Milton Keynes Safeguarding Children Board

Annual Report

1 April 2011 – 31 March 2012

‘Making Safeguarding Children Everybody’s Business’

Ref: Milton Keynes College Students at MKSCB Annual Conference November 2011

Contents

INTRODUCTION

Welcome to the Milton Keynes Safeguarding Children Board (MKSCB) Annual Report and Business Plan which I am very pleased to present.

The report demonstrates the achievements of the past year and looks forward at the challenges for the future.

In September 2010, MKSCB held its annual business planning session where members clearly identified three priorities for the Business Plan 2011 - 2013. The agreed priorities of the impact on children and young people of **domestic abuse, parental substance misuse and parental mental ill-health** have been a focus of MKSCB work this year. These themes have been incorporated into all of our work through the Business Plan which is presented at the back of this report. MKSCB has committed sub-groups, which carry out work on behalf of the Board and contributions from each of the sub-groups are included in this report.

MKSCB membership continues to be strong and reflects the belief that we all have a personal and professional responsibility to ensure children are kept safe from harm and abuse. Children across Milton Keynes rely on us all to make sure they are happy and cared for and to help them grow up to make the most of their lives. The work of the MKSCB is essential in this task; MKSCB has responsibility for co-ordinating and scrutinising the effectiveness of relevant Milton Keynes organisations.

MKSCB depends on everyone, whether professionals or volunteers, parents or members of the public having an understanding of their own personal or professional responsibility to safeguard children and being vigilant and proactive in carrying it out.

This year much attention has been paid to the publication of the final version of Eileen Munro's Review of Child Protection services. Munro's recommended changes to reduce bureaucracy and establish a more child-centred system have been largely endorsed by the government. Consultation is currently taking place on a revised version of Working Together. Working Together 2012 is intended to provide a framework and set of principles within which Local Safeguarding Children Boards can make their own local and specific arrangements using professional guidance and messages from research and we are pleased to note that Munro recognises the value of LSCBs and sees an increased role for us in the future.

These changes will provide an opportunity for MKSCB to build on our current approach of learning and professional development designed to empower the workforce to provide a more flexible, child-centred service. We look forward to another exciting, yet challenging year.

Thank you for your support,

Elaine Coleridge Smith, Independent Chair MKSCB

Safeguarding in Context

It might be difficult to accept, but any child can be hurt, put at risk of harm or abused, regardless of their age, gender, religion or ethnicity, and child maltreatment is unfortunately all too common in most cultures and countries.

Within the UK, Ofsted estimates that three children per week die as a result of child abuse and neglect (Ofsted, 2009[1]) and research suggests at least 16 per cent of the population will experience some form of serious maltreatment during their childhood (May-Chahal and Cawson, 2005[2]). Research also tells us that a history of maltreatment is related to negative impacts throughout a child's life, as victimised children are more vulnerable to repeated abuse and are more likely to experience poor physical and mental health in adulthood.

The Children Act 1989[3] introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm. Under this Act:

> 'harm' means ill-treatment or the impairment of health or development, including for example impairment suffered from seeing or hearing the ill-treatment of another.'
>
> *(Ref: s31 (9) of the Children Act 1989 as amended by the Adoption & Children Act 2002)*

Safeguarding legislation and government guidance defines safeguarding as:

- "protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care

and

- undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully."

(Ref: Ch 1, 1.20, Working Together to Safeguard Children 2010[4])

MKSCB is a strategic board which was established in 2006 to oversee the work of partner agencies in Milton Keynes to safeguard children and young people. It is the statutory mechanism for agreeing how these agencies co-operate to safeguard and promote the welfare of children, ensuring that there are common practices and policies in place across the agencies and that all agencies are effective in their safeguarding responsibilities.

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[1] OFSTED (2009) *The annual report of Her Majesty's chief inspector of education children's services and skills 2008/09*. London, The Stationery Office (TSO)

[2] May-Chahal, C. and Cawson, P. (2005) Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect. *Child Abuse and Neglect* 29*:* 969–984

[3] http://www.legislation.gov.uk/ukpga/1989/41/contents

[4] Working Together to Safeguard Children (1.20 HM Government 2010

Milton Keynes in Context

Milton Keynes is the fastest growing urban centre in the UK with an increasing growth in ethnic diversity. Milton Keynes is characterised by a young population that is growing rapidly. The latest figures from the Office for National Statistics indicate that the population of children and young people aged 0 – 19 years will increase from 64300 in 2010 to 74690 in 2020. This is an increase of 16% across the borough. Population growth is occurring at a time when efficiency savings are required in many organisations. The demands of a growing population can place services under pressure, particularly in the current financial climate of resource and budget cuts.

Milton Keynes places considerable importance on a Family Support approach when working with children. As a result Milton Keynes stands out when compared to England and its Statistical Neighbours.

In Milton Keynes, the family support ethos means that wherever child protection issues can be safely and effectively managed without entering formal child protection processes, this is the preferred way of working. This involves working explicitly with the family and professional network to identify risks and strengths, to agree goals to be achieved in order to safeguard the child and to evaluate progress.

As a result of the positive family support and risk management approach, Milton Keynes has a comparatively low number of children who are subject to Child Protection plans.

MKSCB has endorsed the Family Support Approach and continues to work with partners to monitor and scrutinise its effectiveness.

Child Protection in Milton Keynes

Milton Keynes has two Child Protection Co-ordinators who are responsible for managing the child protection conference process, including chairing meetings. They also provide objective, expert consultation regarding evaluation and management of risk and are responsible for quality and scrutiny functions and training, which contribute to an assurance that Milton Keynes' approach to child protection is a safe and robust one.

A child protection consultation takes place in cases where assessment identifies a child protection element. During 2011/12, Child Protection Co-ordinators undertook 199 consultations in respect of 166 children. Of these, 64 children (38.5%) from 37 families went on to become subjects of Child Protection Plans and seven children (from six families) were removed into care when Child Protection Plans were deemed to be unable to provide sufficient protection. Of the children who were not subsequently subject to Child Protection Conference, the risk was managed through ongoing Family Support plans in two-thirds of cases. The consultation process is proactively used as a risk-management and decision-making tool that operates alongside other operational processes, including supervision.

