CORPORATE PARENTING BOARD

A meeting of the Corporate Parenting Board was held on 17 February 2011.

PRESENT: Councillor Carr (Chair), Councillors Brunton, P Rogers, Rooney and J A Walker.

OFFICERS: S Harker, I Parker, G Rollings and G Watson.

****ALSO IN ATTENDANCE:** B Simpson, Foster Carer.
M Braithwaite, Middlesbrough Safeguarding Children Board.

****APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Dryden and Mawston.

****DECLARATIONS OF INTEREST**

No Declarations of Interest were made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Corporate Parenting Board held on 18 January 2011 were taken as read and approved as a correct record.

MIDDLESBROUGH SAFEGUARDING CHILDREN BOARD

Members received a presentation regarding safeguarding in Middlesbrough and the work of the Middlesbrough Safeguarding Children Board (MSCB).

The Children Act 2004 required each Local Authority to establish a Local Safeguarding Children Board (LSCB) by 1 April 2006. Middlesbrough formed the MSCB in April 2010 following the dissolution of the South Tees arrangements. The MSCB appointed Mark Braithwaite as the Independent Chair in October 2010. The MSCB was working to the guidance contained in Working Together 2010 and the latest recommendations, as they became available from the Coalition Government.

The MSCB was the key statutory mechanism for agreeing how partner organisations in Middlesbrough worked together to safeguard and promote the welfare of children and young people and to ensure the effectiveness of that work.

The role of the MSCB was set out in primary legislation and regulations, and included:

- Co-ordinating what was done by agencies for the purposes of safeguarding and promoting the welfare of children in the area of the Authority.
- Ensuring the effectiveness of what was done by each agency.
- Safeguarding and promoting the welfare of children and protecting them from harm.
- Implementing preventative work to avoid harm being suffered.

Safeguarding was defined as protecting children from maltreatment, preventing the impairment of children's health and/or development and ensuring that they grew up in circumstances consistent with the provision of safe and effective care.

The scope of the MSCB covered three broad areas of activity which were:

- Activity that affected all children and aimed to identify and prevent maltreatment, or impairment of health or development and to ensure that children were growing up in circumstances consistent with safe and effective care.
- Pro-active work that aimed to target particular groups.
- Reactive work to protect children who were suffering, or were likely to suffer significant harm.

Some examples of the activities, proactive and responsive work of the MSCB were highlighted in the presentation. It was noted that Middlesbrough had a high rate of child deaths and this was a key issue for the MSCB.

Work was ongoing to develop procedures and make them available on the website. A newsletter had been produced and the Independent Chair was working with the media to improve public awareness and perception of safeguarding. The MSCB newsletter contained details of the all the training available from January to March 2011.

The main functions of the MSCB were to:

- Develop policies and procedures for safeguarding and promoting the welfare of children in the area of the Authority.
- Communicate to persons and bodies in Middlesbrough the need to safeguard and promote the welfare of children, raise their awareness of how this could best be done, and encourage them to do so.
- Monitor and evaluate the effectiveness of what was done in Middlesbrough across MCSB partners individually and collectively to safeguard and promote the welfare of children and advise on ways to improve.
- Produce and publish an annual report on the effectiveness of safeguarding in Middlesbrough.
- Participate in the planning and commissioning of children's services in Middlesbrough to ensure that they take safeguarding and promoting the welfare of children into account.
- Collect and analyse information about child deaths in Middlesbrough and put in place procedures to ensure any lessons were learned following any unexpected death of a child.
- Commission reviews of cases where abuse or neglect of a child was known or suspected, where a child had died or a child had been seriously harmed and where there was cause for concern as to the way in which the Authority, MSBC partners or other relevant persons had worked together to safeguard the child.

The latest figures on Looked After Children (LAC), Child Protection and Open Cases were highlighted and it was noted that there had been a decline in the number of Child Protection cases over the last year and the number of LAC had increased. The Open Cases were those children in need who were receiving support to try and prevent them going into the other two categories. The relatively high number of Open Cases, approximately 2500, was a contributory factor to the lower number of Child Protection cases.

The MSCB was still developing and was working towards the following aims:

- Ensuring the implementation of recommendations from the recent Serious Case Review.
- Reporting on Safeguarding in Middlesbrough.
- Appointing lay people onto the MSCB.
- Developing and agreeing longer term Child Death Overview Panel (CDOP) provision.
- Revising data collection requirements both locally and pan-Tees to ensure effective performance monitoring and evaluation.
- Ensuring effective reporting and challenge between MSCB and the Children and Young People's Trust.

The child death overview responsibility was a statutory responsibility of the Board and there was also a Child Death Overview pan-tees Panel. The Panel had been in operation for two years and reviewed all child deaths across the Tees including neo-natal and premature baby deaths. The CDO Panel had responsibility for looking at each case and identifying whether there was any learning for the agencies involved. The CDO complemented the Coroner's role and that person's statutory duty to try and prevent child deaths.

Where a child had died or received injuries as a result of abuse, a Serious Case Review was undertaken and the findings published in an Executive Summary. The MSBC's responsibility was to ensure that any lessons learned and recommendations made as a result of the Serious Case Review were properly implemented. It was a source of frustation that the outcomes of Serious Case Reviews often made headline news but were generally reported from a negative point of view. The reality was that staff were working in very difficult circumstances, making difficult decisions and needed support rather than criticism when mistakes were identified. It was also noted the time for completion of a Serious Case Review could be lengthy, and often during the time of the incident and the publication of the Review, new processes in response to the lessons learned had already been implemented. In future the full final report of a Serious Case

Review would have to be published rather than just the Executive Summary, although it would be anonymised.

The MSCB was funded through a pooled budget to which all partners contributed. The current year's budget was approximately £193K. Within that funding there was a requirement to fund Serious Case Reviews and a contribution of £35K to the training budget. Efforts were being made to secure a contingency fund for Serious Case Reviews as these could cost anywhere between 14K and 400K depending on the complexity of the case.

The Chair, on behalf of the Board, thanked the Chair of the MSCB for his presentation.

RECOMMENDED that the Corporate Parenting Board advise the Executive to note the content of the report.