BRISTOL SAFEGUARDING CHILDREN BOARD

BSCB
Bristol Safeguarding Children Board
making safeguarding everybody's business

ANNUAL REPORT 2017-18

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FOREWORD FROM BSCB INDEPENDENT CHAIR

It is the right of every child to be safe, to thrive and achieve their potential. The Safeguarding Children Board brings together key partners from across the city to ensure we are working together effectively to prevent children from coming to harm and take appropriate action in the unfortunate circumstances where this has happened. Every member of our community has an important role to play in being vigilant to the welfare of all our children and the information we give to the public is intended to assist in this shared endeavor. Our Board has the particular advantage of an effective and dedicated Lay Member who provides scrutiny from the perspective of a member of the public and I am exceedingly grateful for the work she undertakes.

At the heart of our partnership is a strongly held principle that we listen to the voice of the child. It is critical that, as much as possible, we are able to see the world as it is viewed through the eyes and the lived experience of children. In this respect our Shadow Board of children and young people are an invaluable resource in sharing their perspectives and providing robust challenge to the work we do. Their engagement and confidence is impressive and crucially, their impact is tangible.

There are many stereotypes about the risks that children face and an important part of our continuous learning is to highlight those matters that are more easily overlooked. We know, for example, that society and professionals easily underestimate the threats experienced by young adolescent males and the complexities they face in receiving the services they require. It is important therefore that we continue to work with partners to increase our shared understanding and appropriate prioritisation of their needs and others whose safeguarding needs are less easily recognised.

In October 2017 we were pleased to be subject to a Joint Targeted Area Inspection focusing upon the issue of child "neglect" and the extent to which this is perceived and effectively acted upon. We all need to be better at recognising neglect and naming it as such. The inspection was enormously valuable in identifying where structures and practice was particularly good and in working with us to identify an action plan for continued improvements. Professionals and members of the public often only see single dimensions of neglect although in many cases the young person is experiencing a host of difficult and adverse experiences which, felt together, are severely debilitating and harmful. Strong partnership work provides a more full and accurate picture of the reality and can ensure effective intervention.

Partnership safeguarding arrangements for children are subject to transition following the Children and Social Work act 2017 and the Local Authority, Police and Clinical Commissioning Group are currently in discussions to agree what the new arrangements will be from September 2019. I am pleased that Bristol has a strong foundation and highly effective business unit to support this transition. Bristol partners are ambitious for children and have always maintained a resolve for continuous learning despite the extraordinary challenges of austerity and restructure that organisations have, and continue to, encounter.

I am pleased to report that relationships between partners in Bristol benefit from a high degree of willingness to work together and appropriately robust candour in challenging (and hearing) evidence about where practice needs to be improved. We can never wholly eliminate risk but it is right that agencies have worked hard to learn from serious incidents and families have been afforded respect and a high level of influence in shaping the way forward.

It is a privilege to act as Independent Chair and work with highly skilled and committed professionals and community representatives in this most important setting.

Sally Lewis,

Independent Chair of Bristol Safeguarding Children Board

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1. ABOUT THE BOARD

> " The multi-agency partnership has a strong commitment to the protection of children in Bristol... Strong foundations to further improve are in place and there is significant evidence of the partnership agencies in Bristol being able to work together effectively. " Bristol JTAI Report, 2017

The BSCB is the key statutory body overseeing multi-agency child safeguarding arrangements across the City of Bristol. Governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2006, the BSCB comprises senior leaders from across the statutory and voluntary sectors. It has two basic objectives defined within the Children Act 2004; **to co-ordinate the safeguarding work of agencies** and **to ensure that this work is effective.** 2018-2019 will be a time of significant change for the Board as the Children and Social Work Act 2017 removed the requirement for an LSCB, giving flexibility to local areas to determine strategic safeguarding arrangements. The BSCB will be working with partners over 2018-19 to determine the new arrangements.

INDEPENDENT CHAIR

The Independent Chair of the BSCB is Sally Lewis OBE. The Independent Chair is tasked with ensuring that the Board fulfils its statutory objectives and functions. Key to this is the facilitation of a working culture of transparency, challenge and improvement across all partners with regards to their safeguarding arrangements.

Whilst being unable to direct organisations, the BSCB Chair does have the power to **influence** and **hold agencies to account** for their role in safeguarding. This influence can touch on matters relating to governance as well as impacting directly on the welfare of children and young people.

The ultimate responsibility for the effectiveness of the BSCB rests with the political leaders of Bristol City Council and the Board's Chair is accountable to Bristol City Council's Mayor and Head of Paid Services.

JOINT BUSINESS UNIT

The work of the BSCB is supported by an independent Business Unit, funded in partnership with the Bristol Safeguarding Adults Board to aid co-working across the whole system.

The team supports the work of both Boards and their Sub Groups.

1 Business Manager
1 Policy and Projects Officer
1 Project Officer
0.5 Safeguarding Data Analyst
1.5 Business Support Officer
1 BSCB-only Inter-Agency Safeguarding Trainer
1 BSCB-only Training Business Support Officer

"There is increasing evidence of a responsive and self-aware BSCB." Bristol JTAI report, 2017

In 2017-2018 the team recruited to the part time Safeguarding Data Analyst role and part time Business Support Officer role, and have been fully staffed for six months.

This year the team has focused on supporting the BSCB to increase its quality and assurance functions through an improved data oversight, audit framework and reviews of policy implementation. Other key achievements have been the launch of the new BSCB website, development of the Bristol Neglect Strategy and the Workforce Learning and Development Strategy, and support of the completion and publication of four Serious Case Reviews.

SHADOW BOARD

At the BSCB Annual Conference

Our BSCB Shadow Board has had a very busy year! The Shadow Board is made up of young people aged 13-21 who act as the BSCB's youth advisory and challenge group. All our members represent youth participation groups in the city including the Bristol Youth Council, Bristol Children in Care Council, Young Carers, Mentality, Freedom, and Unity. We are responsible for holding the BSCB to account on behalf of the children of Bristol.

Some of our members meeting with DCI Nigel Colston discussing how to improve relationships between young people and the police in the community

We started the year with running and presenting at the BSCB Annual Conference to nearly 200 professionals. We spoke about our findings from last year's safeguarding service and delivered presentations on how to work with young people's diverse identities and needs.

This year we challenged the city to do more to support young people who are being bullied. We wrote to Mayor Marvin Rees and asked him to encourage schools to get involved in the Anti-Bullying Alliance work in the city, which he did. We also did a podcast on bullying which we sent to senior managers around the city to get a better understanding of the issues. You can listen to it here!

This year we also raised concerns with the BSCB about risk from other children and the BSCB developed the new Harmful Sexual Behaviour Guidance to make sure all children are safe and get the right support, and supported the Barnardo's BASE Participation Group who launched new films raising awareness of the impact of child sexual exploitation at their Free From Fear event.

The Shadow Board has raised issues of the availability of mental health support, protecting young people from criminal exploitation and gangs, and safety within education settings to the Board as areas needing progress in 2018-2019.

LAY MEMBER

“I have now been a member of the Bristol Safeguarding Children’s Board (BSCB) for 18 months or so. As well as attending Board Meetings, I am a member of the Quality and Performance and the Communications Sub Groups of the Board.

In particular, I find being a member of the Quality and Performance sub group very useful as the performance score card, which is updated every month, gives me a picture and an understanding of what is happening to children across the city. For example the number of children being educated at home, the number of children excluded from school etc. Having access to these statistics enables me to question and ask for further information if I have safeguarding concerns.

Being a member of the Communications subgroup has enabled me on a number of occasions to encourage and support publicity campaigns that stress the message that “Safeguarding is everyone’s business”.

I think it is very important that the Board is aware of and in touch with what children and young people want and need to keep them safe. To improve my understanding of these issues, I recently met with a number of young people from the Shadow Board.

During the past year I have gained a clearer understanding of the links between and the roles played by the many different organisations involved in safeguarding children and an appreciation of the scale of the challenge of working in partnership.

I very much see the role of the Lay Member as holding the professionals to account on behalf of the public. I do this by asking the questions that members of the public might ask. Quite often these questions have raised further issues which needed to be addressed.”

