with regards to fireguards for use on wall mounted fires and any new products that come onto the market.
- Awareness of safety around fireplaces to be raised as part of Child Safety Week.

Specific clinical incidents:

- Clinical Risk investigation completed at Bradford Teaching Foundation Hospital Trust (BTHFT) and recommendations for Obstetric and Paediatric staff in place for high risk pregnancies
- Internal investigation report at BTHFT and recommendations to review vaginal birth after caesarean (VBAC) guideline, implementation of VBAC and use of escalation guide
- Internal investigation report recommendation for BTHFT to increase awareness and training regarding use of foetal monitoring equipment including the different CTG settings to be appropriate as part of mandatory training, documentation in general and the bleep process
- Haematology Department at BTHFT to review their processes to increase fail-safes for reporting of abnormal blood results
Co-sleeping with unsafe practices:

- Assurance sought from the Maternity Network and all key organisations regarding sharing information with parents about safe sleeping practices – highlighting not to bed share after drinking, taking drugs, medication, excessively tired etc.

The summary Action Plan for Modifiable deaths is updated and audited regularly to ensure the actions recommended are completed in a timely manner by the organisations and also CDOP ensures the Issue log actions are completed.

General Recommendations (CDOP)

- Annual Away Day in June 2015 will consider all key analysis, trends for deaths for 2014/15 and the total period 2008-2015 and include a focus on obesity and smoking in pregnancy. This will be repeated annually.
- CDOP will continue to monitor key themes for modifiable child deaths to include drowning in baths, co-sleeping and Sudden Infant Death Syndrome (SIDS) road traffic accidents and clinical incidents over the next year and will seek assurance organisations have addressed the key areas of concern and monitor any new similar cases arising.
- Key recurrent issues identified, which may not be identified as modifiable factors for an individual child, but are relevant at a population level, will also be monitored. Examples include smoking and obesity in pregnancy which are linked to increase risk of infant death, and consanguinity which is linked to an increased risk of congenital abnormalities and in some cases infant death. CDOP will continue to seek assurance organisations and partners are also addressing these key areas of concern.
8.8 Business Planning Group

Chair’s Name: Julie Jenkins

Terms of reference

- To plan meetings of BSCB
- To provide leadership for the work of BSCB
- To provide liaison between the sub-groups of BSCB
- To guide the Chair in offering clear leadership to the BSCB

Contextual information

The group is made up of the chairs of sub-groups which meet under the mandate of BSCB. It meets approximately one month before forthcoming meetings of BSCB. Attendance levels are high and it provides an important co-ordination function and ensures that cross cutting issues are well managed.

Main issues covered and analysis of sub-group’s effectiveness

The Business Planning Group has overseen the recruitment of BSCB representatives, new policy items, funding opportunities, analysing learning and new demand for safeguarding services. The BPG offers leadership to the work of BSCB in general and to the effective operation of the BSCB meetings in particular. The BPG ensures that the full BSCB meetings are as efficient and effective as possible. The BPG is an effective mechanism for ensuring that BSCB is a child centred organisation and high functioning partnership.

Links to other sub-groups

The role of BPG is to ensure that sub-groups are aware of each other’s content and that they do not overlap their work. All chairs of groups are represented on the BPG.

Demonstrate how the sub-group’s work has fed into the BSCB’s business

The BPG drives the Business Plan and overall operation of the BSCB. It has overseen a successful Development Day, a review of the CSE Hub,
the delivery of a challenge session on dangerous dogs, and the delivery of the post Ofsted Inspection Improvement Plan.

Priority Issues for 2015-16

- To continue to offer leadership and the efficient co-ordination of the work of BSCB
- To enhance the development of participation by children and young people in the work of BSCB
- To take advantage of funding opportunities and ensure that the resources to BSCB are utilised as efficiently as possible
- To ensure that BSCB priorities are fully addressed and advanced
9 Safeguarding in the Voluntary and Community Sector

Introduction

Bradford District has a diverse voluntary and community sector (VCS) comprising hundreds of organisations ranging from small community groups addressing needs in their local areas, to medium and larger sized organisations working across the district.

Young Lives Bradford is a project of Bradford CVS, which co-ordinates a network of VCS organisations, who deliver services to children, young people and families. Our aim is to support our members to achieve better outcomes for children and young people in the District. The network currently has over 360 members and is recognised by the local authority, the Children’s Trust partners and the Bradford Safeguarding Children Board (‘BSCB’) partners as the co-ordinating body for the children and young people’s VCS for Bradford District.

We provide regular up to date information to our members through a range of communication methods on issues relating to children and young people’s services and act as a conduit between the voluntary and community sector and our statutory partners.

We work to increase the sector’s awareness of the need to have safeguarding policies, procedures and practices in place to help ensure the safety and well-being of children and young people in the district. We do this by providing sign-posting, advice and guidance through our information resources, training and telephone support. Over the past year we have worked in partnership with our Bradford CVS training team to highlight the safeguarding training needs of the sector and supported the promotion and delivery of training on Basic Safeguarding Awareness; Designated Safeguarding Leads and Safeguarding for Trustees in the voluntary sector.

Voice and Influence

The Young Lives Bradford Core Strategic Group is recognised by our statutory partner agencies as the key strategic forum within the sector on all issues relating to children and young people’s service
delivery and policy in the District. The group acts as the approving body for representatives to all Children’s Trust Partnership Boards, the BSCB and Local Strategic Groups. We have a VCS representative on each of the sub-groups of the BSCB who bring shared knowledge and experience on a range of issues relating to the delivery of children's services and an understanding of their vulnerabilities. Our representatives contribute to the strategic planning of services, bringing the wider views and expertise of the sector and report back on any relevant information, which requires cascading to the wider voluntary and community sector. We greatly value the opportunity through our VCS representatives on the Board’s sub-groups towards contribute to effective inter-agency working to safeguarding children.

**VCS Safeguarding Steering Group**

The Young Lives Bradford Team facilitates the co-ordination of the VCS Safeguarding Steering Group which has two functions:

- to act as an advisory body to the VCS, by sharing information and promoting good safeguarding practice for children and young people within the sector
- to contribute to the work of the BSCB.

The group is currently chaired by our VCS representative on the BSCB. Membership of the Group includes our nominated VCS representatives who sit on the BSCB sub-groups, a BSCB staff member and other VCS colleagues who have a remit for safeguarding in their own organisations who have expressed an interest in contributing to the work of the group. We also welcome colleagues from other agencies to be part of the group, where their work may cross over with the voluntary sector.

**Contribution to BSCB / Multi-Agency Working**

As well as our contribution to strategic planning across the district through our VCS Representatives, our VCS colleagues actively engage in multi-agency collaboration through their direct work with partners on safeguarding issues and their contribution in District-wide initiatives such as Safeguarding Week and Takeover Day.
The VCS made a considerable contribution to Safeguarding Week 2014 by delivering learning and development opportunities covering a range of topics such as:

- Child Protection Practices in Adult Counselling and Mental Health Settings (Relate Bradford);
- Domestic Violence (DVS Keighley and Family Action Bradford’s HOPE Service);
- Awareness of Grooming and Sexual Exploitation of Boys and Young Men (The BLAST Project);
- Working With Families with Neglect (NSPCC);
- Working with the Aftermath of Sexual Abuse (The Alma Project);
- Safeguarding in a Residential Context (Brathay); Safeguarding Young Disabled People (Barnardo’s);
- Safeguarding in Outdoor Activities (NEAT);
- Working with South Asian Male Victims of Sexual Abuse, (Breaking The Silence);
- Internet Safety (BYDP).

We are expecting to see many more examples of the work of the VCS to promote safeguarding in the District during Safeguarding Week in 2015. A member of the Young Lives Bradford staff team has been part of the planning team on the Safeguarding Week each year and on the planning team for the Spring 2015 conference on Central and Eastern European Migrants to raise awareness of the issues for these vulnerable groups and to help practitioners develop a better understanding of how to support them. The key message from this event is the need for more centrally accessible online information about current services supporting these groups.

VCS colleagues have been working with our partners to support multi-agency training for this district. Barnardo’s has been delivering the Neglect and Young People course on the BSCB training schedule and OASIS (Domestic Abuse) has been working with the BSCB and BMDC Workforce Development team providing input on the Forced Marriage and Honour Based Violence training. Both of these courses will continue this year, with support from Bradford Women’s Aid on the Neglect course.
Contributions to Work around Early Help

Early intervention and preventative work is a key aspect of much of the work of the VCS with children, young people and families and takes place at a point before they meet the thresholds for statutory service involvement. Examples of this work includes counselling, play provision, children’s centres, mentoring and targeted youth work.