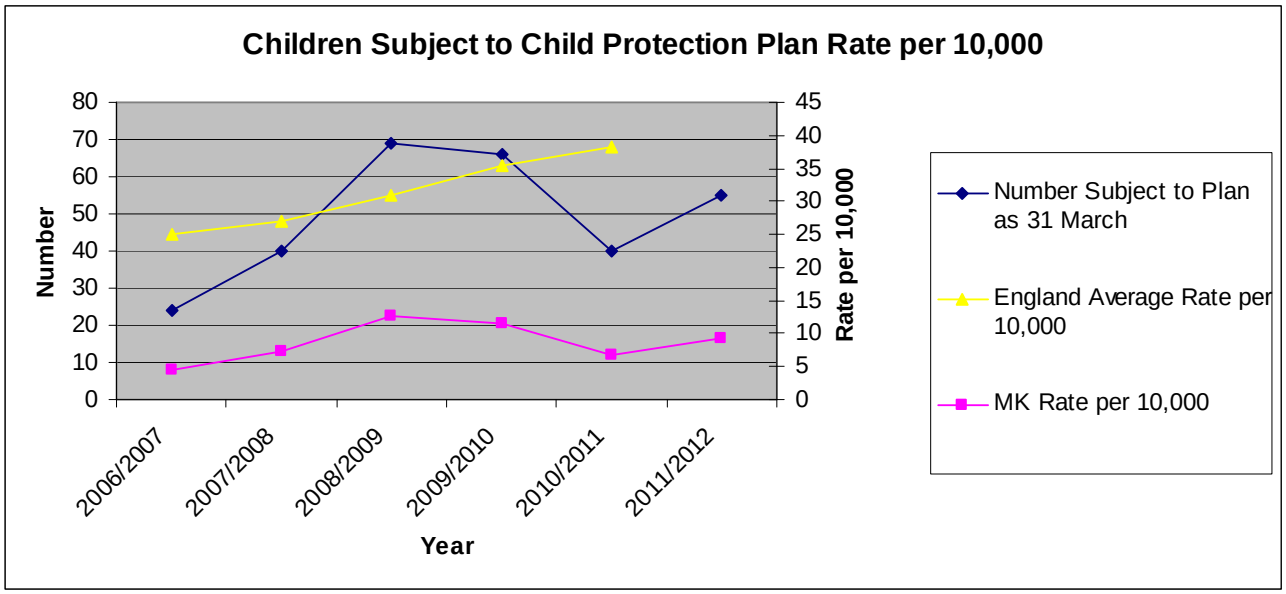
Children Subject to Child Protection Plans

At year end 2011 - 12, a total of 55 children (from 30 families) were subject to Child Protection (CP) Plans, representing 9.4 children per 10,000 of the 0 - 17 population. This is an increase on last year (40 children from 22 families) but is still less than in 2009/10 (66) and in 2008/09 (69). As a result of the Family Support approach, Milton

Keynes numbers have historically been substantially lower than the England average and Statistical Neighbour (SN) average, which by 2010/11 had increased to 38.3 and 44.3 per 10,000 respectively. Statistical Neighbour and England average data for 2011/12 will not be available until October 2012.

In 2011 - 12, the main category under which children were made subject to Child Protection Plans was 'neglect'. At 74.7% of all Child Protection Plans, this was a significant increase compared to 47% in 2010/11. Nationally, neglect has always been the largest category and it will be interesting to see whether this increase is reflected in Statistical Neighbour and England Average data when available. Emotional abuse represented 10.5% of Plans, compared to 43% last year. The majority of emotional abuse cases relate to the impact on children of living with domestic abuse. Recently neglect has been viewed as the preferred category to reflect the impact of domestic violence, accounting for the proportionate shift in percentages. Overall, neglect and emotional abuse combined have remained consistent. The younger age groups of children are most prevalent: ages 1-4 (38%) then 5-9 (31%) respectively.

For more detailed information the full 'Child Protection in Milton Keynes Annual Report April 2011 – March 2012' is available on the MKSCB website.



PART 1 GOVERNANCE & ACCOUNTABILITY ARRANGEMENTS

1.1 Role, Structure & Function of the MKSCB and its Sub-Groups

MKSCB is made up of senior representatives from the key organisations that work with children and their families in the area, plus two lay members who represent the community. MKSCB partners work together to ensure that children in Milton Keynes are safe from abuse or harm at home, and in our communities.

MKSCB meets four times a year and is supported by the Business Management Group (BMG) and sub-groups, which meet more frequently to drive the implementation of the Business Plan. MKSCB has six sub-groups and a Child Death Overview Panel (CDOP), responsible for the effective delivery of the MKSCB Business Plan. These groups report to the Board via the Business Management Group (BMG).

MKSCB SUB-GROUPS and CHAIRS 2011 - 12

Quality Assurance (Zareen Hayat - Probation)
Policy and Procedure (Jo Ulyett - Health)
Serious Case Review (Amanda Blake - Police)
Safer Workforce (Jo Hooper - Children & Families Service, MK Council)
Communication (Jo Hooper - Children & Families Service, MK Council)
Training and Development (Ruth Hester - Education)
Child Death Overview Panel (Phil Latham - Health)

1.2 MKSCB Relationship with Children & Families Partnership

The relationship between the MKSCB and the Children and Families Partnership has been formalised with a partnership agreement.

Both partnerships have agreed to

- have an ongoing and direct relationship with each other
- communicate regularly
- work together to ensure that action taken by one body does not duplicate that taken by the other
- ensure strategic and operational coherence across policies, protocols, services and practices

Elaine Coleridge Smith, (MKSCB Independent Chair) is a member of the Children and Families Partnership. Gail Tolley, the Chair of the Children and Families Partnership, is a member of the MKSCB.

1.3 MKSCB Membership & Attendance

Membership records are kept and monitored to ensure attendance is regular and appropriate. These records are presented to members on an annual basis as part of the LSCB's quality assurance process. If a member is unable to attend they are asked to send a deputy to ensure all messages are disseminated to and from each agency.

Attendance figures recorded below are based on five meetings - four MKSCB business meetings plus the MKSCB Development Day - held between 1 April 2011 and 31 March 2012.

Agency	Attendance
Independent Chair	100%
Adult Mental Health Service	40%
Milton Keynes Council Adult Social Care	60%
CAFCASS	40%
Designated Doctor – Safeguarding	100%
Director of Children's Services	80%
Head teacher, representing primary schools	100%
Head teacher, representing secondary schools	60%
Head teacher, representing special schools	60%
Strategic Health Authority	40%
HMP Woodhill	40%
Lay Member 1	40%
Lay Member 2	25%
Lead Member	60%
Milton Keynes College	60%
Milton Keynes NHS Foundation Trust	80%
Milton Keynes Community Health Services	100%
Milton Keynes Council Children & Families	100%
*NHS Milton Keynes & Northamptonshire	100%
NSPCC	0%
Oakhill Secure Training Centre	40%
Safer MK	80%
Thames Valley Police	60%
Thames Valley Probation	60%
Voluntary Sector	20%
Youth Offending Team	80%

* NHS Milton Keynes & Northamptonshire has been represented on MKSCB from September 2011.