Patsy Hudson, BSCB Lay Member

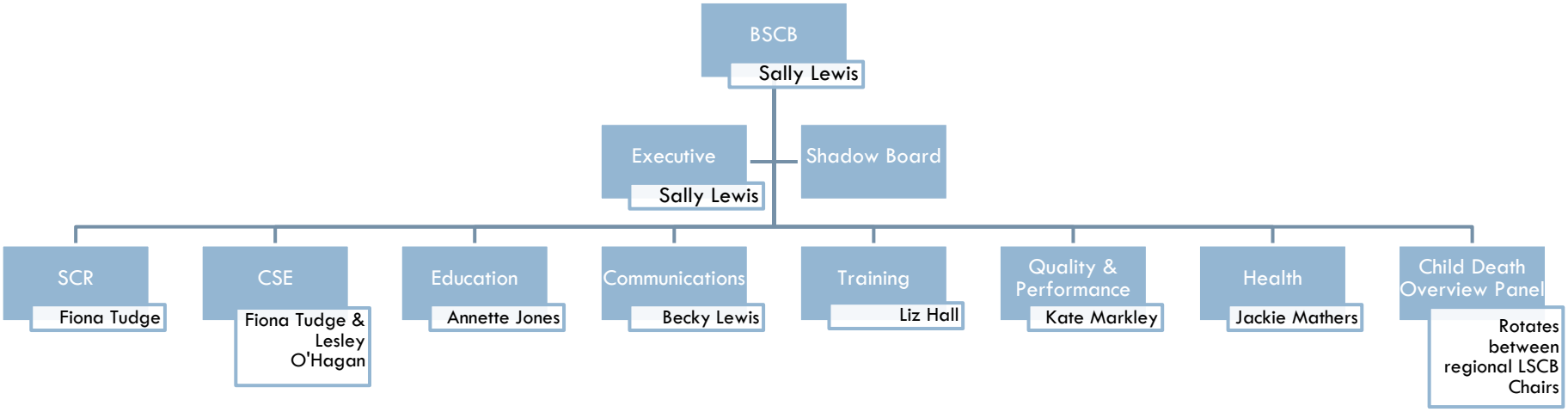
BOARD STRUCTURE AND SUB-GROUPS

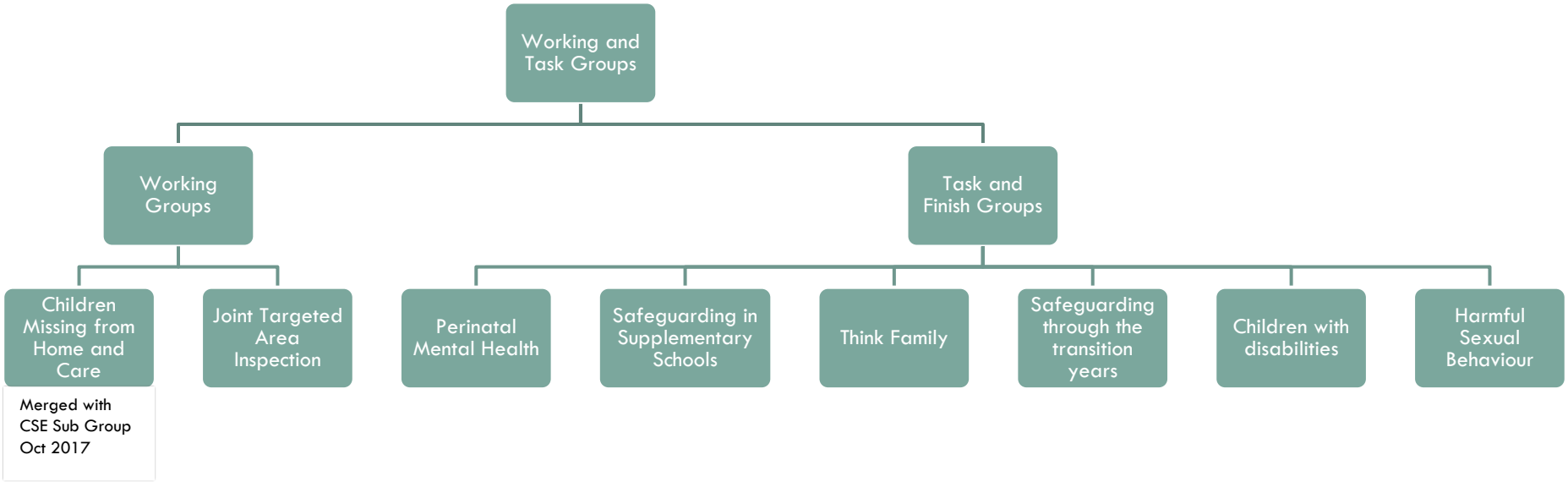
The BSCB meets as a full Board four times a year at a minimum. At the full Board decisions are made on the Business Plan for the year, agreement is sought for new policies or procedures, reports and audits are scrutinized in respect of the effectiveness of safeguarding arrangements in the city, Serious Case Reviews are received and new operating models are reviewed and evaluated. Board members are senior decision-making managers from their agency who can be held accountable for practice within their organisation or agree to align resources to respond to identified issues.

The full Board is supported through the Executive Group. This group is attended by the senior managers from the core funding agencies, Sub Group Chairs and the BSCB's Independent Chair. This group drives forward strategic improvement, maintains oversight of the resourcing of the Board, and ensures compliance with governance arrangements.

The operational work of the BSCB is undertaken by the Board's Sub-Groups and Working Groups. A Sub-Group is a permanent standing group of the Board and a Working Group is a time-limited group supporting the delivery in a specific area of practice. These groups are chaired by representatives from across the Board's organisations including Operational Managers from the Police, Bristol City Council Social Care, Education and Health. They are attended by representatives from across the city who ensure that the Strategic Business Plan for the year is delivered. This includes activities such as developing new resources, designing training programmes and undertaking multi-agency audits.

Glossary	
BSCB	Full Statutory Board
Shadow Board	Youth Advisory and Challenge Group
Executive	Core Funding Partners and Sub Group Chairs
Sub Groups	Standing Permanent Operational Groups of the BSCB
Working Groups	Thematic Short Term Operational Group
Task and Finish Group	Short Term Project Group


BSCB
Sally Lewis
Executive
Sally Lewis
Shadow Board
SCR
Fiona Tudge
CSE
Fiona Tudge & Lesley O'Hagan
Education
Annette Jones
Communications
Becky Lewis
Training
Liz Hall
Quality & Performance
Kate Markley
Health
Jackie Mathers
Child Death Overview Panel
Rotates between regional LSCB Chairs


Working and Task Groups
Working Groups
Task and Finish Groups
Children Missing from Home and Care
Joint Targeted Area Inspection
Perinatal Mental Health
Safeguarding in Supplementary Schools
Think Family
Safeguarding through the transition years
Children with disabilities
Harmful Sexual Behaviour
Merged with CSE Sub Group Oct 2017

BSCB BOARD ATTENDANCE

P	Present
D	Deputy attended
A	Apologies sent
NA	No attendance or apologies
0	Not Board member at the time
NR	Not required (Associate Member)

Membership	Role	Agency	Apr -17	July -17	Oct- 17	Feb–18	% attended by board member
EXECUTIVE	Independent Chair	Independent Chair	P	P	P	P	100%
	Director of Nursing and Quality	BNSSG CCG	D	D	D	D	0%
	Bristol Police Commander	Avon & Somerset Police	P	P	P	A	75%
	Service Director, Children's Services	Bristol City Council	P	P	P	P	100%
FULL BOARD MEMBER	Clinical Director	Bristol Community Health	D	D	P	D	25%
	Chief Nurse	UHB	P	D	P	P	75%

	Head of Bristol & South Glos LDU	NPS	A	D	D	D	0%
	Regional Assistant Director	Barnardo's	D	A	P	A	25%
	Lead Cabinet Member	Bristol City Council	P	A	P	P	75%
	Consultant in Public Health; Children & Young People	Bristol City Council	P	A	P	P	75%
	Designated Doctor for Safeguarding Children	CCHP	P	NA	P	P	75%
	Assistant Chief Officer	BGSW CRC	D	NA	D	D	75%
	Associate Director	AWP	D	P	P	P	75%
	Lay Member	Independent	P	A	P	P	75%
	Assistant Chief Officer / Manager Women's Services	BGSW CRC	A	NA	P	P	50%
	Service Director, Education & Skills	Bristol City Council	D	D	P	NA	25%
	Director of Nursing/Executive Lead Safeguarding Children	NBT	P	P	P	P	100%
	Principal Social Worker	Bristol City Council	P	P	P	0	100%
	Service Manager	CAFCASS	P	P	P	NA	75%
	Head of Service, Safeguarding	Bristol City Council	P	P	A	P	75%
	VCSE Rep	VOSC UR	P	A	P	P	75%

SUB GROUP CHAIRS	Sub Group Chair	CSE & SCR Sub Groups	P	P	A	P	75%
	Sub Group Chair	Communications and Quality & Performance Sub Groups	P	P	P	P	100%
	Sub Group Chair	Health Sub Group	P	P	P	P	100%
	Sub Group Chair	Education Sub Group	P	P	A	P	75%
	Sub Group Chair	Training Sub Group	P	P	A	A	50%

VOLUNTARY AND COMMUNITY SECTOR REPRESENTATION

Voscur is a council for voluntary service and a development agency for the voluntary, community and social enterprise (VCSE) sector in Bristol. Voscur is committed to supporting and improving safeguarding practice across the VCSE sector in Bristol. This is done in a number of ways, including working directly with local groups on relevant policies and practice, to more strategic level work, bringing the voice of the VCSE to key decision making bodies/working groups in the city. Voscur recruits and supports VCSE sector advocates on the BSCB. These Advocates are elected by local organisations that make up Voscur's Children and Young People's Network. Advocates take an active part in the work of the BSCB and its subgroups, highlighting issues pertinent to the VCSE sector and giving a voice to the sector: Advocates then feedback relevant information to the sector via regular reports. Voscur has also worked with BSCB to promote relevant training and safeguarding resources to the VCSE sector. In 2017-2018 a new Voscur Advocate was recruited, Jackie Citron – Circles South West.
In addition to Voscur representation, Barnardo's Assistant Director for Bristol is also a Board Member.

FINANCIAL ARRANGEMENTS 2017-2018

Expenditure		Income	
Employment Costs		**Partner Contributions**	
Recharge from Joint Business Unit (inc website)	92,599	Bristol City Council:	153,345
BSCB Independent Chair & expenses	24,919	North Bristol NHS Trust	15,187
BSCB Staff training & expenses	3,030	Bristol CCG	27,776
Training Team Salaries	68,687	National Probation Service	1,780
		Avon & Somerset Constabulary	19,000
Total Employment Expenditure	**189,235**	BGSW CRC	1,500
		CAFCASS	550
Serious Case Reviews			
SCR Fees 2017/18	43,802	**Total Partner Contributions**	**219,138**
Associated SCR Support Costs	1,916		
		Other Income	
Total SCR Expenditure	**45,718**	Training & Conference	92,575
		Surplus Brought Forward from 2016/17	93,281
Training & Conference		Safer Bristol contribution to SCR	13,268
Training Venue Hire & hospitality	22,812	BSAB contribution to 16/17 website costs	1,826
Training Team Office Supplies and Equipment	426		
BSCB Conference Speakers & Expenses	3,500	**Total other income**	**200,950**
Total Training & Conference Expenditure	**26,737**		
Contributions to other projects			

University Of Bristol - Child Death Review Service 2017/18	12,048	**Balance at Year end**	
QA Supervision	1,375	**Total available (Contributions & other income)**	**420,088**
		Surplus	**-111,296**
Total Contributions	**13,423**		

Other Expenditure	
Conference expenses	19
Association of Independent LSCB Chairs subs	2,500
Expenses for BSCB lay members	7
Room hire, catering & equipment	1,958
Translation	1,834
Survey monkey	299
Car hire & Taxis	1,707
Printing & documents	1,409
Facilities Management	540
ICT & Phones	1,070
BCC Overheads	22,335
Total Other Expenditure	**33,678**

Total Expenditure	**308,791**

2. RIGOROUS TRANSPARENT ANALYSIS OF SAFEGUARDING IN BRISTOL

SNAPSHOT

28% of children living in poverty

45 unaccompanied child asylum seekers

83 children & young people flagged at high risk of CSE by Bristol City Council Social Care and Barnardo's BASE Specialist CSE Project

1457 episodes of children going missing from home or care

>23,000 contacts with Bristol First Response

26% re-referrals

361 Children on a Child Protection Plan at 1st March 2018

1545 open Children in Need cases as of March 2018

507 children with a disability supported by the 0-25 service throughout the year

645 children & young people looked after at the end of 2017/18

27 children permanently excluded from school

846 children in **427** families in temporary accommodation due to homelessness

370 children and young people living in families with domestic violence heard at MARAC meetings with social care involvement between April and December 2017

2782 child victims of crime recorded by the police

SECTION 11 SAFEGUARDING AUDIT

To ensure our agencies meet their statutory objectives under Section 11 of the Children Act 2004 of ensuring the effectiveness of safeguarding; Bristol, North Somerset, Banes and South Gloucestershire Safeguarding Children Boards worked together to agree a three year cycled audit process for 2016-19 which followed on from a full Section 11 audit in 2016/17. This audit required organisations to complete a full self-assessment of their performance against the Section 11 duties. Following this, the agreement was then for themed audits to take place in 2017-18 and in 2018-19 to further strengthen this oversight and provide additional support to partner agencies.