The BLAST Project has been supporting Bradford schools to develop effective lesson plans around relationships and sexual exploitation work with city-wide practitioners in supporting young males at risk of CSE through their facilitation of the Boys and Young Men’s forum.

SNOOP, a local registered charity who work with children and young people with disabilities and complex needs has been working with statutory partners on the issues surrounding safeguarding young people and carers.

Relate Counselling Services has raised the issue of child protection and the importance of keeping the child in mind in adult mental health and counselling practice through their training delivered during Safeguarding Week.

Our VCS colleagues are key partners on the Families First programme and continue to support the delivery and development of the programme in Bradford which has received recognition nationally for the contribution to supporting vulnerable families.

Better Start Bradford, a community partnership led by Bradford Trident, a voluntary sector organisation, has been awarded £49 million following their successful bid to the Big Lottery Fund to help parents give their children the best start in life.

The partnership will intervene early and, through integrated working and involving parents in developing and delivering its projects. It will provide additional antenatal support, early years and peer support. Projects will address the social and emotional needs of families and babies, enhance the development of language and communication skills and support new mums in breastfeeding and in learning about the nutritional requirements of babies and toddlers. Simultaneously, community initiatives will improve the local environment for children.
and families in the Better Start Bradford area. This is an excellent example of how the VCS are able to access funding to support the needs of children and young people in Bradford District.

Focus Going Forward

Over the next year, Young Lives will be engaging constructively with the agenda of change, including Youth Offer, New Deal, Early Help. This offers opportunities to consider new ways of working and new approaches. Clearly change can also bring risks as well as opportunities, and from a safeguarding perspective we will particularly be looking at how we can support the VCS though change whilst mitigating risks and ensuring services for the most vulnerable continue.

Young Lives will also be looking to broaden our network and enhance our links with uniformed and faith organisations. This is in line with the Youth Offer review and will provide opportunities to broaden the reach of safeguarding messages, training and support.

In conjunction with statutory partners, Young Lives will be looking at ensuring there is a greater role for young people’s voices in the work of the organisations and there are routes for young people’s voices to be heard at key decision making bodies on matters of interest to them. This should contribute to decision making processes relating to safeguarding, but we will also focus on ensuring there are appropriate safeguarding processes in place for any emerging initiatives.

Last year we acknowledged the need to focus on the additional support needs arising through the new communities in the district, such as the Roma and Eastern European communities as an emerging issue. We will continue to support the VCS on this and other emerging issues, such as radicalisation of young people and will seek to ensure there is effective dialogue between statutory and VCS agencies regarding co-production of services which meet emerging priorities.

Young Lives will also continue to provide information and guidance to the voluntary sector and signpost organisations to appropriate training and support. We will also be working to develop online Safeguarding Resources to the VCS which will be made available through the VCS section on the BSCB website.
We will also continue to contribute to the work of BSCB through VCS Representation and consultation with the wider sector when needed, on behalf of the Board.
Participation and the Views of Children and Young People

Context

The participation of children and young people in the development, delivery and evaluation of services is an essential, core principle of any agency or body that delivers or oversees such services. It is underpinned by international, national and local legislation and policy drivers.

Actively seeking the participation of Children and Young People, their families and carers brings many benefits, not only for the service users but for the service too. Benefits for the child and young person include self-learning, self-respect and respect for others, a sense of ownership, self-confidence and many other key skills that are essential to a young person’s development.

In Bradford District, the Children’s Trust has long endorsed this key principle and takes responsibility for the establishment and implementation of a Participation Strategy and action plan which all partner agencies, including the Bradford Safeguarding Children Board, commit to embedding in their governance and operation. The current Participation Strategy is for the period 2014-16. The Participation Champions Group (Bradford Children’s Trust) exists to oversee the definition of the strategy, and to manage the development of the other key components of the strategic and operational framework for participation.

In practice, the core principles of participation can take many forms such as: consultation, representation, decision-sharing, involvement in implementation and young people initiating ideas for action. The extent to which agencies involve children and young people varies with the nature of the service they deliver but the commitment must always be meaningful and not tokenistic. The BSCB take this commitment seriously and shares the understanding that the views of children and young people provide a valuable input to shape the development of safeguarding arrangements in the District.
This commitment cannot be undertaken without resources and the Board identified funds in the past year alongside contributions from partners to enable participation activity to be embedded in several areas of operation.

In the course of 2014-15, Children’s Social Care Services (‘CSCS’) has continued to embed the use of Viewpoint, a computer assisted self administered questionnaire for all looked after children over the age of 4. Further work was developed last year so the views and experiences of children who are subject to a child protection plan can also be captured.

There is now a Bradford Children’s Trust-wide enhanced Viewpoint license enabling each member agency, at no additional cost, to make use of the extensive library of questionnaires to survey the views of children in the Bradford District. For a small additional charge organisations can design their own individualised questionnaires.

Interagency work has taken place throughout the year to capture the voice of specific groups of young people in order to inform BSCB safeguarding decision making. As part of an audit of safeguarding arrangements by LSCBs for deaf children and young people, a core group of young people from Bradford Deaf Youth Club contributed throughout the audit process. Their views have been included in a report which was presented to the BSCB Pro-active and Responsive Sub-group in 2014.

The views of young people were incorporated into the BSCB organisation of events for 2014 Take Over Day an initiative of the Office of the Children’s Commissioner. This was a highly successful event which included over 40 young people involved in the takeover. Feedback from young people identified that they had a really positive experience, were motivated and inspired and treated with respect and dignity. Agencies contributing to this event included CSCS, Police, Bradford District Care Trust, Clinical Commissioning Groups, youth work agencies, VCS organisations.

Findings from the Children and Young People’s Lifestyle Survey in the Bradford District have been analysed and reported back through the Universal Safeguarding Sub-group.
The survey was funded by local Clinical Commissioning Groups and raised several issues in relation to safety and young people’s perceptions. These are being considered and will be important in commissioning Early Help services.

**Vision and Priorities for 2015-16**

As a partner agency in the Bradford Children’s Trust, BSCB intend to further integrate the core principles and good practice contained in the Bradford Participation Strategy into our activities. This will manifest itself in a number of ways.

BSCB will continue to support a young person’s group in conjunction with VCS partners in Bradford. This activity will further develop the user voice methodologies established in 2013-14.

Development of a looked after young people’s App for access via mobile phones, and ensuring young people are consulted through the Children in Care Council.

BSCB will aim to increase the voice of the child is fed into the work of all sub-groups and reflect this in the Board’s Business Plan 2015 – 16.
Conclusions and Priorities for BSCB in 2015-16

The Bradford Safeguarding Children Board is the partnership responsible for keeping children safe. It was externally evaluated by Ofsted in 2014 as ‘Good’. You will have read in this report that there is good leadership in place, clear governance arrangements and a strong commitment from partner agencies. The staff in Bradford want to learn and improve their practice; challenge panels are effective and the Hamzah Khan serious case review has had a positive impact on the work in the District. Safeguarding procedures are comprehensive and up-to-date and the Board delivers a comprehensive multi-agency training programme. There is a good understanding of children missing from home or care and improving inter-agency responses to child sexual exploitation.

However we know in the current financial context that the priorities for 2015-16 need to be more focused on a reduced number of areas. Our aim is to have an outstanding Safeguarding Board and we have agreed four priorities to help us make that step change:

1. Safeguarding all children who are vulnerable, including newer challenging forms of abuse
2. Engagement with the wider community, schools and participation from young people
3. Effective challenge, learning, communication, information exchange and embracing change
4. Performance information to inform the BSCB of the effectiveness of the safeguarding system

Our aim is to be at the forefront of cutting edge child protection service delivery. In Bradford we lead the way in shaping practice and responses to new challenges and safeguarding issues. Safeguarding children exposed to violent extremism and trafficking are two recent examples.
Learning from the experiences of children, young people, families and carers is key. Disseminating the learning from serious case reviews will be a high priority this coming year and this will help shape and improve our service to children who are sexually exploited. The Board will make sure that sufficient, high-quality multi-agency training is available and will evaluate its effectiveness and impact on improving front-line practice.

The Board’s aim is to become a highly influential strategic arrangement that directly influences and improves performance in the care and protection of children in this city. We want to see by the end of the year that improvement is sustained and extended across multi-disciplinary practice with children, young people and families in Bradford.

Julie Jenkins
Appendix 1

Governance Accountability and Resources

Bradford Safeguarding Children Board meets bi-monthly. These meetings are chaired by the Interim Chair, Julie Jenkins. BSCB has a Business Planning Group which plans the agenda for Board meetings and ensures that the decisions of the Board are acted upon. This also meets bi-monthly, and is chaired by Julie Jenkins.