1.4 Role of Independent Chair, Director of Children's Services, Lead Member

Working Together to Safeguard Children 2010, chapter 3 states that:
"It is the responsibility of the local authority, after consultation with the LSCB partners, to appoint the LSCB chair…. There should be a presumption that the chair will be someone independent of the local agencies so that the LSCB can exercise its local challenge function effectively".

Working Together further states that "The chair will have a crucial role in making certain that the Board operates effectively and secures an independent voice for the LSCB. He or she should be of sufficient standing and expertise to command the respect and support of all partners. The chair should act objectively and distinguish their role as LSCB chair from any day-to-day role".

Elaine Coleridge Smith was appointed by a partnership panel in September 2009 as Independent Chair of Milton Keynes LSCB. This position was reviewed by partners in September 2011 and continued for a further two years.

Lead Members for Children's Services have delegated responsibility from the Council for children, young people and families and are politically accountable for ensuring that the local authority fulfils its legal responsibilities for safeguarding and promoting the welfare of children and young people. The Lead Member should provide the political leadership needed for the effective co-ordination of work between relevant agencies with safeguarding responsibilities. Lead Members should also take steps to assure themselves that effective quality assurance systems for safeguarding are in place and functioning effectively.

Working Together to Safeguard Children 2010 states that "the Lead Member should be a 'participating observer' of the LSCB. In practice, this means routinely attending meetings as an observer and receiving all its written reports. Lead Members should engage in discussions, ask questions and seek clarity, but not be part of the decision-making process. This will enable the Lead Member to challenge, when necessary, from a well-informed position".

Councillor Andy Dransfield was appointed the Lead Member for Children's Services in May 2011.

1.5 Financial Arrangements

The MKSCB budget for 2011/12 was £237,571.

The table below outlines MKSCB expenditure as at 31 March 2012.

Category	Actual Budget	Spend as at 31 March 2012
Staffing	153,216	123,318
Independent Chair	13,160	15,538
Child Death Overview Panel Co-ordinator and costs	17,500	16,495
Publicity & engagement	2,808	6,511
Training: development of materials and buy-in of trainers, includes CAF, e-learning, Annual Conference	34,887	19,522 -5,350
Procedures maintenance	6,000	3,500
Office expenses		1,849
Serious case review & legal advice (contingency)	10,000	550
TOTAL	**237,571**	**181,933**

An additional £20,000 was brought forward from 2010 – 11 and was used to fund the Missing Children Pilot Project, which was completed to budget within the financial year 2011 – 12.

The carry forward from 2011 – 12 will be offset against the budget contribution asked of each agency for the 2012 – 13 period on a pro rata basis.

Additionally, MKSCB was allocated £23,902 from the Social Work Improvement Fund in the autumn of 2011. This funding was provided to support the work of Local Safeguarding Children Boards, and the redesign of services to enable earlier intervention. In early 2012 MKSCB commissioned the company Reconstruct to undertake a multi-agency audit commencing in April 2012. This work will incorporate an evaluation of how agencies work together to address the three MKSCB themes of the impact on children and young people of domestic abuse, parental substance misuse and parental mental ill-health, and aims to inform the Board on the effectiveness of inter-agency working and early intervention in Milton Keynes.

PART 2 MONITORING & EVALUATION

2.1 Summary of Quality Assurance Activity Undertaken This Year

The Quality Assurance Sub-Group

The Quality Assurance sub-group is responsible for monitoring and evaluating the safeguarding work of the partner agencies and is a key feature of the work of the MKSCB. The sub-group oversees the delivery of Objective 5 in the 2011 – 13 MKSCB Business Plan:

'Effective quality assurance systems are in place across and within all partners, and that scrutiny systems across agencies are in place'.

MKSCB Audit priorities for 2011 – 12 were:

- To complete Section 11 audit of statutory partners
- To commission a multi-agency audit into the effectiveness of partners to work together to safeguard children living with parental mental ill-health, parental substance misuse and/or domestic abuse

MKSCB Progress in Response to National Expectations and Local Need

- The Quality Assurance sub-group has refreshed its annual audit programme against Working Together guidance.
- There are so many dimensions to safeguarding that trying to quality-assure everything would be overwhelming. MKSCB has focused on a discrete number of defined areas which we have agreed to be the most important based on statutory and local requirements.
- The multi-agency audit into the effectiveness of partners to work together to safeguard children living with parental mental ill-health, parental substance misuse and/or domestic abuse reflects national concerns relating to these issues, and emerging learning from serious case reviews.
- The Quality Assurance sub-group has received and commented on a wide range of single-agency audits and annual reports.

During this year the MKSCB commissioned Barnardos to carry out a missing children pilot project. The aim of the project was to provide MKSCB with data on the numbers of Milton Keynes children who go missing, why they go missing and where they are found. The Pilot Project was allocated £20,000 from the MKSCB budget to carry out this piece of work and Barnardos was asked to report on the findings.

The MKSCB Business Manager was responsible for overseeing the Missing Children Pilot Project commissioned by the MKSCB.

Impact on Local Arrangements

- The Quality Assurance sub-group has completed a base line audit of statutory partners (Section 11 audit) and is monitoring the action plans of partners against the audit.

- The Quality Assurance sub-group monitored the progress of the Health and Probation IMR action plans for case CD and these were signed off during the latter part of the year.

- The Quality Assurance sub-group has identified opportunities for learning and referred requests for briefings to the MKSCB Training sub-group.

- The Missing Children project provided information on why young people were going missing in Milton Keynes, and where they went when missing. This work will inform MKSCB work in the coming year.

Outcomes for Children

- Learning from audits is taken forward with agencies and training needs for staff are identified.
- Audits of Initial Assessments by the Child Protection Co-ordinators monitor that risk of harm to children is appropriately identified and addressed. Routine monthly case audits by managers across Children's Social Care include a sample of child protection cases and provide an additional level of scrutiny of inter-agency safeguarding work, including child protection planning.

Future Priorities

The priorities for the sub-group for 2012 - 2013 are to:

- Complete the SWIF-funded multi-agency audit.
- Monitor the effectiveness of organisations' implementation of their duties under section 11 of the Children Act 2004 and undertake a similar audit for schools and settings.
- Continue to monitor single-agency audits, utilising the standard summary sheet and provision of an executive summary.
- Undertake multi-agency case file audits and feed back recommendations to relevant agencies.

2.2 Statutory Obligations under Section 11 of the Children Act 2004

Section 11 of the Children Act 2004 places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children and young people.

MKSCB has a statutory responsibility to periodically assess the level of compliance of all partners with these responsibilities.