All four LSCBs introduced an inter-agency peer 'Walk-about' for the themed 2017-2018 Section 11 audit returns based upon Interagency Working and Information Sharing. These walkabouts took place in Bristol throughout November and December 2017 and were undertaken by senior staff from Partner agencies, the BSCB Lay member and members of the Joint Business Unit. The visits included an introductory meeting with a senior manager of the agency being visited with the aim of providing an overview of the service followed by conversations with operational staff doing the direct work with children and families.

Organisations delivering services across the region were visited by different LSCBs and we are awaiting the findings of these visits. The agencies visited in Bristol were Bristol Youth Offending Team (YOT); University Hospital Bristol (UHB); Avon Fire and Rescue.

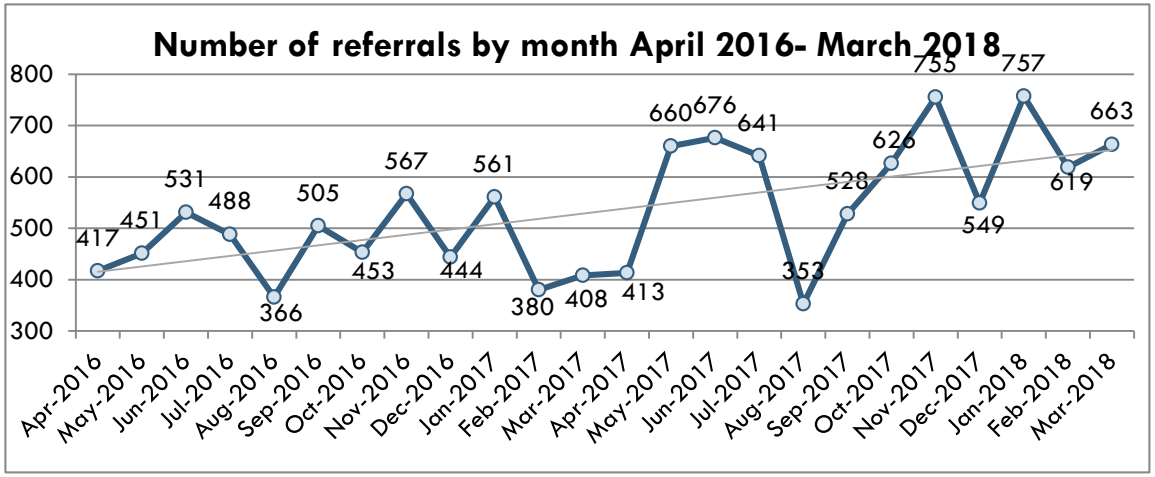
For UHB and Avon Fire and Rescue, the review team were able to triangulate the data captured in 2016/17 and conclude that they had made full and accurate Section 11 submissions. YOT had not completed their Section 11 submission which is why they were visited. In YOT it was concluded that practice was good in the areas audited with a number of good practice examples highlighted.

The Walkabout sessions gave the review team a valuable insight into front line practice and a better understanding of how child protection arrangements operate within the agencies visited. Members of the review team that took part in the process noted that it was a significant step towards the BSCB providing further strategic oversight and assurance that the data collected in 2016/7 was accurate. The agencies that took part in this process felt that it was a valuable experience that gave them the opportunity to quality assure, reflect on and improve safeguarding services for children and young people in a more supportive, meaningful and collaborative way.

This interactive model gave us the opportunity to promote the work of the LSCB, assist the partnership in their common understanding of how child protection arrangements in Bristol operate and provided further quality assurance to assess safeguarding arrangements. Further Walkabout sessions will be arranged for future audits to build connectivity between strategic self-assessment and operational practice.

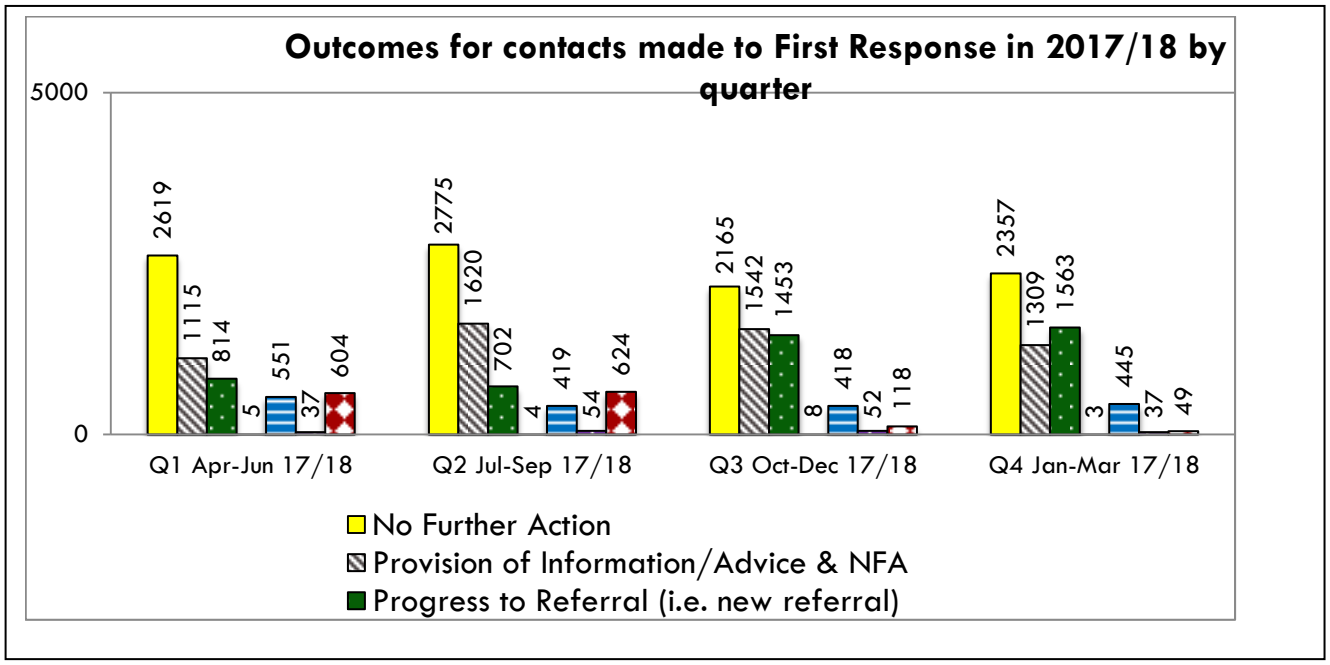
REFERRALS AND ASSESSMENT

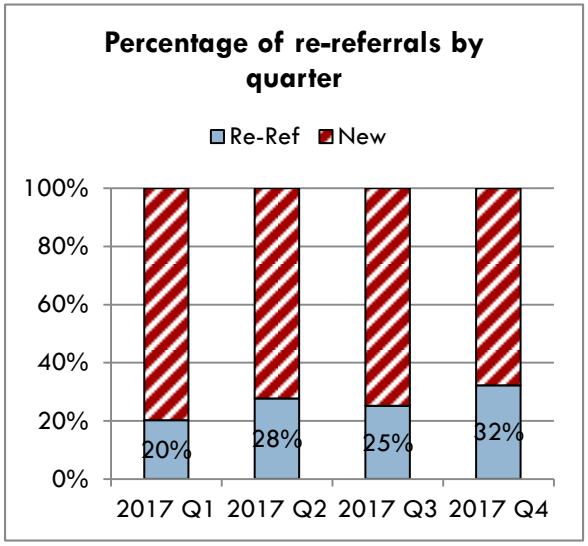
In our last Annual Report we reported on a reduction in the number of contacts with First Response, the front door to Bristol City Council's Early Help (now known as Families in Focus) and Social Care services. This reduction has been sustained. The Board has been concerned however about the proportion of contacts with First Response where there is no role identified for Children's Social Care or Early Help. A multi-agency audit was undertaken to explore this. The audit found that decision-making by social care was consistent and appropriate to the information provided but that the quality of the referrals received by Children's Social Care from partner agencies required



improvement. This finding was repeated in the JTAI inspection. This is an area of significant concern for the Board. A response plan has been implemented including training across the partnership to improve referral quality.

There has been a continued upward trend in the number of contacts progressed as referrals into Children's Social Care and the Bristol City Council Early Help services across the last two years. This is at the same time as Social Workers' caseloads are higher in Bristol than the national average and vacancy rates in the city, like in many other areas, are increasing. The Board recognises that this puts increased pressure on social care resources particularly at a time when other provision in the city has shrunk. Bristol City Council has a transformation plan in place which is successfully reducing social care caseloads by targeting issues of drift in cases. The BSCB is monitoring the impact of this plan.



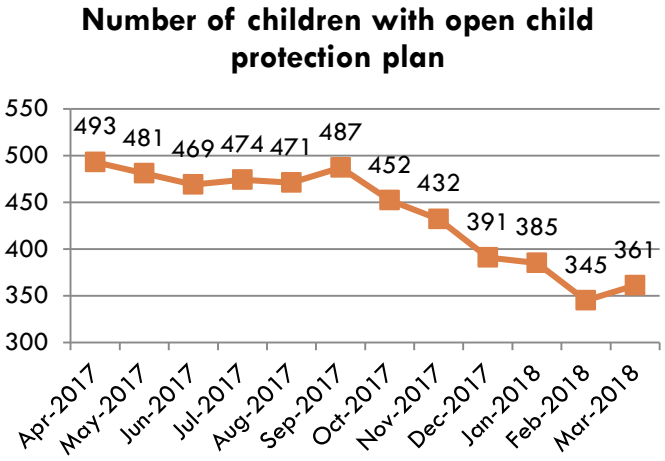


If a child has had a referral in the 12-month period prior to the new referral, then the new referral is counted as a re-referral. This is an important measure of the effectiveness of the safeguarding system. Throughout the year re-referral rates for referrals made to Children Social Care was at an average of 26%. The re-referral rate has increased significantly in quarter 2 (28% compared to 20% in Q1) and then dropped slightly in Q3. However in the last quarter of the past year the re-referral rate has gone up significantly again with almost a third of all referrals being for children who had a referral in the previous 12 months. The BSCB is scrutinizing what this measure means in light of the significant system changes this year. One key influencing factor is that contacts with the short-intervention Pathway Decision Team began being recorded as referrals more consistently from Quarter 3. This requires further analysis of the children's pathway through social care which the Board has requested.