Six sub groups of BSCB also meet bi-monthly and are chaired by members of BSCB. These are:

- Serious Case Review Sub-group;
- Learning and Development Sub-group;
- Performance Management, Audit and Evaluation Sub-group;
- Universal Safeguarding Sub-group; and
- Proactive and Responsive Safeguarding Sub-group;
- Child Sexual Exploitation Sub-group

Plus the Child Death Overview Panel meets bi-monthly and is chaired by a BSCB member.

In addition, BSCB has links to independent groups which support safeguarding activity in specific sectors:

- The Voluntary and Community Safeguarding Steering Group;
- The Safeguarding in Health Group;

In the course of 2014/15, the membership of BSCB was strengthened by the addition of two secondary school head teachers, 2 primary school head teachers and a representative of Bradford District’s 3 further education colleges.
The structure and relationships between these groups is mapped below:
The membership of BSCB during 2014 – 15 is shown below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Representing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Jenkins</td>
<td>Vice Chair and Assistant Director - Children's Specialist Services, City of Bradford MDC</td>
</tr>
<tr>
<td>Nancy O’Neill</td>
<td>Director of Collaboration, Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs</td>
</tr>
<tr>
<td>Michael Jameson</td>
<td>Director, Services to Children and Young People, City of Bradford MDC</td>
</tr>
<tr>
<td>Juliette Greenwood</td>
<td>Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Linda Mason</td>
<td>Interim Assistant Director - Access &amp; Inclusion, City of Bradford MDC</td>
</tr>
<tr>
<td>Emma Corbet</td>
<td>NHS England</td>
</tr>
<tr>
<td>Dr Shirley Brierley</td>
<td>Public Health Consultant, City of Bradford MDC</td>
</tr>
<tr>
<td>Superintendent Vince Firth</td>
<td>West Yorkshire Police</td>
</tr>
<tr>
<td>Cathy Woffendin</td>
<td>Deputy Director of Specialist Services and Nursing, Bradford District Care Trust</td>
</tr>
<tr>
<td>Nicola Lees</td>
<td>Director of Operations and Nursing, Bradford District Care Trust</td>
</tr>
<tr>
<td>David Benn</td>
<td>Voluntary Sector (Barnardo’s)</td>
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<tr>
<td>Sharda Parthasarathi</td>
<td>NSPCC</td>
</tr>
<tr>
<td>Mark Nicholas</td>
<td>Service Manager - Safeguarding &amp; Performance Management Bradford Adult Social Care</td>
</tr>
<tr>
<td>Rob Dearden</td>
<td>Director of Nursing, Airedale NHS Foundation Trust</td>
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<tr>
<td>Charlie Jones</td>
<td>Bradford &amp; District Youth Offending Team</td>
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<tr>
<td>Maggie Smallridge</td>
<td>West Yorkshire Probation Trust</td>
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<td>Kevin Ball</td>
<td>Community Rehabilitation Co. Ltd</td>
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<td>Jenny Cryer</td>
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<td>Jane Fisher</td>
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<td>Sami Harzallah</td>
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<td>Michael Thorp</td>
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<tr>
<td>Jez Stockill</td>
<td>Head Teacher, One in a Million Secondary School</td>
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<tr>
<td>Carole Stephenson</td>
<td>Head Teacher, Horton Grange Primary School</td>
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<tr>
<td>Cllr. Ralph Berry</td>
<td>CBMDC Lead Member for Children’s Services</td>
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The following people are advisors to the Board

<table>
<thead>
<tr>
<th>Name</th>
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</table>
| Paul Hill                           | Bradford Safeguarding Children Board Manager  
                                         paul.hill@bradford.gov.uk                                                                 |
| Marion Moraghan, Legal Adviser      | Social Services Law Team, Legal & Democratic Services, City of Bradford MDC                                                                   |
| Sue Thompson (Designated Nurse)     | Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs                                                                   |
| Dr. Ruth Skelton (Designated Doctor)| Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs                                                                   |
| Dr Kate Ward, MBE (Designated Doctor)| Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs                                                                   |
### Attendance of representatives at BSCB meetings during 2014 – 2015

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<th>AGENCY</th>
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### The BSCB Budget: 2014-15

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<td><strong>Total Income (inc. balance b/fwd)</strong></td>
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<td><strong>Total surplus to carry forward</strong></td>
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*Contributions:
- Bradford Council Children’s Services: £176,100
- Health: £148,350
- Police: £17,535
- Probation: £4,690
- Cafcass: £550
| Total Contributions | 347,225 |
Appendix 2

Bradford Safeguarding Children Board
Child Death Overview Panel

Annual Report

April 2014 – March 2015
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1  Introduction and Key findings

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   3.2 Notification of Death
   3.3 Serious Case Reviews
   3.4 Sudden Unexpected Death in Childhood (SUDIC)

4  Population Demographics


6  Analysis of child deaths reviewed by CDOP in 2014/15
   6.1 Demographics, 2014/15
   6.2 Category of death classification, 2014/15
   6.3 Modifiability classification, 2014/15
   6.4 Issues highlighted, 2014/15 reviews
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   7.2 Category of death classification, 2008/09 – 2014/15
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   8.3 Child Mortality Rates (1-17 years)
   8.4 Characteristics of child deaths reviewed by CDOP, 2008/09-2014/15
9 Actions to reduce infant and child mortality

10 Conclusion
   10.1 Specific recommendations
   10.2 General recommendations

References

Appendix 1 (CDOP): CDOP Terms of Reference

Appendix 2 (CDOP): Preventable and Modifiable factors definitions and Categories for Cause of Death

Appendix 3 (CDOP): BSCB Board Structure

Appendix 4 (CDOP): Characteristics of deaths reviewed by CDOP

Appendix 5 (CDOP): Infant and child mortality rates
1. Introduction and Key findings

In April 2008, the Bradford Safeguarding Children Board (BSCB) established the Child Death Overview Panel (CDOP) in response to the statutory requirement set out in Working Together to Safeguard Children\textsuperscript{1,2,3,4}. The aim of the CDOP is to systematically analyse all child deaths from birth to 17 years 364 days of age in order to try to find modifiable causes of death and to prevent similar deaths in the future.

During the year April 2014 – March 2015 (2014/15), 68 child deaths were reviewed by the Bradford CDOP and during this year there were a total of 80 child deaths; some of these 68 reviewed deaths were from previous years. This brings the total number of deaths reviewed by the Bradford CDOP to 528 since April 2008; this equates to 90% of the 586 child deaths which have been reported to CDOP from April 2008 - March 2015 have now been reviewed.

The CDOP has a role in the analysis of any modifiable factors in relation to the deaths reviewed and makes recommendations which are communicated to both National and Local agencies as appropriate. The 8 modifiable deaths were in Category 3 (trauma and external factors), Category 4 (malignancy), Category 8 (perinatal/neonatal), and Category 10 (sudden unexpected and unexplained death).

The key recommendations from the 8 deaths reviewed in 2014/15 as having potentially modifiable factors were to:

- Raise public awareness of the risks of leaving children bathing alone/supervised by another young child
- Raise awareness of safety around fireguards in fireplaces as part of Child Safety Week and specific actions with Trading Standards
- To reduce risks of future specific clinical incidents by changing policies and practice within Bradford Teaching Hospitals Foundation Trust with regard to high risk pregnancies, implementation and review of vaginal birth after delivery (VBAC) guidelines, foetal monitoring and processes for alerts following abnormal blood results
- Increased awareness to avoid co-sleeping with babies especially when risk factors are present
Further to these recommendations, the panel records an issues log. The issues identified in 2014/15 included smoking and obesity in pregnancy, the need for bereavement support and access to chaplaincy services in a timely and appropriate manner, neonatal bed capacity, oxygen saturation level monitoring of babies at birth and issues around genetic counselling and risks in siblings of children who have died of genetically inherited conditions. Specific common risk factors noted in the issue log were obesity in pregnancy, smoking in pregnancy and consanguinity; whilst it is not possible to state specifically that these risk factors caused an individual child’s death in many cases, national evidence clearly demonstrates they all increase risk of infant death at a population level.

CDOP will continue to monitor overall causes of death for children, with a focus on modifiable causes, but also identifying specific recurrent issues and themes and to hold an Away Day every year to discuss all the areas in more detail. Analysis of the reviewed deaths for 0-17 year olds for 2008 to 2015 shows that, of the deaths reviewed, 74% were in Category 7 (chromosomal, genetic and congenital anomalies) and Category 8 (perinatal/neonatal). 70% of deaths were infants (aged under 1 year old). South Asian children are over-represented in the deaths (63%) compared to the demographic profile of Bradford District. Category 7 deaths in the district show a higher percentage of the total as compared to national CDOP data\textsuperscript{5,6,7,8} and this analysis is used to inform focus of key work to reduce death rates in children in the future.