During this year a section 11 audit was carried out with each statutory partner. Agencies were supported by the MKSCB Business Manager to complete the audit. The outcome of this audit demonstrated that most agencies have safeguarding structures and procedures in place. Most agencies that had actions in the previous section 11 audit had made satisfactory progress. There was an improvement on effective information-sharing within organisations in comparison with the previous section 11 audit.

MKSCB will undertake a similar audit with a sample of schools and colleges and settings in the coming year.

2.3 The Effectiveness of Partners

Safer Workforce Sub-Group

The Safer Workforce Sub-Group oversees the delivery of Objective 4 in the 2011 – 13 MKSCB Business Plan:

'Safe recruitment and workforce practices are in place across all services and agencies'

MKSCB Progress in Response to National Expectations and Local Need

- The national context of review of the Independent Safeguarding Authority (ISA) and Vetting & Barring scheme has caused some ongoing uncertainty. The sub-group has kept up to date with changes and proposals and provided communications and briefings for MKSCB partner agencies.

Impact on Local Arrangements

- The MKSCB inter-agency Safer Recruitment Guidance was approved in October 2010 and has been incorporated into MKSCB and Milton Keynes Council Safer Recruitment training.
- The group monitored and evaluated the effectiveness of safer-recruitment policy and practice through the quality assurance process and took action to address gaps and issues as appropriate.
- Based on the MKSCB Safer Recruitment Guidance, a self-assessment audit was carried out and reported in June 2011. This scoping exercise across organisations tested 'compliance' in recruitment, induction/guidance, safe working culture and safer recruitment monitoring.
- Overall, the audit demonstrated a good level of awareness and compliance with safer recruitment policy and good practice across local organisations. Some areas of deficit were identified and sub-group members worked with agencies and settings as relevant to take action to address these.
- The sub-group developed a safer recruitment checklist to supplement the Guidance.
- Ongoing work takes place as required to develop/update relevant policies and procedures. Local safeguarding in education guidance was reviewed in October 2011 and inter-agency procedures on Allegations Management have been revised.
- The children's workforce is kept up to date about changes and developments through training and awareness-raising events and communications.
- Local organisations and settings have addressed specific areas of policy and practice pursuant to implementation of actions following the audit, raising awareness and generating practice improvements amongst the workforce.
- The LADO attends sub-group meetings and reports on LADO activity and local and national allegations management information. The LADO Annual Report is presented to MKSCB.
- The group provided advice and support to schools and settings regarding safeguarding, including recruitment and HR practices through a combination of activities. These included action following the audit, briefings and training, plus individual support as required.

Outcomes for Children

- Children are protected through safer recruitment and employment activities. The safety of the children's workforce in Milton Keynes is optimised through the development of safer recruitment guidance, monitoring of implementation and work to address any areas of deficit.
- Where children are harmed by or are at risk from members of the children's workforce, effective allegations management processes and practice ensure that agencies work together to respond appropriately, proportionately and in a timely manner to protect the child and other children in the setting. The process also seeks to ensure a fair response to the alleged perpetrator.
- The children's workforce is aware of their individual and organisational responsibilities to ensure that children are protected from harm and to respond to concerns about children's safety and welfare, through a programme of communications, training and awareness-raising.

Future Priorities

- The sub-group will review and revise inter-agency policy and guidance relating to safer employment and to allegations management as appropriate, in response to developments in the national and local context and in accordance with good practice.
- The sub-group will undertake further quality assurance of safer employment practice across local organisations and settings.
- The sub-group will continue to scrutinise managing allegations activity and the effectiveness of the LADO process and to promote good practice.

2.4 Serious Case Review

The Serious Case Review sub-group oversees the delivery of Objective 6 in the 2011 – 2013 MKSCB Business Plan:

'Effective arrangements are in place to determine when to hold a Serious Case Review, to ensure the review is carried out in an efficient and independent manner, and to ensure that learning from the review is disseminated across partner agencies and leads to improved practice'.

MKSCB Progress in Response to National Expectations and Local Need

- The MKSCB has not undertaken a serious case review (SCR) since the Child B SCR in 2008.
- Since April 2011 the sub-group has reviewed nine cases:
  - Case 1, did not meet the criteria for a SCR, but Health initiated an IMR.
  - Case 3, did not meet the criteria for a SCR, but a multi-agency review of the case was initiated by the sub-group.
  - Case 5, did not meet the criteria for a SCR, but the Serious Incident report from Milton Keynes Hospital Foundation Trust was shared with the sub-group.
  - Cases 2, 4, 6, 7, 8, and 9 did not meet the criteria for a serious case review.
- The sub-group has considered learning from National SCRs and referred reports to the MKSCB training sub-group for the provision of briefings as appropriate.

Impact on Local Arrangements

- The MKSCB SCR Toolkit has been cited in the Ofsted Good Practice Guidance, and is available for those IMRs carried out for the MKSCB.

Future Priorities

- The group will review and update the MKSCB SCR Toolkit to reflect a systems approach to learning, as required by the revised Working Together guidance.
- The group will assist in the development of computer-based training for all professionals and MKSCB members on the SCR Toolkit.
- The group will continue to review SCR national data relating to domestic abuse, substance misuse and mental health.

2.5 Child Death Overview Panel

The Child Death Overview Panel (CDOP) oversees the delivery of Objective 8 in the 2011 – 13 MKSCB Business Plan:

'MKSCB reviews all deaths of children normally resident in the Milton Keynes area, in line with statutory Working Together guidance.'

MKSCB Progress in Response to National Expectations and Local Need

The CDOP Annual Report April 2011 – 31 March 2012 contains a range of statistics; however the figures remain small and thus difficult to interpret statistically.

Whilst paying due regard to statistical data MKSCB CDOP is looking to answer five questions that are fundamentally qualitative in nature:-

- Were there any safeguarding issues that have been overlooked?
- Was the death investigated appropriately where necessary?
- Were the bereaved supported appropriately?
- Are there any local Public Health issues to address?
- Are there any issues which might contribute to learning nationally?

These are the statutory responsibilities for LSCBs in relation to child deaths as outlined in regulation 6 of the LSCB regulations (2006) and remain unchanged in the recent Working Together consultation document.

Between 1 April 2011 and 31 March 2012 the panel has been notified of eighteen deaths of children residing or dying in the LSCB area under eighteen years of age. The deaths include one child not normally resident in the area.

The numbers compared with eight previous years in the LSCB area: 2003	2004	2005	2006	2007	**2008 – 2009**	**2009 – 2010**	**2010 – 2011**	**2011 – 2012**
34	23	25	28	22	**36**	**34**	**28**	**18**

Impact on Local Arrangements

The Milton Keynes CDOP meets bi-monthly and completed reviews on 29 child deaths over six panels; one of the deaths reviewed occurred in year 1 (2008 – 09), seven occurred in year 2, fourteen in year 3 and seven died during year 4.