CHILD PROTECTION PLANS

In June 2017, the BSCB undertook an audit of children subject to child protection plans under the category of neglect in response to children staying on those plans for long periods of time. The audit highlighted a number of areas requiring improvement:

- insufficient consideration of the voice of the child;
- an approach that is too adult focused and 'incident-led', leading to the cumulative impact of neglect not being recognised;
- a lack of specificity in planning; insufficient understanding of the impact of children living with domestic abuse and substance abuse;
- and a 'misinterpretation of the current strengths-based model of practice'.

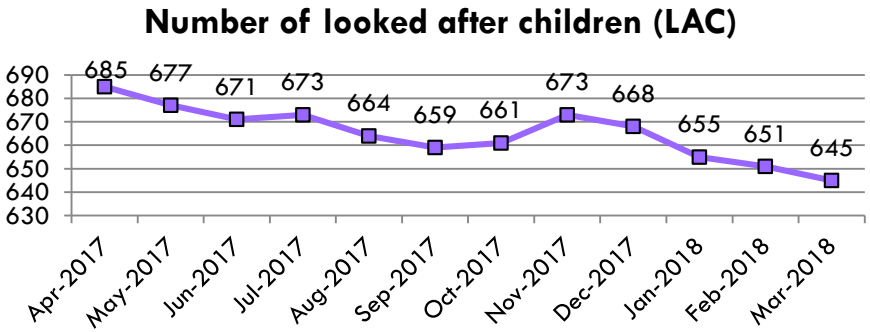


These factors led to drift and delay for some children, as well as 'start again syndrome'. A number of the same issues were identified during this JTAI inspection. Progress is being made against the improvement plan to address these issues.

The number of children on Child Protection Plans has been dropping steadily but significantly across the year. The number of children with child protection plans reduced by over a quarter (27%) by March 2018 when compared to April 2017. This chart shows numbers of children with open CP plans for 2017/18.

The Quality and Performance Sub Group have raised concerns that Bristol has consistently had higher than the national average number of children on Child Protection Plans for more than 2 years. The number of children who have been subject to a child protection plan more than once has been high through 2017/18, with 23% of children with Child Protection Plans in March 2018 having had more than one plan suggesting positive change is not sustained by families with the multi-agency support provided.

LOOKED AFTER CHILDREN



As can be seen in the graph, the number of children looked after in Bristol has been decreasing slowly from a high of 685 in April 2017 to 645 in March 2018 (overall annual reduction of 6%). 20 children were adopted this year which is similar to 2016-2017, but significantly lower than in the previous years (46 children were adopted in each 2015 and 2014). 21 children were made subject to care arrangements under Special Guardianship Orders.

Placement type (at 31st March 2018)	Number of children
Agency Foster Care	153
Bristol Residential	38
Family or Mother & Baby Unit	6
In-House Foster Care	383
Non-Bristol Residential	30
Parent/Ind Living	13
Placed for Adoption	20
Residential School	12
Secure	4
Other	85
Total	659*

*Please note that the different total of LAC is due to the time lag (the monthly figures are based on caseloads of 1st of each month, while the numbers of LAC by placement type are for children looked after as at the last day of March 2018).

Over the year an average of 14.95% of looked after children were placed more than 20 miles away from their families. At the end of 2017-2018, 81% of looked after children in Bristol were placed with foster carers, the majority with in-house foster carers. This evidences that the improvement of increased numbers of young people being placed in foster care settings has been sustained since our last annual report, and remains above the national average.

Placement stability has remained a focus for Bristol City Council. The percentage of children looked after aged under 16 at year end who had been looked after continuously for at least 2.5 years and were living in the same placement for at least 2 years, or are placed for adoption and their adoptive placement together with their previous placement together has lasted for at least 2 years has been maintained at close to 80% target throughout the year, with an annual average of 76%, which is above the England average of 68% (March 2015).

The number of children looked after who had had more than three placements within a 12 month period fluctuated throughout 2017-18. Following a low of 7.5% in March 2017, the % of children with more than three placements went up to 8% in April 2017 and continued to rise until August, reaching a high of 9.6%, before dropping again to 8.1% at March 2018.

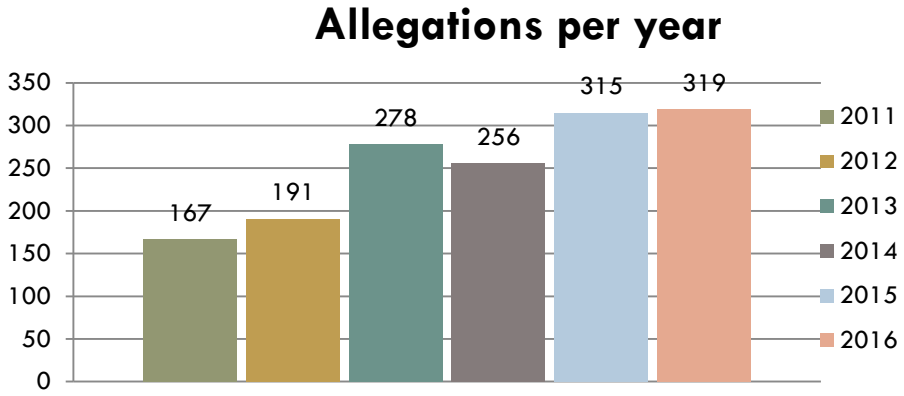
The BSCB is concerned that the biggest group of care entrants is teenage boys. This indicates that safeguarding and support of families with boys and young men is less successful. This supported by data from the Youth Offending Team and Permanent Exclusions data where boys are disproportionately represented, although they are under-represented in our specialist therapeutic services. For this reason safeguarding boys and young men is a strategic aim for the partnership in 2018-19.

This year there were 25 private fostering arrangements recorded in Bristol. This shows a need for ongoing and continued awareness raising of the requirements around Private Fostering. A leaflet is being developed for education settings in 2018-19 building on a successful campaign in a neighboring local authority.

PEOPLE IN POSITIONS OF TRUST AND LOCAL AUTHORITY DESIGNATED OFFICER

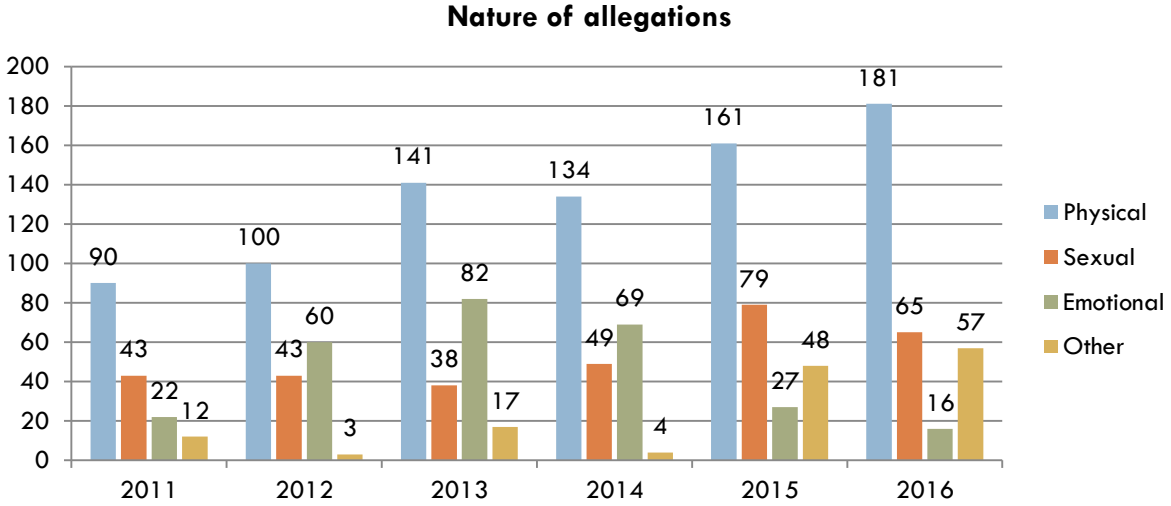
The role of the LADO is to manage allegations and concerns regarding people who are in a position of trust. The LADO provides advice and guidance on how such allegations should be investigated and has overall responsibility for the management and oversight of all allegations. The LADO is involved from the initial reporting of the allegation through to the conclusion of the case.

Between 1 April 2016 and 31 March 2017 a total of 319 allegations were managed by the LADO compared to 315 the previous year, an increase of 1.26%.

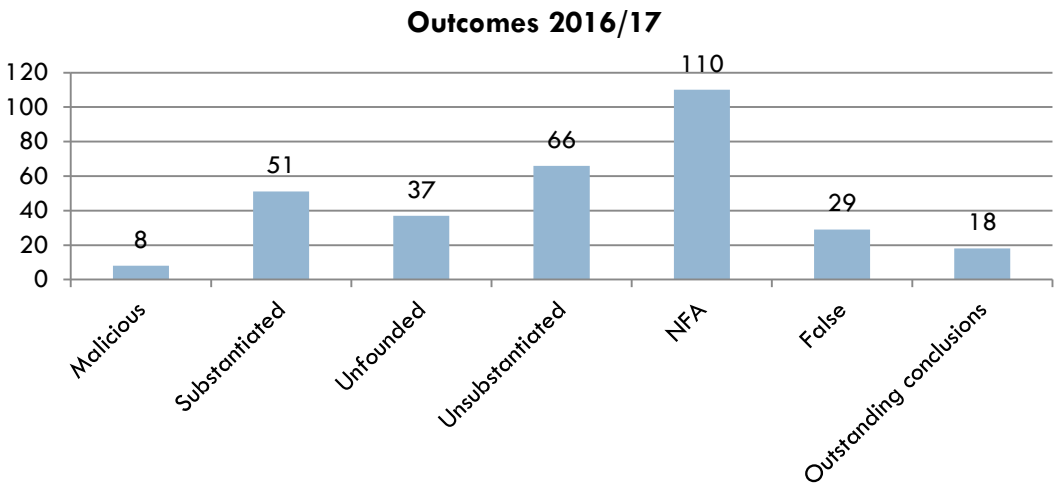


Aside from 2015-16, over the last six years, there has been an upward trend in referrals to the LADO. This is consistent with the trend in the south west LADO region. The increase in referrals to the LADO is positive as it demonstrates an improvement in the recognition and reporting of concerns regarding people in a position of trust. This may be as a result of the LADO continuing to provide training to a wide range of different agencies in relation to the role of the LADO and the allegations management process.