Overall child mortality rates in Bradford district are higher than national and regional averages and the Bradford District infant mortality rate remains higher than nationally and regionally. However, there are some encouraging signs of improvement; the three year infant mortality aggregate rate has reduced year on year for the last six years especially in deprived populations and the child mortality rates are reducing too (see Appendix 5 for details).

Work is on-going in many groups and networks to reduce the risk factors which contribute to the high childhood mortality rate in Bradford District; the Every Baby Matters Steering Group for example leads the partnership working to reduce infant mortality rates\textsuperscript{9}. 


Also, specific strategies and actions plans such as the Road Safety Plan and Accident Prevention in Children Strategy for the district, focus on a range of interventions to reduce the risk of death and ill health for children across the District.

In addition, CDOP had led awareness raising around specific areas encouraging parents to adopt safe sleeping practices and avoiding co-sleeping with their babies with risk factors present and also not leaving young children unattended in baths.

We look forward to continuing to support and develop the key work being undertaken by the Child Death Overview Panel and welcome its on-going contribution to reducing the incidence of childhood deaths in the District in the future.

Julie Jenkins
Vice Chair of Bradford Safeguarding Children Board
2. Background

This report details the work of the Panel during 2014/15. Having been established for seven years the Bradford CDOP is able to identify emerging trends and themes in the data which enables CDOP to make more meaningful recommendations. The CDOP panel is looking for factors contributing to a child’s death that could have been modifiable and where shared learning could reduce the chances of the circumstances around that death occurring again and hence reduce child mortality rates in the future. In addition, CDOP collates key issues identified, including risk factors, which although not specifically identifiable as modifiable factors in relation to individual child deaths, are relevant to the child population as a whole.

3. CDOP process

The remit of the CDOP is fully documented in the Terms of Reference in Appendix 1 (CDOP).

3.1 Membership of the Bradford CDOP

The CDOP is composed of a standing core membership as follows:
- Children’s Social Care
- Health – Primary care
- Education
- Police
- Coroners’ Office
- Hospital Chaplain
- Public Health
- Sudden Infant Death in Childhood (SUDIC) paediatricians
- Senior Manager Children’s Services Acute Trust

Also in attendance is the manager of the Bradford Safeguarding Children Board, as an advisor, and the CDOP Manager and Administrator.
### Figure 1: Membership of the Bradford CDOP

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Dr Shirley Brierley - Chair</td>
<td>Consultant in Public Health</td>
<td>City of Bradford Metropolitan District Council (CBMDC)</td>
</tr>
<tr>
<td>Louise Clarkson</td>
<td>CDOP Manager</td>
<td>Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)</td>
</tr>
<tr>
<td>Paul Hill/Andrew Crabtree</td>
<td>Bradford Safeguarding Children Board Manager</td>
<td>Bradford Safeguarding Children Board</td>
</tr>
<tr>
<td>Dr Eduardo Moya</td>
<td>Consultant SUDIC Paediatrician</td>
<td>BTHFT</td>
</tr>
<tr>
<td>Dr Catriona McKeating</td>
<td>Consultant SUDIC Paediatrician</td>
<td>BTHFT</td>
</tr>
<tr>
<td>Dr Louise Clarke</td>
<td>Clinical Specialty Lead for Children and Young People Named Doctor for Safeguarding Children</td>
<td>NHS Bradford City Clinical Commissioning Group (CCG), NHS Bradford Districts CCG and NHS Airedale, Wharfedale and Craven CCG</td>
</tr>
<tr>
<td>Sue Thompson/Jude MacDonald</td>
<td>Designated Nurse for Safeguarding</td>
<td>NHS Bradford City CCG, NHS Bradford Districts CCG and NHS Airedale, Wharfedale and Craven CCG</td>
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<tr>
<td>Joanna Fraser</td>
<td>Serious Case Review Officer</td>
<td>West Yorkshire Police</td>
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<tr>
<td>Malcolm Dyson/ Sam Cariss</td>
<td>Coroner’s Officer</td>
<td>Coroner’s Office</td>
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<tr>
<td>Cath Dew</td>
<td>Services Manager</td>
<td>Specialist Children’s Services, CBMDC</td>
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<tr>
<td>Linda Chavasse</td>
<td>Principal Educational Psychologist</td>
<td>Bradford Children’s Services, CBMDC</td>
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<tr>
<td>Shaheen Kauser</td>
<td>Muslim Chaplain</td>
<td>BTHFT</td>
</tr>
<tr>
<td>Dr Sam Oddie</td>
<td>Consultant Neonatologist</td>
<td>BTHFT</td>
</tr>
<tr>
<td>Dr Kate Ward</td>
<td>Consultant Paediatrician</td>
<td>Airedale NHS Foundation Trust</td>
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</tbody>
</table>
The Bradford CDOP meets on a monthly basis. Additional members have been co-opted to the panel when relevant for the cases scheduled to be reviewed. Since the establishment of the CDOP in 2008 the panel have consistently strived to increase the number of cases reviewed each month to ensure a backlog does not build up and additional meetings are held if required.

3.2 Notification of Death

Any professional who becomes aware of a child death is required to notify the Child Death Manager at the Child Death Review office either by completing a notification form or by telephoning the office. The Coroner’s Office and the Registrar of Births Deaths and Marriages have a statutory responsibility to engage in the child death review process by notifying the Manager of all deaths reported to them. There can be confidence, therefore, that information on all deaths is captured by the child death review team.

Each agency has a nominated individual who takes responsibility for coordinating the information required for the review of each death. The data collection forms (Agency Report Forms – Form B) are distributed via the administrator and copies of the various forms can be found on the BSCB website.

3.3 Serious Case Reviews

Local safeguarding children boards (LSCB) commission serious case reviews when a child has died or been seriously harmed through abuse or neglect. The purpose of the serious case review is to ensure that lessons are learned which help to better protect children in the future.

The CDOP may refer a case to its LSCB Chair if it considers the criteria for a SCR may be met and a SCR has not been initiated. Any case that is considered under the remit of Serious Case Review will not be reviewed by the Child Death Overview Panel until the Serious Case Review has taken place.
3.4 Sudden Unexpected Death In Childhood (SUDIC)

The Bradford Safeguarding Children Board (BSCB) fund a full-time Child Death Manager post. Funding is also provided by Bradford City, Bradford District and Airedale, Wharfedale and Craven Clinical Commissioning Groups (CCGs) for a part-time SUDIC Paediatrician and the post became operational in November 2008. Bradford Teaching Hospitals NHS Foundation Trust hosts the SUDIC and CDOP posts. The SUDIC Protocol for Bradford and Airedale has been updated. The rapid response process has been improved with multi-disciplinary team discussion surrounding sudden unexpected deaths in children being brought to Accident and Emergency Units as soon as possible to facilitate ensuring key tests are undertaken to identify metabolic or microbiological cause of death with the coroner’s approval. There is a SUDIC box to facilitate this approach and this is approved by the Bradford Coroner. This is especially important as inherited metabolic diseases are a relatively common cause of death in the Bradford district. In addition, the Clinical Commissioning Groups and key partners are presently scoping out existing bereavement services and reviewing provision.

4. Population Demographics

Bradford has a significantly higher proportion of children and young people than the UK average. According to the 2011 census, the population of the area served by Bradford Council was 522,452\(^{10}\). A large proportion of the Bradford population are from ethnic minority communities, which comprise nearly one quarter of the population total; around 23% of the population described themselves as Pakistani (20%) or Indian (3%)\(^{10}\). Just under two-thirds (64%) of the population describe themselves as White British.

The birth rate in Bradford District is continuing to grow and the proportion of the population that is children and young people is forecast to rise at a greater rate in Bradford than nationally. Bradford has a young population with one of the highest percentages of young people in England\(^ {10}\). The 136,579 children in Bradford aged 17 and under represent 26 % of the Bradford population, which compares with 21 % in England as a whole\(^{10}\). In the 2011 census\(^{10}\), 30% of Bradford’s children (under 18 years of age) were of Pakistani, Indian or Bangladeshi
heritage, and 17% were described in other Black and Minority Ethnic group categories – nationally, these figures were 8% and 14% respectively.


The following data includes the deaths of children under 18 years of age, (up to the 18th birthday and described as 0-17 years), resident in Bradford District who died between April 2014 and March 2015.