MKSCB CDOP discussed the first cases of possible suicide at the May 2011 meeting. This was included in last year's report and illustrates neatly that whilst the process can be slow when Coronial or legal action is involved, this need not be a barrier to taking action. Work between Child and Adolescent Mental Health Services (CAMHS) and partner agencies in this area is ongoing.

MKSCB CDOP discussed two cases where there were safeguarding issues. These cases were also discussed at the MKSCB Serious Case Review sub-group. The cases did not meet the criteria for a SCR, however the Health Safeguarding Children Team completed an Internal Case Review to identify lessons learnt which included ensuring better use of information in health records to target support for young parents.

Outcomes for Children

For MKSCB CDOP, of the deaths reviewed this year:

- 45% were caused by neonatal events (42% total years 1 - 4 inclusive)
- 21% known life-limiting condition (22% total)
- 18% other - predominantly infection (24% total)
- 11% apparent suicide (4% total)*
- 4% other non-intentional injury/accident/trauma (2% total)

(*It should be noted that this figure is for the cases REVIEWED during this year. Of the 'apparent suicide' deaths, two occurred in 2010, and one in 2011.)

In reviewing the death of each child, the CDOP considers modifiable factors, for example in the family and the environment, parenting capacity or service provision, and considers what action could be taken locally and what action could be taken at a regional or national level.

Modifiable factors are defined as those, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths. Modifiable factors for consideration by MKSCB CDOP included**:**

- Consanguinity
- Medical care
- Parental care
- Cigarette smoking
- Accident

Modifiable factors identified	**7**
No Modifiable factors identified	**22**
Inadequate information upon which to make a judgement	**0**

MKSCB CDOP did not have any Sudden Unexpected Deaths of Infant (SUDI) cases to discuss.

Currently in Milton Keynes the Care Of Next Infant (CONI) and CONI+ schemes are active. The co-sleeping advice is as per the Foundation for the Study of Infant Deaths

(FSID) leaflet and is given out at least twice verbally and in written form. Smoking advice is given out at each contact and this is recorded on the Health "Rio" system.

The Panel identified lessons to be learnt, recommendations to be made or actions to be taken in response to the review of each death.

Recommendations were made in the following areas: Recommendations specific to the management of an individual case	√	Community education/ awareness	√
Training commissioners/providers		National education/awareness	
Changing local organisational structures and practices	√	Advocacy and health promotion	√
Changing regional policies or practices		Mobilising local communities	
Influencing legislation or national policy	√	No recommendations	√

Future Priorities

MKSCB CDOP will review its current arrangements to ensure effective delivery in line with the revised Working Together guidance.

Current NHS reorganisation has seen Milton Keynes ally with Northampton, Kettering and Corby and become part of the "East of England", moving away from alliances with Buckinghamshire and Oxfordshire. In the coming year the option of joining the Northampton CDOP will be under discussion. MKSCB will continue to meet its responsibilities in respect of the child death review process, regardless of agency reorganisation and geographical alignment.

2.6 Policies and Procedures

The Policy and Procedures sub-group oversees the delivery of Objective 7 of the 2011 – 13 MKSCB Business Plan:

'Multi-agency safeguarding policies and procedures are up to date and easily accessible to staff across agencies'

MKSCB Progress in Response to National Expectations and Local Need

- The MKSCB Policy and Procedure Review Schedule has been finalised, to clarify the status of each chapter to sub-group and MKSCB members. Chapters are reviewed according to changes in legislation or local need, identified either by Policy and Procedure sub-group members or agency request. Priority has been given to reviewing the chapters relevant to the MKSCB key themes. The consultation process has also been formalised with the development of a policy consultation sheet.

- **The following chapters have been updated:**

    - Missing Child
    - Parental Misuse of Drugs or Alcohol
    - Sexually Active Young People
    - HIV and Blood Borne Viruses
    - Abusive Images of Children and Information Communication Technology
    - Allegations Against Staff, Carers and Volunteers
    - Domestic Abuse

- **The following chapters are currently under review:**

    - Mental Health of Parent or Carer
    - Fabricated or Induced Illness
    - Trafficking and Exploitation and Female Genital Mutilation have been identified as requiring reviewing

Impact on Local Arrangements

- Training and briefing sessions have linked to the review of chapters.
- In the sub-group's capacity to advise and support Milton Keynes agencies in the development of their child protection policies and procedures, the sub-group has reviewed policies from COMPASS, Ezycare and Fostering Options
- The Levels of Need document was approved by the MKSCB in October 2011 and is available on the Policy and Procedures page of the MKSCB website. Chapter 7 of the MKSCB Procedures also includes a link to the Levels of Need document.

Future Priorities

- With the expected revision of Working Together, the sub-group will prioritise update of chapters in accordance with this statutory document.

PART 3 COMMUNICATIONS AND ENGAGEMENT

3.1 Communication

The MKSCB Communication Sub-Group oversees the delivery of Objective 2 in the 2011 – 2013 MKSCB Business Plan:

'Information is made available to children and young people, their parents, professionals and communities on how children can be safeguarded and their welfare promoted'

MKSCB Progress in Response to National Expectations and Local Need

- MKSCB Communication Strategy was reviewed and revised (May 2011)
- Following MKSCB approval of the Levels of Need document in October 2011, the document was posted on the MKSCB website
- A MKSCB Induction Pack was developed for new MKSCB members, and sub-group members (November 2011)
- A Communication Survey was carried out (March 2012)
- MKSCB Safeguarding publications continue to be distributed on request
- The MKSCB website is under continuous review and revision: approved MKSCB policies and procedures are posted on the website prior to being incorporated into the web-based MKSCB Procedures
- The MKSCB website and partner agency publications are used to raise issues and provide information

Impact on Local Arrangements

- Safeguarding information is made available to senior managers, practitioners and the public.

Outcomes for Children

- There is a better informed workforce, community and the general public
- Access to information on services for children and young people has improved

Future Priorities

- The sub-group will encourage greater multi-agency representation on the sub-group
- The sub-group will continue the distribution of MKSCB safeguarding publications, and consider additional materials
- The sub group will continue to review and update the MKSCB website
- The sub group will address the 'Munro' recommendation that 'the principles of multi-agency working and creating a culture where all the relevant agencies listen to and engage in dialogue with children, both in decisions and in determining the development and improvement of services'

3.2 Training & Development

MKSCB Training & Development Sub-Group oversees the delivery of Objective 3 in the 2011 – 2013 MKSCB Business Plan:

'Safeguarding training is provided effectively to the children's workforce and promotes the objectives of MKSCB.'