Referrals to the LADO are made by a wide range of agencies. In the reporting period the largest numbers of referrals were made by the education sector; 124 (39%), followed by social care; 57 referrals (18%). The third highest referral agency was the police; 48 referrals (15%). This is reflective of the pattern of referrals to the LADO in the two previous years. It also mirrors the pattern in the south west and nationally. In 2016-17 as in previous years, the trend for the high number of allegations regarding education staff continues with 157 (49%) referrals received by the LADO compared to 152 in the previous reporting period. This is expected given that they are the largest workforce having the most contact with children and young people.



As is clear from the figures, the majority of referrals to the LADO relate to allegations of physical abuse, as has been the case in the last six years, 181 (57%). The majority of these relate to the education sector. This reflects the pattern locally and nationally. The second highest category relates to allegations of a sexual nature, 65 (20%). The third largest category is "other" 57 (18%). This category relates to suitability/conduct issues or issues that relate to their personal life, rather than allegations as a direct result of their position within the children's workforce, e.g. criminal conduct or drug/alcohol issues. Referrals to the LADO regarding issues relating to individuals private lives have been on the increase in recent years. Such referrals often come from social workers within children's social care or the police who become aware that an adult within the family works / volunteers with children. This demonstrates how the role of the LADO is increasingly understood by the children's workforce.



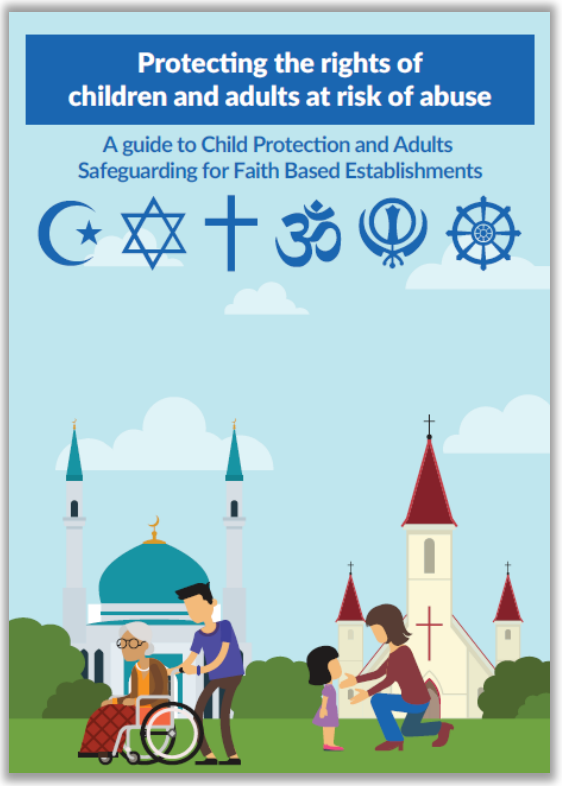
The greatest proportion of allegations reported to the LADO required no further action (NFA) from the LADO, 110 (35% - NFA includes 19 Out of Area cases that were referred to another local authority but require no other action from the Bristol LADO).

In the reporting period, the outcome of the second largest category of cases that required investigation was "unsubstantiated" 66 (21%) ("there is insufficient evidence to prove or disprove the allegation, does not imply innocence or guilt"). Aside from 2015-16 this reflects the pattern locally in previous years.

The majority of cases where an investigation concluded that the allegation was 'substantiated' resulted in training or guidance being provided to the employee/ volunteer - 19 (37%). This reflects the pattern in the previous reporting period. In this reporting period 12 (24%) of the 51 cases where the allegation was substantiated resulted in the subject being dismissed. In these cases, the employer will have made a referral to the Disclosure and Barring Service (DBS) as they have a legal duty to refer if they withdraw a person's permission to engage in regulated activity with children.

The BSCB supported this work by holding a conference in January 2018 in partnership with the Bristol Safeguarding Adults Board. The Conference – Perpetrators in Positions of Trust – provided support to organisations on how to increase safety within organisational structures. The conference was attended by 140 professionals across the city.

ENGAGEMENT WITH FAITH ORGANISATIONS AND SUPPLEMENTARY SCHOOLS



As a result of the LADO highlighting the increase in referrals regarding supplementary schools in their 2015-16 annual report, it was agreed by the BSCB that a supplementary schools task group should be established developing links with faith-based establishments and supplementary schools.

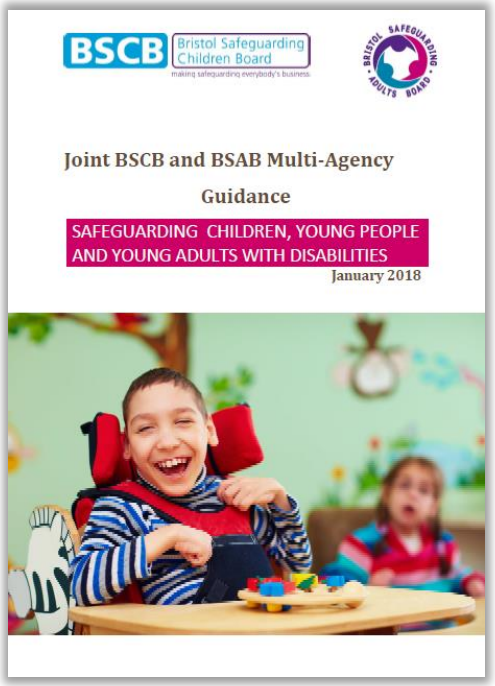
Over the last year the task group has made significant achievements. Firstly, it gained agreement from the Birmingham Safeguarding Children Board to adapt guidance developed by Faith Associates and the Birmingham LADO *"Protecting the rights of children and adults at risk of abuse. A Guide to Child Protection and Adults Safeguarding for Faith Based Establishments".* This sets out comprehensive guidance for faith communities in relation to all aspects of safeguarding regarding children and adults. A consultation process took place with local partners and community groups at which the guidance was positively received. The guidance was published in February 2018 following a launch event.

Secondly, the BSCB training department developed and has recently begun to deliver a free course *Foundation level training in Safeguarding and Child Protection* directed at staff and volunteers working in supplementary schools and faith establishments.

Thirdly, the supplementary schools task group developed a leaflet *"Keeping your child safer out of school"*; advice for parents and carers on keeping children safe when using clubs, activities and tutors. This leaflet encourages parents to undertake checks regarding safeguarding policies and practices when sending their child to a club or tutor, and when to report any concerns.

CHILDREN WITH DISABILITIES

507 children were supported by the integrated 0-25 service at some point during 2017/18 with 274 children supported by the service at the end of the year. On 31st March 2018, there were only 3 children identified in this service as meeting the threshold for a Child Protection Plan. This indicates we are not making the progress necessary as a partnership in this area of work as the identification of disabled children experiencing abuse and neglect remains so low. The Board is going to undertake a root to branch system review of the barriers to identifying abuse for these children in the next business year. This will review how children with disabilities who are not known to the specialist disabled children team are identified and supported through the safeguarding system.



Safeguarding Children, Young People and Young Adults (0-25) with Disabilities Policy

As a result of last year's strategic analysis, the BSCB reviewed the partnership arrangements for safeguarding children with disabilities. Developments in this area resulted in an update to the BSCB policy.

Our consultation process was widespread and included a learning event where over 80 professionals and parents provided input; we consulted children, young people and young adults with disabilities including children that are non-verbal and use communication aids. Our consultation with children and young adults ensured that their experience of the barriers they face were central to the policy document and changes to practice, enabling organisations and professionals to learn from their views, change practice and commissioning arrangements where required.

A multi-agency task group was responsible for developing the new guidance which sets out the need for professionals to identify low level risks and ensure there is early intervention and prevention to minimise the risk and harm that could occur. It makes clear that children with disabilities are more vulnerable to all forms of abuse and neglect including the risk of radicalisation however due to barriers that they face it can be more difficult to identify. The guidance sets out how the barriers that exist can be overcome which includes best practice guidance for Achieving Best Evidence and the importance of advocacy.

A further task group in 2018-19 is to be set up to oversee compliance with the guidance and drive forward further improvements in practice in particular better and more accessible communication aids with safeguarding content, as this has been identified as a key barrier to children disclosing abuse. A series of test and check audits are planned to monitor how senior managers have disseminated this guidance and embedded it into practice.

CHILDREN MISSING FROM HOME OR CARE

Total number of Bristol children missing from home or care in last 12 months	**567**
Total number of times children went missing in last 12 months	**1457**

Children who go missing should be offered an Independent Return Home Interview to explore the reasons they went missing and put in place plans to reduce the risk of them going missing again. The Missing Task Group monitors this data to ensure children are receiving the support they need.

Month of missing date	Total forms	Forms completed by Safe Choices	Does the child meet the criteria for a return interview		Was a Return Interview offered?		Percentage of return interviews offered *	Has the child accepted the offer of a return interview?		Percentage of return interviews accepted **
			No	Yes	No	Yes		No	Yes	
2017 April	72	15	29	43	12	31	72%	16	15	48%
2017 May	80	9	33	47	7	40	85%	13	27	68%
2017 June	112	14	40	72	3	69	96%	25	44	64%
2017 July	115	13	36	79	7	72	91%	46	26	36%
2017 August	69	10	23	46	1	45	98%	27	18	40%
2017 September	104	18	34	70	4	66	94%	41	25	38%
2017 October	102	20	31	71	2	69	97%	38	31	45%
2017 November	92	22	27	65	5	60	92%	32	28	47%
2017 December	39	9	22	17	1	16	94%	9	7	44%
2018 January	62	10	35	27	1	26	96%	14	12	46%
2018 February	50	14	12	38	3	35	92%	10	25	71%
2018 March	39	7	28	11	0	11	100%	5	6	55%
Total	936	161	350	586	46	540	92%	276	264	49%

The number of Return Interviews accepted by children in relation to the number offered averages at 49% over 2017/18. The Local Authority and Barnardo's Safe Choices Missing Project are working hard to increase this percentage. The partnership will be undertaking a NWG Independent Missing diagnostic in 2018-19 and this will be an area of focus.

The analysis of push and pull factors indicate the highest number of children who go missing are running to friends and peer influences. This factor has been discussed in depth and a possible hypothesis is that some of these incidents may have been more accurately recorded as child sexual exploitation. A prompt has now been put into the Return Interview form on LCS to think about CSE and also provides a link to the CSE checklist embedded in LCS. A tab for criminal exploitation has also been added and will now appear in the report.