**Figure 2: Child deaths reported to and reviewed by CDOP, 2008/09-2014/15**

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<tr>
<td>Reviewed deaths</td>
<td>85</td>
<td>108</td>
<td>107</td>
<td>70</td>
<td>67</td>
<td>61</td>
<td>30</td>
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<tr>
<td>Reported deaths</td>
<td>85</td>
<td>108</td>
<td>108</td>
<td>70</td>
<td>68</td>
<td>67</td>
<td>80</td>
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<td>% of deaths</td>
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<td>reviewed</td>
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*Source: Bradford CDOP notifications data and Public Health Intelligence Team, City of Bradford Metropolitan District Council*

A total of 528 deaths of the 586 notified deaths (90%) have been reviewed over the seven years between April 2008 and March 2015. This is an improvement on 2011/12 when only 81% of all reported deaths since April 2008 had been reviewed and is higher than national figures of 82% for 2009-2014 which were published in 2014. Of the 68 reviews this year some will be of the deaths in 2014/15 and some from previous years as there can be delays due to inquests and other investigations outside the control of CDOP. There are 10 categories for cause of death (see Appendix 2).
6. Analysis of child deaths reviewed by CDOP, 2014/15

6.1 Demographics, 2014/15

Of the 68 cases reviewed between April 2014 and March 2015:

- 45 were of children less than a year old (66%)
- 23 of children over the age of one (34%)
- 34 were male (50%)
- 34 were female (50%)
- 48 were children of South Asian ethnicity (71%)
- 16 were children of White British ethnicity (24%)
- 4 were children of other ethnicities, including African, Eastern European and Mixed (5%)

6.2 Category of death classification, 2014/15

Of the 68 cases reviewed between April 2014 and March 2015 76% were in Category 7 or Category 8 as below:

- 28 deaths were categorised as chromosomal, genetic and congenital anomalies (Category 7) (41%)
- 24 deaths were categorised as perinatal/neonatal events (Category 8) (35%)
- 16 deaths fell into other categories (24%)

6.3 Modifiability classification, 2014/15 reviews

See Appendix 2 (CDOP) for the definition of modifiable factors and categories of death.

Of the 68 cases reviewed between April 2014 and March 2015:

- 8 deaths were considered to have modifiable factors (12%)
- The deaths were categorised as trauma and other external factors (Category 3), malignancy (Category 4), perinatal/neonatal event (Category 8), and sudden unexpected or unexplained death (Category 10).
6.4 Issues highlighted, 2014/15

For individual children there may be issues identified which are not identified as modifiable factors to the individual child’s death but are of note and require follow up with organisations or lead clinicians. Any specific individual issues have recommendations and CDOP ensures the appropriate action has been taken by the relevant agency e.g. if referral to genetic counselling was confirmed this would be followed up with the relevant clinician. In addition, common issues are identified including risk factors as below:

- Smoking in pregnancy
- Obesity in pregnancy
- Alcohol misuse
- Mental health issues
- Consanguinity
- Domestic abuse
- Neonatal bed capacity
- In-utero transfer to another unit where necessary
- Genetic testing with biopsy following death
- Genetic counselling and Genetics support in primary care
- Siblings with same inherited condition
- Access to timely and appropriate bereavement support
- Cancer diagnosis in children – ensuring guidance followed
- Co-sleeping with unsafe practices
- Oxygen saturation level monitoring at birth
- Access to chaplaincy services when required for parents/family
6.5 Recommendations, 2014/15

Recommendations identified in the 8 deaths with modifiable factors from 2014/2015 covered the following areas:

Drowning in baths:
- To raise public awareness of the risks of leaving children bathing alone/supervised by another young child – a drowning alert was devised and circulated via Public Health and BSCB.

Fireguards:
- West Yorkshire Fire and Rescue Service to liaise with Trading Standards with regards to fire guards for use on wall mounted fires and any new products that come onto the market.
- Awareness of safety around fireplaces to be raised as part of Child Safety Week.

Specific clinical incidents:
- Clinical Risk investigation completed at Bradford Teaching Foundation Hospital Trust (BTHFT) and recommendations for Obstetric and Paediatric staff in place for high risk pregnancies
- Internal investigation report at BTHFT and recommendations to review vaginal birth after caesarean (VBAC) guideline, implementation of VBAC and use of escalation guide
- Internal investigation report recommendation for BTHFT to increase awareness and training regarding use of foetal monitoring equipment including the different CTG settings to be appropriate as part of mandatory training, documentation in general and the bleep process.
- Haematology Department at BTHFT to review their processes to increase fail-safes for reporting of abnormal blood results.
Co-sleeping with unsafe practices:
• Assurance sought from the Maternity Network and all key organisations regarding sharing information with parents about safe sleeping practices – highlighting not to bed share after drinking, taking drugs, medication, excessively tired etc.

The summary Action Plan for Modifiable deaths is updated and audited regularly to ensure the actions recommended are completed in a timely manner by the organisations.

General recommendations arising from issues identified from the CDOP meetings in 2014/15 included:

1. Annual Away Day in June 2015 will consider all key analysis, trends for deaths for 2014/15 and the total period 2008-2015 and will include a focus on obesity and smoking in pregnancy.
2. CDOP will continue to monitor key themes for modifiable child deaths to include drowning in baths, co-sleeping and Sudden Infant Death Syndrome (SIDS) road traffic accidents and clinical incidents over the next year and will seek assurance organisations have addressed the key areas of concern and monitor any new similar cases arising.
3. Key recurrent issues identified, which may not be identified as modifiable factors for an individual child but are relevant at a population level, will also be monitored. Examples include smoking and obesity in pregnancy which are linked to increase risk of infant death, and consanguinity which is linked to an increased risk of congenital abnormalities and in some cases infant death. CDOP will continue to seek assurance organisations and partners are also addressing these key areas of concern.

7. Analysis of child deaths reviewed by CDOP, 2008/09 – 2014/15

This section will provide an overview of all reviewed child deaths in the Bradford District from April 2008 until March 2015. The data has been collated from the deaths of children up to 18 years of age who have been formally reported to and reviewed by the panel over the course of
the seven years from April 2008 to March 2015. It must be noted that the analysis includes only deaths reviewed by the CDOP, not all child deaths. However, 90% of notified child deaths have been reviewed over the seven years between April 2008 and March 2015.

Tables containing a full breakdown by different characteristics can be found in Appendix 4.

7.1 Demographics, 2008/09 – 2014/15
Age

Of the 528 cases reviewed between April 2008 and March 2015, 70% were infants (aged under 1 year old) and 30% were children (aged 1-17 years).

Figure 3: Age distribution for reviewed infant deaths (<1 year old), 2008/09-2014/15

Source: Bradford CDOP review data
There were 369 cases aged under 1 year old reviewed between April 2008 and March 2015. Figure 3 shows that the majority of reviewed infant deaths (63%) were aged under 28 days old. A further 20% of the infant deaths were aged 28 days to 3 months old.

There were 159 cases aged 1-17 years reviewed between April 2008 and March 2015. Figure 4 shows there was more variation in the ages of the reviewed child deaths than there was in the infant deaths. 56% of the reviewed child deaths were aged 1-4 years old, 18% of the reviewed child deaths were aged 14-17 years old.

**Figure 4: Age distribution for reviewed child deaths (1-17 years old), 2008/09-2014/15**

![Age distribution chart](chart)

*Source: Bradford CDOP review data*

**Sex**

Of the 528 cases reviewed between April 2008 and March 2015, 54% were male and 46% were female.
Ethnicity

Of the 528 cases reviewed between April 2008 and March 2015:

- 330 deaths were South Asian (63%)
- 161 deaths were White British or White Other (30%)
- 16 deaths were Eastern European (3%)
- 11 deaths were mixed ethnicities (2%)
- 10 deaths were other ethnicities (2%) including African, East Asian and Other

South Asian children are over – represented in the reviewed deaths compared to the comparable population for all children under 18 years of age.

7.2 Category of death classification, 2008/09 – 2014/15

There have been 526 cases reviewed between April 2008 and March 2015 where it was possible to classify the cause of death into one of the ten categories used nationally (Appendix 2). The most common causes of death out of all the reviewed cases (children aged under 18 years old) were chromosomal, genetic and congenital anomalies (Category 7) and perinatal/neonatal events (Category 8); these two categories of cause of death accounted for 74% of all reviewed deaths 2008-2015.