MKSCB Progress in Response to National Expectations and Local Need

- Following the approval by the MKSCB of the 'Levels of Need' document in October 2011, the guidance has been used extensively when delivering MKSCB inter-agency training in Milton Keynes, to give practitioners a better understanding of the thresholds in Milton Keynes. It has supported agencies to use a common language and to understand the information required to make a referral to children's services.
- The MKSCB annual conference held in November 2011, 'Supporting Families in our Community', was attended by 270 delegates, an increase of 71% from the previous year. It was hosted by young people from Milton Keynes College and focussed on the three main themes identified by MKSCB.
- Over the year 2860 people attended the training events offered by MKSCB. This represents an increase of 1802 attendees from 2010 - 2011. In addition 609 people accessed the new MKSCB e-learning resource, which includes sessions on Basic Safeguarding and aspects of the Common Assessment Framework.
- This year has again seen an increase in the number of professionals joining the MKSCB Training Pool and this range of different professionals from a variety of agencies ensures that MKSCB models good practice in relation to working together to safeguard children and young people.

Impact on Local Arrangements

- The increased attendance at training events ensures that more professionals working with children and young people are made aware of any new national and local developments and that awareness is raised on the three main themes.
- There is a greater understanding of the 'thresholds' of significant harm as a result of the inclusion of the MKSCB Levels of Need document in both single and multi-agency training.
- The MKSCB training needs analysis suggests that the partner agencies are becoming increasingly aware of their responsibilities in relation to safeguarding training with 98% of respondents having single-agency training in place and 97% accessing inter-agency training.

Outcomes for Children

- Increased knowledge, skills and understanding of safeguarding issues amongst professionals contributes to keeping children and young people safe.

Future Priorities

- To deliver consistently high-quality training as part of the MKSCB training programme to meet the needs of Milton Keynes children's workforce.
- To be proactive in ensuring that professionals are given the knowledge and understanding of emerging safeguarding issues and be confident that the workforce is conversant with the implications of Munro's recommendations and the impact of the revised Working Together document.
- To arrange a conference for Young People in February 2013 to secure their voice in evaluating services and in planning future developments.
- To continue work to engage with voluntary, community and faith groups and encourage representation of these sectors on the sub-group.

CONCLUSION

This report describes the work undertaken by the Milton Keynes Safeguarding Children Board during 2011 - 12.

This year has been characterised by change. All partners have been involved in restructuring their organisations, within tight financial constraints. It is a positive reflection on the partnership that attendance at MKSCB meetings has remained good. Partners have continued to commit to the work of MKSCB and prioritise the importance of safeguarding children within their organisations.

Challenges for 2012 - 13 are significant and include the need to respond effectively to the revised *Working Together to Safeguard Children* guidance.

At the time of writing this report draft guidance on what is expected of organisations, individually and jointly, to safeguard and promote the welfare of children is being consulted on.

New guidance will require MKSCB to oversee the implementation of three key documents:

- *Working Together to Safeguard Children:* guidance on what is expected of organisations, individually and jointly, to safeguard and promote the welfare of children;
- *Managing Cases: the Framework for the Assessment of Children in Need and their Families:* guidance on undertaking assessments of children in need; and
- *Statutory Guidance on Learning and Improvement:* new arrangements for Serious Case Reviews (SCRs), reviews of child deaths and other learning processes led by Local Safeguarding Children Boards (LSCBs).

Nationally we have seen increasing concerns about the impact on children and young people of trafficking, grooming and child sexual abuse. MKSCB will pay attention to these issues in the coming year.

MKSCB has agreed its 2011 – 13 Business Plan and objectives, and will review the plan during its Development Day in September.

MKSCB PRIORITIES for 2012 - 13

In the coming year MKSCB intends to:-

1) Continue to address the objectives in the existing MKSCB Business Plan

2) Implement recommended actions resulting from the SWIF-funded multi-agency audit to address how effectively partners work together to address the three MKSCB priorities of the impact on children of living with
    - Parental mental ill-health
    - Parental substance misuse
    - Domestic abuse

3) Work with partners to ensure safe implementation of revised Working Together 2012, including 'establishing a local learning and improvement framework which is shared across local organisations that work with children'.

4) Work with MKSCB partner agencies to implement the recommendations detailed in Eileen Munro's Review of Child Protection report.

5) Engage with voluntary, community and faith groups.

6) Consider future priorities (beyond 2012 – 13), which will be discussed at the MKSCB Development Day.

Glossary

BMG	Business Management Group
CAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Service
CDOP	Child Death Overview Panel
CONI	Care of Next Infant
CP	Child Protection
CRB	Criminal Records Bureau
FSID	Foundation for the Study of Infant Death
HIV	Human Immunodeficiency Virus
HMP	Her Majesty's Prison
HR	Human Resources
IMR	Individual Management Reviews
ISA	Independent Safeguarding Authority
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MKSCB	Milton Keynes Safeguarding Children Board
NSPCC	National Society for the Prevention of Cruelty to Children
OFSTED	Office for Standards in Education
QA	Quality Assurance
SCR	Serious Case Review
SN	Statistical Neighbour
STC	Secure Training Centre
SUDI	Sudden Unexpected Death in Infancy
SWIF	Social Work Improvement Fund
TNA	Training Needs Analysis

References

OFSTED (2009) *The Annual Report of Her Majesty's Chief Inspector of Education Children's Services and Skills 2008/09*. London, The Stationery Office (TSO)

May-Chahal, C. and Cawson, P. (2005) Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect. *Child Abuse and Neglect* 29*:* 969–984

Children Act 1989: http://www.legislation.gov.uk/ukpga/1989/41/contents
Working Together to Safeguard Children (1.20 HM Government 2010)

TO FIND OUT MORE ABOUT THE BOARD PLEASE LOOK AT THE MKSCB WEBSITE www.mkscb.org

Or contact the MKSCB team:
MKSCB Independent Chair
MKSCB Business Manager
MKSCB Inter-Agency Training Manager
MKSCB Administrators

(tel: 254373/email mkscb@milton-keynes.gov.uk)

Appendix 1: MKSCB Membership (as at 31 March 2012)