Issues of bullying have been identified as a factor for children going missing. This links with priorities of the Shadow Board and is a priority for 2017/2018 BSCB Business Plan. Representatives from the School Safeguarding Education team and The Hope Virtual School sit on the

task group and contribute to improving the experiences of children within school who are reporting they are running away due to school issues.

'Issues with education' was 4th most common push/pull factor in 2017/18. This combined with the fact that the number of children who go missing in August is significantly lower indicates that there's an issue needing investigating and addressing, and this has been raised with the Education Sub Group.

In addition there has been a significant increase in 'Substance misuse' recorded as push/pull factor (increased from position 9 of most common push/pull factors at the beginning of the year to position 5 by Quarter 3). This will be monitored to identify whether this is a new trend in partnership with the youth substance misuse services.

The strategy group requested data for a 3 month period to analyse the number of children who did not meet the criteria for a Return Interview but then went missing again. The purpose of this data was to understand the issue and measure the impact of not offering every child who goes missing a Return Interview. Over a 3 month period there were 107 children who went missing that did not met the criteria for a Return Interview and of those 107, 42 children went missing within a 6 month period. The BSCB will be reviewing the use of criteria in 2018-19 based on this finding.

PREVENTING RADICALISATION

In 2017-18 there were 93 prevent referrals in total assessed and reviewed. This compares to 60 in 2016-17 reflecting improved training across the partnership. Of these referrals 36 were cases involving young people (39%). Cases where there is a high risk of radicalisation are managed through the Channel Panel process. In Bristol numbers of referrals meeting this threshold has been very low. There have been no cases relating to young persons in 2017-18.

CHILD SEXUAL EXPLOITATION, SEXUAL ABUSE AND HARMFUL SEXUAL BEHAVIOUR

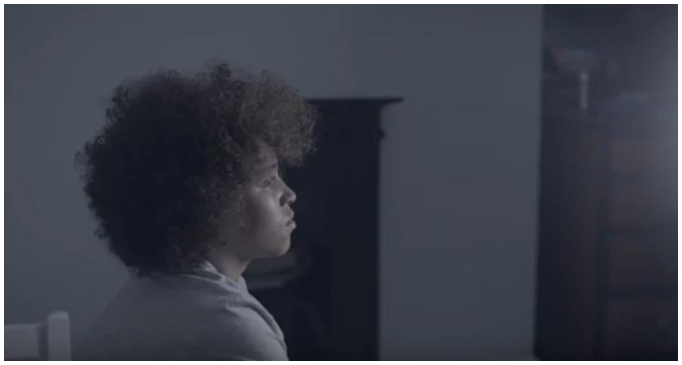
This was the first CSE profile that was produced at the end of 2016-17 and provided a picture of CSE across the city. Agencies across Bristol contributed their data in order for the profile to be produced. The profile identified that there was a focus on 2 wards within the city, most children were aged 14-17yrs and 90% were girls and 10% boys. From data on the suspects; 58% were lone perpetrators, 9% were more than 2 perpetrators and 33% there was no indication on the records. Of the type of offences recorded 38% were online and most related to indecent images of children. This profile has informed the work of the Education Sub Group E-Safety Working Group, including the BSCB funding an E-Safety Conference for schools across the city. In 2018-19 the BSCB plans to further develop our child protection processes for online abuse. In addition the profile influenced the commissioning of a new pan-constabulary CSE service that started October 2017 building on identified patterns of pan-regional sexual exploitation.

This year CSE champions have been established in the core agencies; Police, Local Authority, Education and Health. Terms of Reference for these Champions have been provided to the CSE sub group. The Champions are responsible for disseminating new research and best practice and are available to provide advice and consultation to practitioners within their respective agencies.
Building on delivering the disruption element of the Bristol CSE strategy, the Public Safety & Protection Committee has now agreed to put in place mandatory refresher training for all existing taxi drivers in Bristol. This will cover a range of matters including safeguarding, human trafficking and disability awareness training. This training is in addition to the requirement that all new drivers undertake Gold Standard training prior to obtaining a licence.

Operation Topaz, the specialist disruption approach to CSE, continued to develop this year. It has been found that the Topaz model can act as a successful supplementary mechanism to allow the police to better identify and manage risk; focusing on disruption and safeguarding opportunities to protect victims and the community when the ‘normal’ responsive model isn’t fit for purpose. Operation Topaz has been able to demonstrate through a different model of policing they can:

- Identify and assess risk indicators to identify victims and offenders without the need for disclosure
- Engage and empower victims to report when they're ready
- Identify disruptive opportunities to reduce risk posed by offenders until victims make a disclosure

The Board have identified that there needs to be a focus on improving transitions to adult services for victims, increase the identification of boys who are being sexually exploited, and a review of the use of identification tools. These will be the areas of focus in 2018-19.



This year the BSCB supported the launch of three awareness raising films developed by young victims of CSE supported through Barnardo's BASE. The films, Free from Fear, can be accessed here.

In 2017 347 crimes were recorded as sex offences against an under 18 victim. These offences related to 301 children. In respect of the 347 crimes, 240 offenders were identified. 173 were adults and 67 were under 18. 3% of Child Protection Plans in Quarter 2 of 2017-18 were made in respect of sexual abuse. Only 16 children were referred to the STAR clinic in Bristol in 2017 for a pediatric medical due to concerns about possible sexual abuse. This led the BSCB to undertake an audit of Child Sexual Abuse practice in March 2018. The audit found that there were examples of excellent multi-agency responses to sexual abuse but that the practice was inconsistent. The BSCB recognized thes a need to improve holistic whole family assessments of sexual abuse, recognizing the impact across a range of family members. It also identified the need to challenge the use of written agreements in these cases and ensure a consistent use of Signs of Safety safety plans. Intervention from the city's specialist sexual violence services was found to be of excellent quality but statutory agencies need to improve engaging these services in multi-agency plans.

THE SURVIVOR PATHWAY
Sexual Violence Support Services

The BSCB identified concerns that there are significant risks associated with the delays experienced in access to therapeutic services by young people whose behavior is sexually harmful when the Criminal Justice process starts. This task group included specialist input from BeSafe, Police, YOT, Social Care, Education, the Police and the District Crown Prosecutor, to develop a **Protocol for Children who Display Harmful Sexual Behaviour** that effectively responds in a timely manner to children who display harmful sexual behaviour. The BSCB and partners recognised that whilst children and young people who abuse others should be held responsible for their abusive behaviour that it is vital to identify and respond to it in a way that meets their needs as well as protecting others. In addition it is likely that these children could be experiencing/at risk of abuse or neglect and that they are likely to be children that need support and some may be in need of protection. This protocol sets out how professionals will respond across the City and the need to not criminalise children. There is a commitment to these cases being prioritized to ensure both children can be protected. A further guidance document **Aide Memoir** for practitioners when conducting strategy discussions that involve Harmful Sexual Behaviour, and a Bristol Protocol for Decision Making in cases of HSB has been included, so, when appropriate, it can be dealt with outside the Criminal Justice Process whilst still insuring that appropriate rigorous interventions and the victim's needs are met.

MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS

Multi-Agency Public Protection Arrangements (MAPPA) are the statutory measures for managing sexual and violent offenders. The Police, Prison and Probation Services (Responsible Authorities) have the duty and responsibility to ensure MAPPA are established in their area and for the assessment and management of risk of all identified MAPPA offenders. Other agencies including children's services have a duty to co-operate with MAPPA.

There are three categories of violent and sexual offenders who are managed through MAPPA:

- Category 1: Certain Sex Offenders are required to register their name, address and other personal details with the police. The length of time an offender is required to register with the police can vary between 12 months and life.

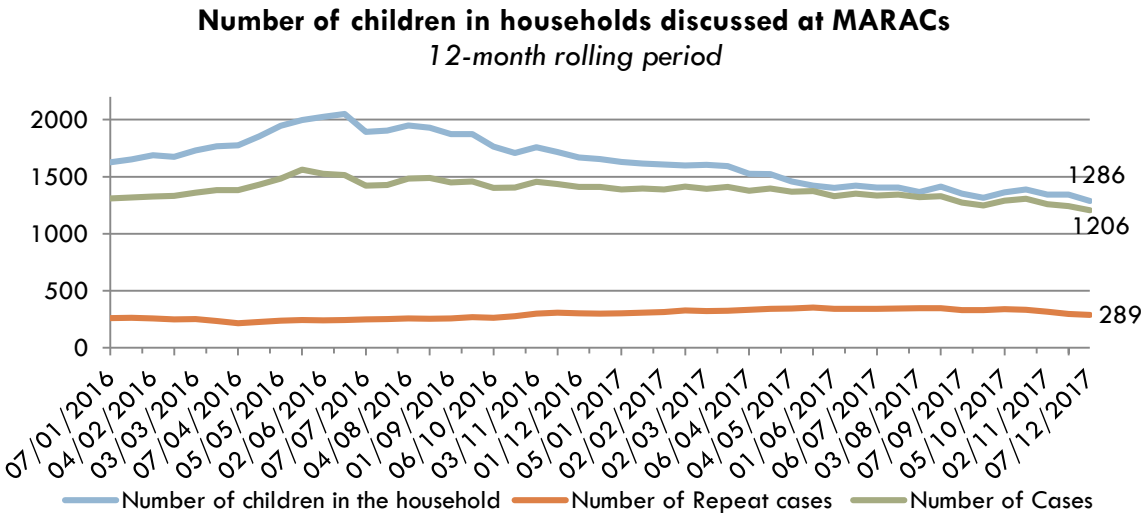
- Category 2: Certain Violent Offenders who have been sentenced to 12 months or more in custody, or to detention in hospital and who are now living in the community subject to probation supervision.
- Category 3: Other Dangerous Offenders who have committed an offence in the past and who are considered to pose a risk of serious harm to the public.

All MAPPA offenders are assessed to establish the level of risk of harm they pose to the public. Risk management plans are then worked out for each offender to manage those risks. MAPPA allows agencies to assess and manage offenders on a multi-agency basis by working together, sharing information and meeting, as necessary, to make sure that effective plans are put in place. Offenders are managed at one of three levels, based on the level of multi-agency co-operation required and can move up and down the levels as appropriate. In 2016-2017 there were 1,910 MAPPA Offenders across the five Avon and Somerset local authorities, an increase of 70 since the previous year. The Bristol Safeguarding Adults Board has identified a need to improve Persons of Concern processes in Bristol for people of concern who do not meet the MAPPA criteria. The BSCB will be supporting this work in 2018-19.