Figure 5: Category of death classification for reviewed deaths by age group, 2008/09-2014/15

Source: Bradford CDOP review data
Figure 5 shows that the most common causes of death for infants (under 1 year old) were Category 7 (chromosomal, genetic and congenital anomalies) and Category 8 (perinatal/neonatal event) which accounted for 42% and 46% of the reviewed infant deaths respectively. Out of all the child deaths attributed to Category 8 (perinatal/neonatal event), 98% of the reviewed deaths were infants (under 1 year old).

For children (aged 1-17 years old), the most common cause of death (39% of reviewed deaths) was Category 7 (chromosomal, genetic and congenital anomalies). After this, the causes of death for children were split over more categories than for infants and included Category 3 (trauma and other factors), Category 4 (malignancy), Category 5 (acute medical or surgical condition), Category 6 (chronic medical condition) and Category 9 (infection).

7.3 Preventability/modifiability classification, 2008/09 – 2014/15

Of the 528 cases reviewed between April 2008 and March 2015:

- 54 cases were deemed to have been preventable, potentially preventable or to have had modifiable factors (10%)
- 471 cases were deemed to have been not preventable or to have had modifiable factors (89%)
- 3 cases were deemed to not have sufficient information to make classification (1%)

The classification was changed from preventable/potentially preventable to modifiable factors in April 2010 (see Appendix 2).
For the 54 cases deemed to have been preventable, potentially preventable or to have had modifiable factors, the causes of death related to:

- deliberately inflicted injury, abuse or neglect (Category 1)
- trauma and other external factors (Category 3)
- malignancy (Category 4)
- acute medical or surgical condition (Category 5)
- chromosomal, genetic and congenital anomalies (Category 7)
- perinatal/neonatal event (Category 8)
- infection (Category 9)
- sudden unexpected or unexplained death (Category 10)

Analysis of themes and trends over time for 2008-2015 for modifiable deaths showed the following recurrent causes:

- Road traffic collisions
- Co-sleeping with risk factors and Sudden Infant Death (SIDS)
- Drowning in the bath
- There have been 3 Serious Case Reviews over time and a Learning Lessons Review identifying specific areas of neglect
- Swine Flu deaths up to 2011
- Specific Clinical incidents

All the above have specific recommendations made and these have been monitored and audited by CDOP to seek assurance all actions have been completed.
7.4 **Recommendations summary, 2008/09-2014/15**

Some of the key recommended actions from the panel for modifiable deaths have included the following:

**Deliberately inflicted injury, abuse or neglect (Category 1):**
- To give support to families with mental health issues

**Trauma and other external factors (Category 3):**
- To raise public awareness of the risks of leaving children bathing alone/supervised by another young child
- Actions to reduce further deaths from road traffic collisions

**Malignancy (Category 4):**
- To improve the diagnosis of cancer in children.

**Acute medical or surgical condition (Category 5):**
- To change a relevant pathway for recording information.

**Chromosomal, genetic or congenital anomalies (Category 7):**
- To ensure that the family are offered a referral for genetic counselling.

**Perinatal/neonatal event (Category 8):**
- To address range of specific clinical incidents during pregnancy, delivery (including home delivery) and infant care with relevant individuals and teams.

**Infection (Category 9):**
- To roll out the swine flu (H1N1) vaccination programme in alternative settings including special schools and to provide opportunistic flu vaccines in hospital and other health care provider settings.
Sudden unexpected or unexplained death (Category 10):
- To train staff in BTHFT, AFT and Bradford District Care Trust services to explain recommendations for safe sleeping and to ensure all parents have the correct advice.
- To monitor the uptake of the BSCB e-learning package - this includes advice about safe sleeping.

Insufficient information to categorise:
- To contact families to offer support and try to ascertain cause of death for child deaths that occur abroad in future.

7.5 Risk factors

Data is collected by the CDOP on a range of risk factors that potentially influence child deaths. These include, for example, smoking, alcohol intake, obesity and domestic violence. Some of these risk factors have a clear link with poor outcomes; for example, smoking in pregnancy is known to be associated with increased low birth weight rates.\(^1\)

Further classifications have been agreed by the CDOP to further investigate the more common causes of death in Bradford. To help investigate perinatal/neonatal events (Category 8), extreme prematurity is recorded.

For chromosomal, genetic or congenital anomalies (Category 7), since September 2011, there has been sub classification of the genetic conditions to indicate whether the deaths were due to an autosomal recessive condition, autosomal dominant condition, a sporadic genetic cause or if this information was not known. Sporadic causes are not predictable and can occur across all communities. In communities where consanguinity (marriage between cousins) is more common, it is more likely that genes that are rare within the general population are carried by both parents. Therefore, a child born from a consanguineous relationship is at greater risk of inheriting genes which could cause congenital anomalies or chronic diseases - in some cases the conditions are fatal.
A paper published in the Lancet 2013, based on the Born in Bradford cohort, confirmed an increased risk of congenital anomalies within the South Asian population in consanguineous marriages from 3% to 6% and also increased risk of congenital anomalies for older White women.\(^{14}\)

The CDOP panel will continue to monitor the data and information for both deaths of infants and children up to the age of 18 years and as more data becomes available over time these will inform future recommendations. The information collated at each CDOP meeting also informs the CDOP issues log. These issues lead to more general recommendations by CDOP and emerging themes worthy of being highlighted are identified and monitored. Findings from CDOP are also shared with key groups and leads such as the Every Baby Matters steering group, Road Safety Team and Accident Prevention Lead and are shared as part of Safeguarding Week.

8. Comparison to Infant and Child Mortality Rates

There was a higher proportion of deaths due to chromosomal, genetic or congenital anomalies (Category 7) deaths in Bradford compared to national CDOP data – this difference in the profile of category of death could in part explain some of the difference between local and national infant and child mortality rates. The proportion of Perinatal/neonatal events (category 8) for 2010/11-2012/13 was similar to the national CDOP data\(^{5,6,7,8}\) but, overall, neonatal mortality rates are higher than regional and national averages (Figure 1, Appendix 5). This analysis indicates our focus to reduce child deaths should cover all cause of death for children but a significant focus should be on preventing deaths in Category 7 and 8.

8.1 Infant Mortality Rates (under 1 year)

Infant mortality is defined as the number of deaths in the first year of life per 1,000 live births. The latest infant mortality rate for Bradford District (5.9 per 1,000 live births) remains above the England average (4.1 per 1,000 live births) for the period 2011-2013 but has decreased each year for the last five years. Although the Bradford infant mortality rate remains high compared to regional and national rates, the gap is reducing. See Figures 1 and 2, Appendix 5 for more information.
The infant mortality rate in the most deprived quintile in Bradford has reduced much faster over time than the Bradford, Yorkshire and The Humber and England rates (Figure 3, Appendix 5).

8.2 Characteristics of infant deaths reviewed by CDOP, 2008/09-2014/15

The number of infant deaths being reported each year to the CDOP has decreased from a peak of 77 deaths in 2009/10 to 51 deaths in 2014/15 (Figure 4, Appendix 5).

Using the first six years of CDOP data for which almost all infant deaths have been reviewed (99%), a comparison can be made between the first three years and the last three years to look at differences over time.

- Between 2008/09-2010/11 and 2011/12-2013/14 there were 79 fewer infant deaths.
- There were fewer reviewed deaths between the two time periods attributed to all of the ten categories of death, more noticeably in Category 7 (chromosomal, genetic or congenital anomalies), Category 8 (perinatal/neonatal events) and category 9 (infection) (Figure 5, Appendix 5).
- The proportion of deaths within each of these categories has changed between the two time periods, there was a greater proportion of deaths due to chromosomal, genetic or congenital anomalies (Category 7) and a smaller proportion of deaths due to both perinatal/neonatal events (Category 8) and infection (Category 9) (Figure 6, Appendix 5).

8.3 Child Mortality Rates (1-17 years)

Child mortality is defined as the number of deaths for children aged 1-17 years old per 100,000 population. The child mortality rate for Bradford has been consistently higher than the national rate; in 2011-13, the child mortality rate for Bradford District was 17.4 per 100,000 compared to 11.9 per 100,000 for England. The gap between the local and national rates is narrowing over time. (Figures 1 and 7, Appendix 5).
8.4 Characteristics of child deaths reviewed by CDOP, 2008/09-2014/15

The number of child deaths (aged 1-17 years old) notified to the CDOP has fluctuated over time and there has been year on year variation with no discernible trend. There have been much smaller numbers compared to the number of infant deaths which makes it difficult to draw comparisons to the child mortality rate.

Using the first six years of CDOP data for which almost all child deaths have been reviewed (97%), a comparison can be made between the first three years and the last three years to look at differences over time. There were 23 fewer child deaths in 2011/12-2013/14 compared to 2008/09-2010/11. The number of deaths in each of the ten categories varied between the two time points and there was variation as to whether there was a greater or lesser number of deaths in each category (Figure 4, Appendix 5).