Elaine Coleridge Smith	MKSCB Independent Chair
Jill Wilkinson (vice chair)	Director of Nursing/Operational Director of Community Health Services
Jane Appleby	Lead Children, CAMHS and Safeguarding (Adults and Children) East Midlands Strategic Health Authority (SHA)
Christianne Best	Lay Member
Sue Cox	Head teacher Priory Rise, representing Primary Schools
Cllr Andy Dransfield	Lead Member, Children and Learning, MK Council
Andy Grout	Director, MK Play Association, representing Voluntary Sector
Tony Halton	Director of Nursing, MK Hospital Foundation Trust
Jo Hooper	Professional Advisor to MKSCB/Head of Safeguarding Children & Families, MK Council
Nick Jackman	Head teacher Walnuts School, representing Special Schools
Phil Latham	Designated Doctor Safeguarding
James Lynch	Senior Probation Officer, Offender Management, HMP Woodhill
Sylvia Manson	Head of Safeguarding, NHS Milton Keynes & Northamptonshire
Lisa Milligan	Vice Principal, Milton Keynes College
Jan Norman	Director of Nursing, NHS Milton Keynes & Northamptonshire
Richard North	Detective Chief Inspector, Thames Valley Police
John O'Donnell	Head teacher Radcliffe School, representing Secondary Schools
Vince Raymond	Director, Oakhill Secure Training Centre
Nicky Rayner	Assistant Director, Social Care & Integrated Support, Children & Families, MK Council
Jane Reed	Housing Assistant Director, MK Council
Dan Russell	Regional Head of Services, NSPCC
Lyn Scott	Assistant Director, Adult Social Care, MK Council
Anna Selby	Director of Joint Mental Health Services
Richard Solly	Head of Community Safety, Safer MK
Zeinab Sulemani	Lay Member
Sally Thomas	Head of Service, Thames Valley CAFCASS
Gail Tolley	Director of Children's Services Children & Families, MK Council
Jo Ulyett	Designated Nurse Safeguarding, NHS Milton Keynes & Northamptonshire
Kilvinder Vigurs	Director, Thames Valley Probation
Lee Westlake	Head of Service, Youth Justice, MK Youth Offending Team

Appendix 2 Annual Reports, Updates, Consultations & Inspection Reports

During this period the following 2010 – 11 annual reports were received and considered by the MKSCB, or one of the MKSCB sub-groups.

- MK Council Private Fostering
- MK Council Report on Child Protection in Milton Keynes
- MKSCB Child Death Overview Report
- MK Council LADO Annual Report
- MK Council Children in Care Service Report
- MK Council Children in Need Annual Report

The following updates were received and considered by the MKSCB or one of the MKSCB sub-groups during the year:

- The Outline Safer MK Plan 2011 - 2014
- Children and Families Partnership Relationship with MKSCB
- Safeguarding in Health Services

Members from the MKSCB contributed to the Ofsted 'Good Practice by LSCBs' report in which they highlighted work around the development of a MKSCB serious case review toolkit, quality assurance audit framework, and an induction booklet for MKSCB Lay Members.

The MKSCB and the Quality Assurance sub-group also considered the following Ofsted Inspection Reports:

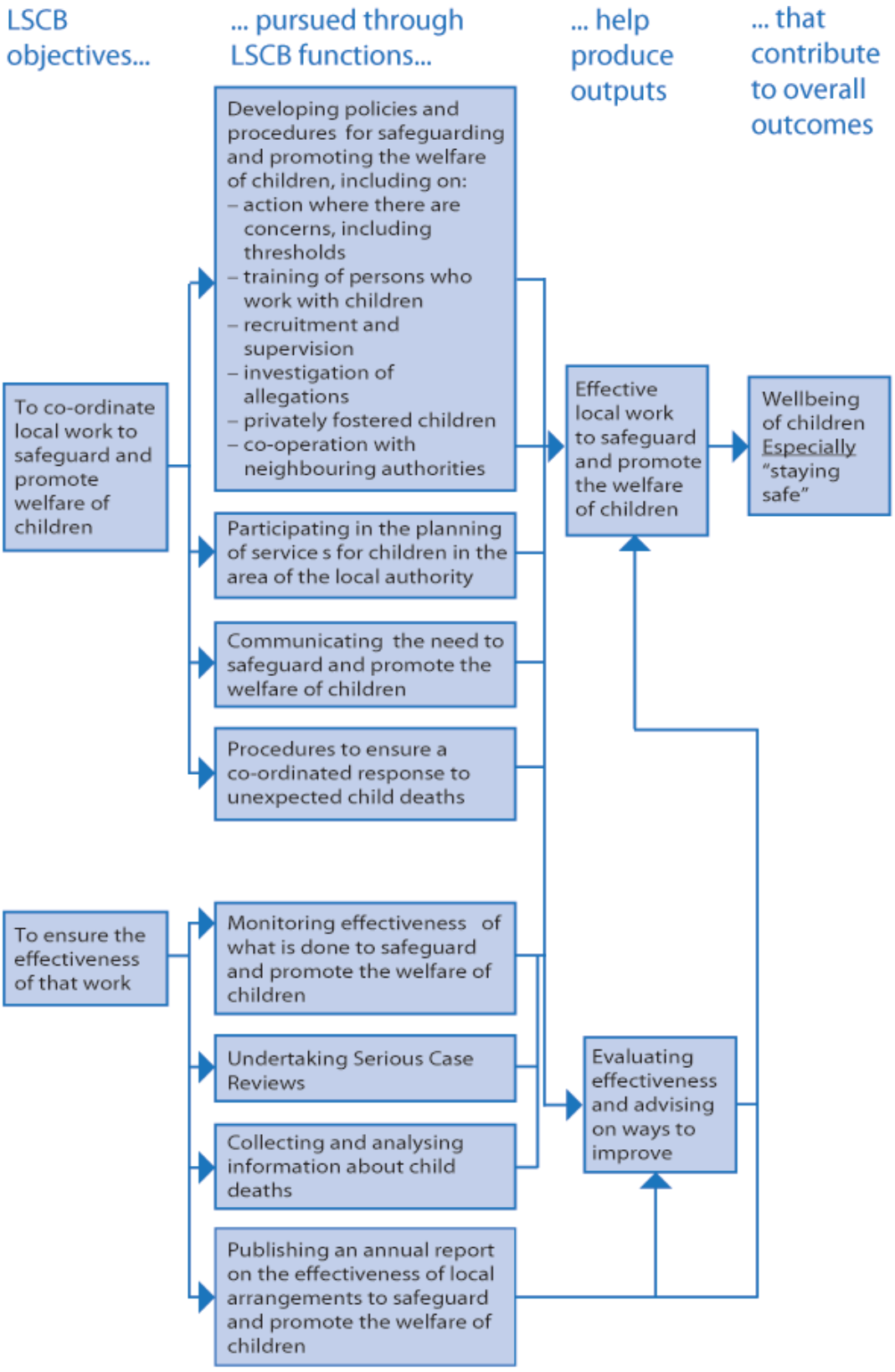
- Oakhill STC Unannounced Inspection November 2011
- Radcliffe School Ofsted Inspection December 2011

In February 2012 the MKSCB Business Management Group, on behalf of the MKSCB, submitted a response to the national survey to explore how local areas are responding to recommendations outlined in the Munro Review of Child Protection. The Loughborough University Centre for Child and Family Research carried out the national survey.