The MAPPA Annual report is not available for 2016-2017 as it will not be published until later in the year. The report for 2015-2016 is available here

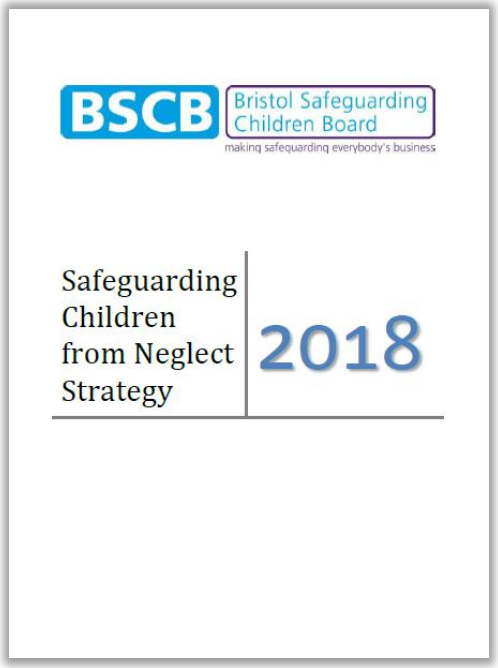
DOMESTIC VIOLENCE AND MULTI-AGENCY RISK ASSESSMENT CONFERENCES (MARAC)

MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC also makes links with other structures and processes to safeguard children and manage the behaviour of the perpetrator.



The data presented in the table represents the total number of children in households reviewed at a MARAC from January 2016 to December 2017. 1,286 children have been discussed in the 12 months preceding period. The number of children who have been heard at repeat MARACs has been decreasing gradually since June 2017. The MARAC review mentioned in the 2016-17 Annual Report has continued in 2017-18. A new MARAC process for Bristol is intended to be implemented by the end of 2018. The BSCB will have oversight of these changes.

3. JOINT TARGETED AREA INSPECTION - NEGLECT



In October 2017 Bristol LSCB and other local partners were inspected as part of the joint targeted area inspection of the multi-agency response to abuse and neglect in Bristol. A JTAI (Joint Targeted Area Inspection) is an inspection by four inspectorates at the same time, to examine how partner agencies are working together to protect children. The four inspectorates involved in the inspections are: HMI Constabulary and Fire and Rescue Services; HMI Probation; Care Quality Commission (CQC); Ofsted. The full report can be read here

The inspection focus was on children living with Neglect, with a particular focus on children aged 7-15 years. The purpose of a JTAI is to provide findings about what partner agencies are doing well, and what they need to improve. There is no 'judgement' given; a narrative report is provided following the inspection.

Working from points of learning identified by the inspection, Bristol has now published a response and multi-agency action plan to tackle neglect across Bristol which can be read at JTAI Bristol Statement of Action. The early identification and response to neglect is a priority for Bristol and robust governance arrangements are in place to ensure that all agencies fulfil their roles and responsibilities with regard to neglect. Delivery of the action plan is overseen by a multi-agency working group that reports to the BSCB.

Part of this action plan includes the development and implementation of a multi-agency neglect strategy, which can now be found on our website: BSCB Neglect Strategy 2018. This strategy includes the implementation of the NSPCC Graded Care Profile 2 Neglect Risk tool, focus on improving attendance and clearer links being made between contextual safeguarding issues and adolescent neglect.

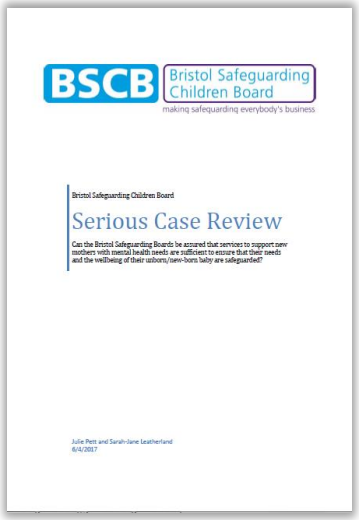
PARTNERSHIP STRENGTHS IDENTIFIED IN THE JTAI

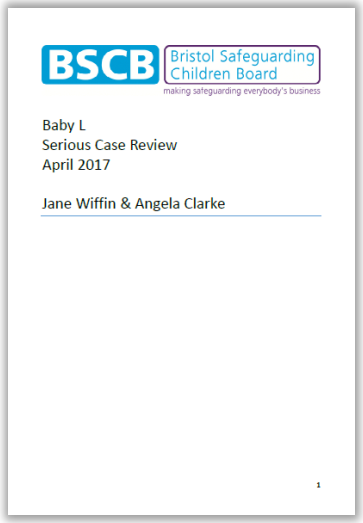
- A strong commitment across agencies to the protection of Bristol children
- The BSCB's participation approach including the Shadow Board which ensures that the child's voice is central to strategic decision making
- Excellent work in schools to support children identified as suffering from neglect
- Sensitive and creative direct work helping children to build trusting relationships with social workers
- Youth Offending Teams use of a trauma recovery model and good practice in engaging parents
- The Police's development of innovative approaches that are leading to earlier identification and response to neglect and vulnerability, particularly the 'One Team' (a pilot in South Bristol in which families are visited within 24 hours of a domestic abuse incident) and Operation TOPAZ (a proactive approach to identifying and engaging with children at risk of, or subject to, child sexual exploitation and the identification and disruption of perpetrators)
- Staff in the National Probation Service (NPS) understand the signs and impact of neglect, and there is evidence that they assess these when seeing offenders with their children
- The BGSW Community Rehabilitation Company's women's centre provides specific interventions for women with complex needs, including supporting women whose children may be experiencing neglect
- Named GPs and designated professionals at the Clinical Commissioning Group have strengthened safeguarding performance through network meetings and sharing good practice

4. SERIOUS CASE REVIEWS

In 2017-2018 the BSCB published five Serious Case Reviews and is waiting to publish a fifth once Home Office quality assurance has been received (it is a joint Domestic Homicide Review so has to go through Home Office procedures pre-publication). The BSCB commissioned one new Serious Case Review and one non-statutory Child Protection Incident Review this year. They are due to be presented to the BSCB in 2018-19. Professional Briefing documents, full Board responses and reports can be found here.

PERI-NATAL MENTAL ILL HEALTH AND DENIED PREGNANCY – 'BABY L' AND 'ZBM'





Early in the Business year the BSCB published two Serious Case Reviews concerned with maternal mental health in the peri-natal period. ZBM considered the professional response to a mother with a history of mental ill health who died with her newborn daughter shortly after her birth, having walked out of the maternity hospital. Baby L reviewed what professionals could have done differently in a case of a newborn baby being killed by its mother who was experiencing pathological denial of pregnancy. In this case no professionals or family members were aware of the pregnancy as it had been concealed.

In response to these cases the BSCB Joint Business Unit facilitated 5 Multi Agency Briefings, attended by over 130 professionals that included learning from the ZBM and Baby L Serious Case Reviews, details of new guidance and

good practice around referrals to First Response. The need for greater public awareness campaigns on concealed and denied pregnancy were raised with public health and the West of England Child Death Overview Panel. A new specialist mental health team has been established providing consultancy, support and direct work to women at high risk of and experiencing peri-natal mental ill health.

Joint BSCB and BSAB Multi-Agency Protocol for Perinatal Mental Health

In response to learning from the **ZBM Serious Case Review,** the Perinatal Mental Health Protocol was created by a large group of multi-agency professionals across the City. It provides:

- A clear understanding of the systems/pathways in place in Bristol;
- It sets out the importance of professionals taking collective responsibility for women, baby and the family and responding effectively and quickly;
- It encourages signposting at the earliest opportunity;
- Greater role and professional awareness;
- Clear, concise and regular communication between professionals;
- Defines best practice and the role of the Lead Professional;
- Focuses on early intervention, to prevent the onset of Mental Health illness in women and help those known to be at risk and act quickly when illness occurs.

A consultation took place with mothers and their partners facilitated by one of our third sector agencies in Bristol. This ensured that their voices were recorded throughout the document so that our professional practice is more person and outcome focused.

A Perinatal Mental Health Multi-agency Audit of randomly selected cases has recently been

completed to provide further assurance that front line practice complies with the protocol. This audit found pre-birth planning had significantly improved however mental ill health in the post-natal period continued to require further coordination, particularly when professionals were balancing dual presenting issues such as maternal mental ill health and domestic abuse.

ABUSE OF YOUNG BABIES – 'AYA' AND 'NEGLECT OF A BABY'

This year the BSCB published two cases concerned with the abuse and neglect of young babies. The Aya Serious Case Review was commissioned following the death of a six month old girl in December 2016. Aya died from non-accidental traumatic injuries while in the sole care of her father. Her father plead guilty to her murder. Aya's family were not known to safeguarding services. They received universal care and there was evidence of good practice found in the support provided to them. The review found that her death was not predictable or preventable by the professionals involved. It highlighted the need for the BSCB to continue to work with commissioners to promote the commissioning and delivery of ante- and post-natal services which are accessible to fathers. Working with fathers will be a key theme of our 2018 Annual Conference.

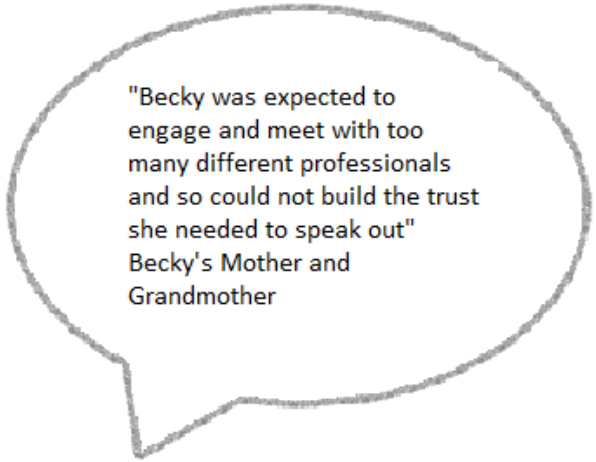
The 'Neglect of a Baby' review was published as a briefing only, with the agreement of the National SCR Panel. The review considers the professional response to neglect of a newborn baby in the first three months of its life in 2015-2016. The review found that there was too much delay in the professional response to the baby. Furthermore, professionals did not effectively adapt their approach to working with a parent with learning difficulties which were as a result of trauma. The review also provided evidence to the BSCB that there was too narrow an understanding of domestic abuse in the city, and professionals were not sufficiently appreciating the impact of abuse and violence on children when it occurred between family members who aren't partners.

Much of the work to respond to the Neglect of a Baby review is now integrated as part of the city's neglect strategy. We are also reviewing our escalation procedure to support professional challenge where there is unacceptable delay. There is also work underway to improve co-

working across children and adults services when an adult in a caring role has support needs which impact their parenting capacity. The issues around Domestic Violence are informing the MARAC review work which is referred to earlier in this report.