9. Actions to reduce infant and child mortality

There are a range of strategies across the district to reduce infant and child deaths.

The very high rate of infant mortality in 2000-2002 initiated an independent Infant Mortality Commission in Bradford District in 2004-2006. The Commission investigated why some babies born in the District die during their first year of life and a key report was produced which demonstrated that infant mortality is linked with poverty and deprivation as well as other risk factors such as smoking, alcohol and substance misuse, young motherhood and consanguinity. Young motherhood, smoking, alcohol and substance misuse are significantly higher risk factors within the White population of the District and consanguinity, which is linked to an increased risk of congenital anomalies, is common in the South Asian community – around 60% of marriages within the Pakistani population in Bradford District are consanguineous.
The work of the Commission and further in depth analysis of data on infant deaths continues as part of the Every Baby Matters Steering Group agenda; the current Strategy and Action Plan focuses on the 10 recommendations within the original report to continue to reduce infant mortality rates:

- Recommendation 1a – To reduce poverty in families in Bradford
- Recommendation 1b – To reduce unemployment in families in Bradford
- Recommendation 2 – To improve the availability of good quality and affordable housing for families
- Recommendation 3a – To improve the health and nutrition of women, before and during pregnancy, and their babies
- Recommendation 3b – To increase breastfeeding rates
- Recommendation 4 – To ensure equal access to all aspects of pre-conception, maternal and infant health care
- Recommendation 5 – To improve social and emotional support for vulnerable parents
- Recommendation 6a – To reduce smoking rates in the district with a focus on women during pregnancy
- Recommendation 6b – To reduce high levels of alcohol and/or non-prescribed drugs in pregnancy
- Recommendation 7 – To increase community understanding of genetically inherited congenital anomalies
- Recommendation 8 – To ensure these recommendations are shared widely
- Recommendation 9 – To develop further data collection and monitoring procedures
- Recommendation 10 – To conduct future research to understand causes of death

To reduce the risks of child death, some of the strategies and action plans in place across the District include the following:

- Accident Prevention Strategy for Children
- Road Safety Plan
- Bradford Children Safeguarding Board – Serious Case Reviews and Learning Lessons Reviews
10. Conclusion

10.1 Specific Recommendations

The focus of this report is on the recommendations for 2014/15. These were identified in the 8 deaths with modifiable factors reviewed in 2014/2015 which covered the following areas:

- Drowning in baths: Alerts and awareness for the district
- Fire and Fireguards: Awareness in Child Safety Week and specific action with Trading Standards
- Specific clinical incidents: Specific recommendations for high risk pregnancies, vaginal birth after caesarean, foetal monitoring and processes for abnormal blood test alerts at BTHFT
- Co-sleeping – Awareness and alerts re safe sleeping practice and avoiding co-sleeping with risk factors

The summary Action Plan for Modifiable deaths is updated and regularly audited regularly to ensure the actions recommended are completed in a timely manner by the organisations. In addition, CDOP provides a valuable opportunity to review all causes of death in detail and hence every year the updated analysis for 2008-2015 is also reviewed. This information is fed into key networks, groups and safeguarding week to inform plans for the future to reduce the risk of child deaths in the future.

General Recommendations

- Annual Away Day in June 2015 will consider all key analysis, trends for deaths for 2014/15 and the total period 2008-2015 and will include a focus on obesity and smoking in pregnancy.
- CDOP will continue to monitor key themes for modifiable child deaths to include drowning in baths, co-sleeping and Sudden Infant Death Syndrome (SIDS) road traffic accidents and clinical incidents over the next year and will seek assurance organisations have addressed the key areas of concern and monitor any new similar cases arising.
• Key recurrent issues identified, which may not be identified as modifiable factors for an individual child, but are relevant at a population level, will also be monitored. Examples include smoking and obesity in pregnancy which are linked to increase risk of infant death, and consanguinity which is linked to an increased risk of congenital abnormalities and in some cases infant death. CDOP will continue to seek assurance from organisations and partners that they are addressing these key areas of concern.

Report Authors:

Shirley Brierley - Chair of Bradford CDOP, Consultant in Public Health
Louise Clarkson - CDOP Manager
Joanna Garner - Public Health Information Analyst

July 2015
References


Appendix 1 (CDOP) : Terms of Reference

1 Purpose
The purpose of the Child Death Overview Panel is to:

a) collect and analyse information about each child’s death with a view to identifying:
   i) any case giving rise to the need for a serious case review
   ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and
   iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area

b) put in place procedures for ensuring that there is a coordinated response by professionals to an unexpected death.

The Panel will review deaths of all children aged 0-17 (excluding stillbirths) normally resident in the Local Authority area of the Bradford Safeguarding Children Board. Where the Panel is made aware of the death of a child in their area who would normally be resident in another Local Authority area, or vice versa the Child Death Review Administrator will liaise with his/her opposite number in the other Local Authority area to ensure both Panels are notified of the death and to determine which Panel is best placed to carry out a review of that child’s death. Where possible it is advised that the panel in the child’s area of residence takes responsibility for the review although it is recognised that circumstances will dictate the most appropriate outcome.

2 Functions
The Child Death Overview Panel:

- Meet regularly to complete a multi-agency evaluation of all child deaths in their area;

- Where appropriate undertake a detailed and in-depth evaluation into specific cases, including all unexpected deaths, assessing all relevant social, environmental, health and cultural aspects, or systemic or structural factors of the death, along with the appropriateness of the professionals’ responses to the death and involvement before the death, in order to complete a thorough consideration of whether and how such deaths might be prevented in future;
• Collect and collate information using the agreed templates and where relevant seek further information from professionals and family members;
• Identify local lessons and issues of concern, requiring effective inter-agency working;
• Identify and report any local Public Health issues and consider, with the Director of Public Health and other provider services how best to address these and their implications for both the provision of services and for training;
• Identify and advocate for needed changes in legislation, policy and practices, or public awareness, to promote child health and safety and to prevent child deaths;
• Ensure concerns of a criminal or child protection nature are shared with the police, children’s social care and the coroner;
• Ensure any case identified as meeting criteria for a Serious Case Review are referred to the chair of the BSCB;
• Provide information to professionals involved with families so that this can be passed on in a sensitive and timely manner;
• Implement, review and monitor the local procedures for rapid response arrangements in line with Working Together;
• Monitor the quality of information, support and assessment services to families of children who have died;
• Co-operate with any regional and national initiatives in order to identify lessons on the prevention of child deaths.

3 Accountability

• The Child Death Overview Panel will be responsible, through its chair, to the chair of the Bradford Safeguarding Children Board. The Panel will provide to the BSCB and all constituent agencies, an annual report (in which all information should be aggregated and anonymised) which shall be a public document. In addition, the Panel will report to the BSCB any matters of concern arising from the course of its work as set out above.

• The BSCB will take responsibility for disseminating the lessons to be learned to all relevant organisations; ensuring that relevant findings inform the Children and Young People’s Plan; and acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
• The BSCB will supply data regularly on every child death, as required by the Department for Education, to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.
Appendix 2 (CDOP): Definition of Preventable and Modifiable Deaths and 10 Categories for Cause of Death

Definitions Used as cited in Statistical Release for Child Death Reviews: year ending March 2011 Dept for Education July 2011:

1. Preventable/Potentially preventable death: Definition used from April 2008 to March 2010
Preventable - A preventable child death is defined as events, actions or omissions contributing to the death of a child or a sub-standard care of a child who died, and which, by means of national or locally achievable interventions, can be modified.
Potentially preventable - A potentially preventable death with same definition as above.

2. Modifiable death: Definition changed from April 2010 onwards
A modifiable death is defined as “The Panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths”.

10 Categories for Cause of Death
Category 1 – Deliberately inflicted injury, abuse or neglect: this includes suffocation, shaking injury, knifing, shooting, poisoning and other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes sever neglect leading to death
Category 2 – Suicide or deliberate self-inflicted harm: this includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger people.
Category 3 – Trauma and other external factors: this includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis and other extrinsic factors. Excludes deliberately inflicted injury, abuse or neglect (Category 1).
Category 4 – Malignancy; solid tumours, leukaemias and lymphomas and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
Category 5 – Acute medical or surgical condition; for example Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
Category 6 – Chronic medical condition; for example, Crohn’s disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.
Category 7 – Chromosomal, genetic and congenital anomalies; Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis and other congenital anomalies including cardiac.
Category 8 – Perinatal/neonatal event; Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week).
Category 9 – Infection; Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
Category 10 – Sudden unexpected death; where the pathological diagnosis is either ‘SIDS’ or ‘unascertained’, at any age. Excludes Sudden unexpected death with epilepsy (Category 5).
Appendix 3 (CDOP)

Board Structure

Chair/Vice Chair

BSCB

Business Planning Group

VCS Safeguarding Steering Group

Safeguarding in Health Group

Child Death Overview Panel

Serious Case Review Sub-group

Child Sexual Exploitation Sub-group

Learning & Development Sub-group

Performance Management, Audit & Evaluation Sub-group

Universal Safeguarding Sub-group

Pro-active and Responsive Sub-group
Appendix 4 (CDOP): Characteristics of deaths reviewed by CDOP

Characteristics of the child deaths reviewed between April 2008 and March 2015.