SAFEGUARDING ADOLESCENTS – 'BECKY'

The final Serious Case Review published this year concerns the care provided to Becky, a 16 year old female, by local agencies in the years before her death in 2015. Becky's Step-Brother and his partner were convicted of her murder and manslaughter respectively.



Among the findings of the review was that there were too many professionals involved and not sufficient coordination of services when she did not have an allocated social worker. There is a transformation project underway to restructure and better integrate services in the city. This will establish multi-agency locality meetings to support children to get the most appropriate support at the right time in a more coordinated way.

Further to this, the review found that additional support was needed for alternative education settings. Training has also been rolled out to schools across Bristol that brings together mental health leads and Child and Adolescent Mental Health Services (CAMHS) to embed long term collaboration and integrated working. This programme is establishing an important network of professionals from across the organisations involved to promote closer working and improve responses to children and adolescents' emotional wellbeing. It includes Primary Mental Health specialists linked to schools providing consultation and support, including in the hospital education service where Becky was a pupil.

This SCR highlighted the need to strengthen the City's Think Family approach, including the consideration of family members not living with the child when undertaking assessments. Since Becky's death we have continued to implement the Signs of Safety Strengths Based approach which includes models for family meetings and improved partnership with families. We will continue to audit the effectiveness of these models.

5. WEST OF ENGLAND: CHILD DEATH OVERVIEW PANEL

Bristol works in partnership with three other LSCBs (Bath & North East Somerset, North Somerset and South Gloucestershire) to deliver the West of England Child Death Overview Panel (WofE: CDOP). An annual meeting of LSCB chairs and managers to oversee the operation of the WofE takes place and the LSCB Chair rotates annually to take the CDOP Chair role.

The West of England CDOP has undertaken detailed overviews of child deaths which have occurred in the area since its inception in 2008. The CDOP has benefitted from the availability of local and national expertise to inform their deliberations and case reviews and has been proactive in pursuing modifiable factors which indicate the potential for improvements in policy, procedure, practice and wider learning for the future.

	2012/13	2013/14	2014/15	2015/16	2016/17
Number of Child Deaths in Bristol	43	30	31	35	28

An annual report is provided to the four LSCBs each autumn, therefore reporting in the LSCB annual report is for the preceding 12 months. 557 child deaths were notified to the West of England Child Death Enquiries Office between 1st April 2012 and 31st March 2017. 167 of these children were from Bristol. In April 2016- March 2017 28 children died who were from Bristol.

Between 2012 and 2017, 261/557 (47%) of children were not residents of Bristol, North Somerset, South Gloucestershire or Bath and North East Somerset (BANES). The great majority of these children were receiving specialist medical care in Bristol Children's Hospital or St Michaels Hospital (NICU).

THEMES ARISING FROM REVIEWS OF CHILD DEATHS

Themes were presented to representatives from the LSCBs and Partners at an Annual Conference in September 2017. Key findings were that:

- A number of deaths from Group A streptococcal infection were noted and although not necessarily modifiable individually these are important for Public Health strategy and future research opportunities
- The Panel has been aware of some inequalities of health provision across the areas within West of England, and this year noted cases illustrating a difference in provision of pre-hospital care and in staff experience in managing paediatric resuscitation situations.
- Choice of place of End of Life care is sometimes limited by the lack of availability of community based palliative care
- Coordination of hospital care for those with complex medical needs
- There has been no formal support for parents in the next pregnancy after a sudden unexpected death in infancy although CDOP have now been able to support a pilot Care of the Next Infant programme

CDOP will review progress in these areas over the next year and share them as part of the National dataset on child deaths.

6. TRAINING AND ANNUAL CONFERENCE

This year the BSCB recruited a new Inter-agency Trainer. The full BSCB Training programme has been reviewed and updated and a new multi-agency Training Strategy has been launched.

The BSCB Training team ran 23 different courses in 2017-2018 over 71 training days. 60 courses were conducted by the BSCB Trainer and 11 by external agency trainers. 44 of the courses run by the BSCB Trainer had speakers from other agencies. In 2017/18 we trained 1510 professionals compared to 1640 professionals trained in 2016/2017 which was an 8.6% decrease. This decrease was due to two months without a trainer in post and an increased focus on SCR Briefings and three conferences which are not included in the data.

Data from our Initial Child Protection training feedback showed that the training delivered is upskilling professionals effectively. There was a significant increase in confidence in Safeguarding Practice reported with an increase from 33% pre-course to 85% post course increase in reporting Confidence in their own Safeguarding Practice.

Some examples of respondents' feedback on actions taken after training:

- By delivering a briefing to my team, they have realised that they are frequently aware of neglect but don't specifically record it as neglect. By recognising that they need to record it, they are now consciously aware of when referrals need to be made to First Response, as well as other things they can do to address the neglect with families.

- I am feeling more confident about asking honest questions about domestic violence and where to refer and/or signpost.

- By looking through the policy again, it not only refreshed my knowledge but also gave me more confidence in how/where I needed to go to get the support I may require to help children and families. The Quiz I prepared for the staff not only embedded my own knowledge, but gave me the reassurance that staff would know what to do should a child protection issue arise.

- When working on referrals for children who are at risk of CSE I am better able to identify where inappropriate language has been used and where alternative terms can be used and more context can be given.

- I now record any safeguarding concern in a timely way, ensuring I make time to do so while the information is fresh, I also make sure I share relevant information with my safeguarding lead and any other professionals who may need to know. I have also been able to share best practice with my team who have not been on the training, ensuring they record any relevant information

- I have made sure I have considered the whole family's needs as well as the child I am focusing on. An example today is that we discussed the timing of an Autism assessment with a family who are going through cancer treatment for dad and they were very clear that the child's needs come first and we should go forward at this time. I feel more comfortable asking questions now, knowing I am doing it for the child's best interests.

ANNUAL CONFERENCE

This year's BSCB Annual Conference "*Who am I? The relationship between identity and abuse in Safeguarding Children*" was held on Monday 10th July 2017. There were 129 attendees at the conference representing 26 agencies in the city. The Conference this year was used to highlight young people's participation as central to the partnership's approach. The Conference was opened and co-chaired by the members of the Shadow Board, who spoke about the links between the need for tailored interventions, sensitivity to the diversity needs of

adolescents and adolescent vulnerabilities and behaviours to early experiences of neglect and abuse. The Conference heard from children in care, young carers, LGBTQI+ young people, young people accessing mental health services, and BME young people spoke to the audience about accessibility of services, informed and considered assessments, and all groups advocated on the importance of embedding participatory approaches within all work with children. This was reinforced by the messages from the professional speakers who reflected on the impact of neglect on adolescent safeguarding issues, and challenged conceptions of adolescent resilience.

Delegates heard talks from a range of professional speakers and practitioners:

- Dez Holmes, Director Research in Practice; Adolescent Risk and Resilience
- Jamie Barry, Headteacher Parson St; LGBTQ – Challenging Mindsets
- Melissa Atkinson, University West of England; Body Image and Groupwork for Adolescents, Learning from the Dove Project
- Alyas Kimani, Director of STREET; Preventing Youth Violence

7. PRIORITIES FOR 2018-2019

1. Strengthen strategic safeguarding arrangements

The Children and Social Work Act 2017 removes the requirement for an LSCB. This provides an opportunity for us to determine what arrangements are most locally appropriate for effecting lasting positive change for children and families. The Board will oversee a smooth transition to new safeguarding arrangements and will be responsible for ensuring that the functions of the Board are not negatively impacted during this time of change.

2. Reduce Neglect

A Joint Targeted Area Inspection in October 2017 highlighted a range of areas in which organisations in Bristol could improve the safeguarding of children from abuse and neglect. It is the priority of the Board to act robustly to these findings and launch the BSCB Neglect Strategy to drive forward improvements. This work will link closely to Bristol City Council's Attendance Improvement Strategy, and the Board is committed to supporting a whole city approach to safeguarding children through improving attendance at school.

3. Safeguarding Boys and Young Men

The BSCB is concerned that the vulnerability of boys and young men is not being as effectively responded to in Bristol as we would expect. We have a high rate of adolescent boys entering care and low numbers of boys and young men being identified as victims of sexual violence. We also recognise that the Bristol Boys Project has found that there is already an educational attainment gap for boys at the age of 5 compared to their female peers. We are committed to improving the identification of boys and young men as vulnerable, removing structural barriers to safeguarding them and engaging them more effectively with services.

4. Responding to Domestic Abuse, Coercive Control and Violence in Families

Domestic abuse is the highest referred issue to the Children and Families Service. 26,355 of incidents and 13% of crime recorded in Avon and Somerset Constabulary in 2016-17 were related to domestic abuse. 2017-2018 has seen an increase in the number of domestic homicides resulting from domestic abuse and coercive control in Bristol. Two Serious Case Reviews in the last three years have also met the criteria for a Domestic Homicide Review highlighting the vulnerability of our older adolescents to violence. Recent Serious Case Reviews have highlighted that professionals and systems in Bristol have too narrow a focus on domestic abuse and do not always recognise incidents of domestic abuse when they are perpetrated by non-intimate partners such as siblings, older adults, or children. We recognise that we need to improve cross-working with adult services and address systemic barriers to these forms of abuse being recognised and responded to.

5. Safeguarding Children with Complex Health and Mental Health Needs

Children with disabilities, SEND, complex health and mental health needs are more vulnerable to all forms of abuse and neglect than their peers. Despite this there are very low numbers of children with an allocated Disabled Children's Team social worker who are subject to a Child Protection Plan. A number of serious incidents have highlighted gaps in the provision for children with mental health needs, and a lack of multi-agency coordination for those in alternative education or transitioning back from inpatient care.

Furthermore, work to update the Safeguarding Children, Young People and Young Adults with Disabilities policy has highlighted that there is a lack of safeguarding specific communications tools, and that many professionals lack confidence in this area. Furthermore, recent cases have highlighted that there is insufficient provision in the city for children with mental health needs or poor emotional wellbeing. The BSCB will take a robust approach in seeking assurance that these issues are responded to effectively.

6. Improving Assessments

Good quality assessments that are clearly communicated between professionals of different disciplines are the cornerstone of effective partnership working and safeguarding. They rely on: robust information sharing systems; a culture of open and transparent partnership with children, families and other professionals; evidence-based tools; outcome-focused interventions; and clear understanding of child

development and needs. We recognise that to achieve our vision of an integrated, effective system for children we need to improve single and multi-agency assessment processes. This includes formal and on-going assessments.

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