Age

Figure 1: Age distribution of all reviewed deaths, 2008/09-2014/15

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>369</td>
<td>70%</td>
</tr>
<tr>
<td>1-17 years old</td>
<td>159</td>
<td>30%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>528</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Bradford CDOP review data

Figure 2: Age distribution of all reviewed infant deaths, 2008/09-2014/15

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 28 days</td>
<td>232</td>
<td>63%</td>
</tr>
<tr>
<td>28 days to 2 months</td>
<td>74</td>
<td>20%</td>
</tr>
<tr>
<td>3 months to 1 year</td>
<td>63</td>
<td>17%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>369</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Bradford CDOP review data

Figure 3: Age distribution of all reviewed child deaths, 2008/09-2014/15

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4 years old</td>
<td>89</td>
<td>56%</td>
</tr>
<tr>
<td>5-13 years old</td>
<td>41</td>
<td>26%</td>
</tr>
<tr>
<td>14-17 years old</td>
<td>29</td>
<td>18%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>159</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Bradford CDOP review data
Sex

**Figure 4: Sex distribution of all reviewed deaths, 2008/09-2014/15**

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>283</td>
<td>54%</td>
</tr>
<tr>
<td>Female</td>
<td>245</td>
<td>46%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>528</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: Bradford CDOP review data*

Ethnicity

**Figure 5: Ethnicity distribution of all reviewed deaths, 2008/09-2014/15**

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Asian</td>
<td>330</td>
<td>63%</td>
</tr>
<tr>
<td>White British or White Other</td>
<td>161</td>
<td>30%</td>
</tr>
<tr>
<td>Eastern European</td>
<td>16</td>
<td>3%</td>
</tr>
<tr>
<td>Mixed ethnicities</td>
<td>11</td>
<td>2%</td>
</tr>
<tr>
<td>Other ethnicities including African, East Asian and Other</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>528</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: Bradford CDOP review data*
Category of death

Figure 6: Category of death distribution of all reviewed deaths, 2008/09-2014/15

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>12</td>
<td>2%</td>
</tr>
<tr>
<td>Category 2</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Category 3</td>
<td>26</td>
<td>5%</td>
</tr>
<tr>
<td>Category 4</td>
<td>17</td>
<td>3%</td>
</tr>
<tr>
<td>Category 5</td>
<td>16</td>
<td>3%</td>
</tr>
<tr>
<td>Category 6</td>
<td>22</td>
<td>4%</td>
</tr>
<tr>
<td>Category 7</td>
<td>216</td>
<td>41%</td>
</tr>
<tr>
<td>Category 8</td>
<td>173</td>
<td>33%</td>
</tr>
<tr>
<td>Category 9</td>
<td>34</td>
<td>6%</td>
</tr>
<tr>
<td>Category 10</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>No category</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>528</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Bradford CDOP review data

Modifiability

Figure 7: Modifiability classification of all reviewed deaths, 2008/09-2014/15

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventability/potentially preventable/modifiable</td>
<td>54</td>
<td>10%</td>
</tr>
<tr>
<td>Not modifiable</td>
<td>471</td>
<td>89%</td>
</tr>
<tr>
<td>Inadequate information</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>528</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Bradford CDOP review data
Appendix 5 (CDOP): Infant and child mortality rates

Figure 1: Mortality rates, 2011 - 2013

<table>
<thead>
<tr>
<th></th>
<th>Neonatal (&lt;28 days) mortality rate, per 1,000 live births</th>
<th>Infant (&lt;1 year) mortality rate, per 1,000 live births</th>
<th>Child (1-17 years) mortality rate, per 10,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradford</td>
<td>4.0</td>
<td>5.9</td>
<td>17.4</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>3.0</td>
<td>4.5</td>
<td>-</td>
</tr>
<tr>
<td>England</td>
<td>2.9</td>
<td>4.1</td>
<td>11.9</td>
</tr>
</tbody>
</table>

Sources: NHS information Centre Indicator Portal and Child Health Profile 2015, ChiMat

Figure 2: Infant Mortality Rates for Bradford District vs England and Yorkshire and The Humber, 2005-07 to 2011-13

Source: ONS data
Figure 3: Infant mortality rates in the most deprived quintiles Bradford District, Region and England during 2007-09 to 2011-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Bradford's most deprived quintile</th>
<th>Bradford</th>
<th>Yorkshire and the Humber</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-2009</td>
<td>10.6</td>
<td>7.9</td>
<td>5.3</td>
<td>4.6</td>
</tr>
<tr>
<td>2008-2010</td>
<td>10.2</td>
<td>7.9</td>
<td>5.2</td>
<td>4.4</td>
</tr>
<tr>
<td>2009-2011</td>
<td>9.0</td>
<td>7.5</td>
<td>5.0</td>
<td>4.3</td>
</tr>
<tr>
<td>2010-2011</td>
<td>7.8</td>
<td>7.0</td>
<td>4.6</td>
<td>4.1</td>
</tr>
<tr>
<td>2011-2013</td>
<td>6.9</td>
<td>5.9</td>
<td>4.5</td>
<td>4.1</td>
</tr>
<tr>
<td>% Change between 2007-2009 and 2011-2013</td>
<td>-34.9%</td>
<td>-25.3%</td>
<td>-15.1%</td>
<td>-10.9%</td>
</tr>
</tbody>
</table>

Source: Public Health Analysis Team City of Bradford Metropolitan District Council, based on ONS data

Figure 4: Numbers of deaths notified to the CDOP by age category and year of death, 2008/09 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>63</td>
<td>77</td>
<td>74</td>
<td>44</td>
<td>46</td>
<td>48</td>
<td>51</td>
</tr>
<tr>
<td>1-17 year old</td>
<td>22</td>
<td>31</td>
<td>34</td>
<td>26</td>
<td>22</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>No date of death in notification</td>
<td>85</td>
<td>108</td>
<td>108</td>
<td>70</td>
<td>68</td>
<td>67</td>
<td>80</td>
</tr>
</tbody>
</table>

Source: Bradford CDOP notifications data
Figure 5: Numbers of reviewed infant deaths in each category of death, 2008/09-2010/11 compared to 2011/12-2013/14

Source: Bradford CDOP review data

NB: The deaths with inadequate information to make a category of death classification were removed from the analysis

Figure 6: Proportion of reviewed infant deaths in each category of death, 2008/09-2010/11 compared to 2011/12-2013/14

Source: Bradford CDOP review data

NB: The deaths with inadequate information to make a category of death classification were removed from the analysis
Figure 7: Child mortality rates over time, 2008-10 to 2011-13

Child mortality rate, per 100,000, 2008-13

<table>
<thead>
<tr>
<th>Year</th>
<th>Bradford</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-10</td>
<td>26.3</td>
<td>16.5</td>
</tr>
<tr>
<td>2009-11</td>
<td>23.6</td>
<td>13.7</td>
</tr>
<tr>
<td>2010-12</td>
<td>20.7</td>
<td>12.5</td>
</tr>
<tr>
<td>2011-13</td>
<td>17.4</td>
<td>11.9</td>
</tr>
</tbody>
</table>

Source: Child Health Profiles, ChiMat

Figure 8: Numbers of reviewed child deaths (1-17 years old) in each category of death, 2008/09-2010/11 compared to 2011/12-2013/14

Source: Bradford CDOP review data

NB: The deaths with inadequate information to make a category of death classification were removed from the analysis for Fig 8 and Fig 9
Figure 9: Proportion of reviewed child deaths (aged 1-17 years old) in each category of death, 2008/09-2010/11 compared to 2011/12-2013/14

Source: Bradford CDOP review data
If you wish to find out more about the Bradford Safeguarding Children Board, please contact us at:

Sir Henry Mitchell House
4 Manchester Rd
Bradford
BD5 0QL

t - 01274 434361
f - 01274 434345
e - info@bradford-scb.org.uk
w - www.bradford-scb.org.uk