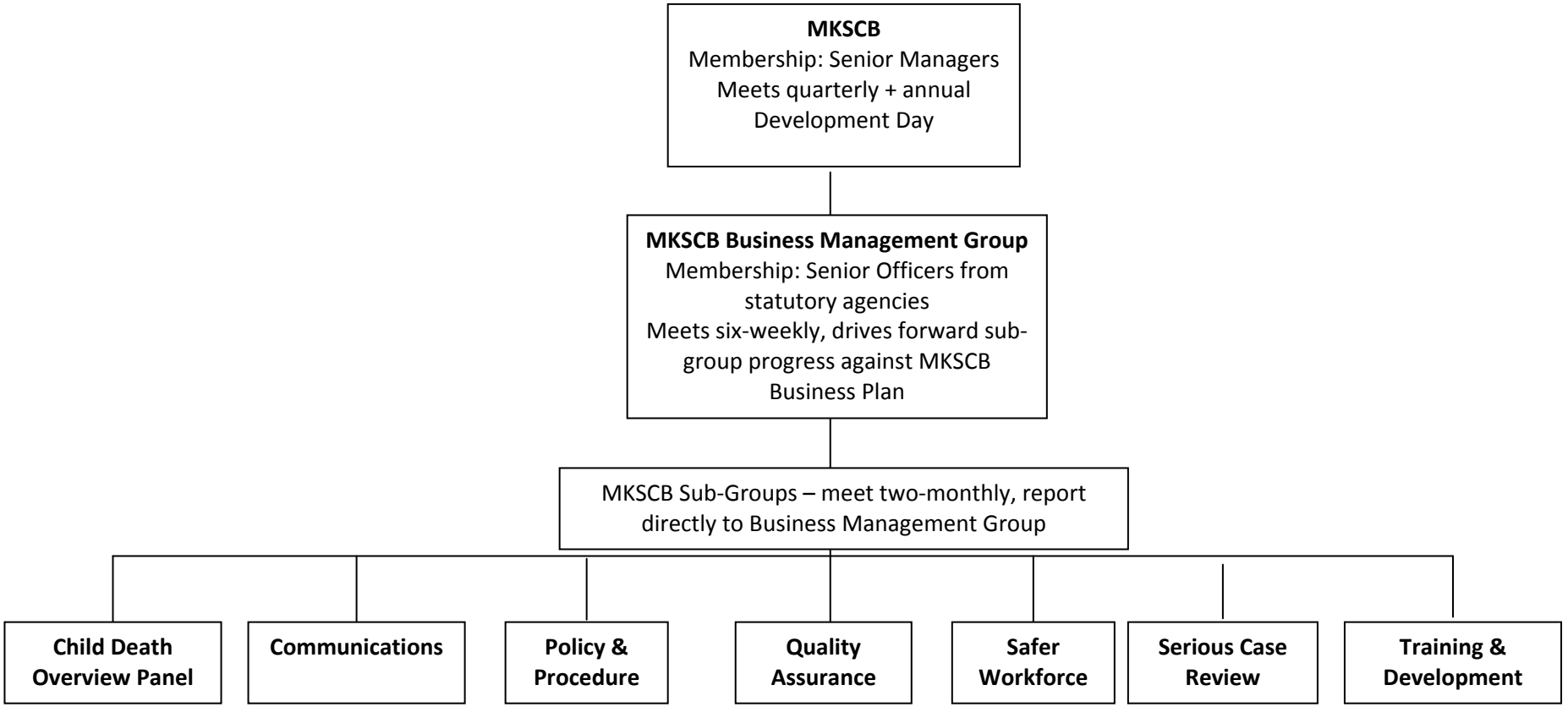
Appendix 3: Child Protection Data for Milton Keynes Safeguarding Children Board, as at 31 March 2012

	2010 - 11	2011 - 12
Number of initial assessments completed in the year	**1331**	**1451**
Number of core assessments completed in the year	**666**	**664**
Number of section 47 enquiries initiated during the year	**391**	**312**
Number of children subject to an initial child protection conference during the year	**87**	**97**
Number of children subject to a child protection plan at 31 March 2012	**40**	**55**
Number of children who became subject to a child protection plan during the year	**84**	**95**
Of those children becoming subject to a child protection plan during the year, the number who had a previous child protection plan (at any time)	**2**	**4**
Number of children with a child protection plan ceasing during the year	**110**	**80**
Of the child protection plans ceasing during the year, the number of children whose child protection plan had lasted for two years or more	**2**	**0**
Of the child protection plans which should have been reviewed during the year, the percentage reviewed on time	**100**	**100**

Appendix 4


LSCB objectives...
... pursued through LSCB functions...
... help produce outputs
... that contribute to overall outcomes
To co-ordinate local work to safeguard and promote welfare of children
To ensure the effectiveness of that work
Developing policies and procedures for safeguarding and promoting the welfare of children, including on:
– action where there are concerns, including thresholds
– training of persons who work with children
– recruitment and supervision
– investigation of allegations
– privately fostered children
– co-operation with neighbouring authorities
Participating in the planning of service s for children in the area of the local authority
Communicating the need to safeguard and promote the welfare of children
Procedures to ensure a co-ordinated response to unexpected child deaths
Monitoring effectiveness of what is done to safeguard and promote the welfare of children
Undertaking Serious Case Reviews
Collecting and analysing information about child deaths
Publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children
Effective local work to safeguard and promote the welfare of children
Evaluating effectiveness and advising on ways to improve
Wellbeing of children Especially "staying safe"

Appendix 5: Milton Keynes Safeguarding Children Board Structure Chart



Appendix 6: MKSCB Business Plan 2011 - 2013

The MKSCB Business Plan 2011-13 describes how MKSCB priorities will be addressed at a strategic level. **The majority of the work is ongoing and developmental.** Sub-Group progress is monitored by the MKSCB Business Management Group.

Objective 1: Clear governance arrangements are in place for safeguarding children **MKSCB Lead Responsibility: Business Management Group**	
Activity	**Outcome**
All partners have signed up to the MKSCB Constitution and attend meetings regularly, avoiding substitution wherever possible	An appropriate membership results in effective partnership work, improved communication, better understanding of roles and policies and an improved ability to safeguard children through collaboration.
Attendance at MKSCB, BMG and sub-groups is 80% and consistent	Appropriate & consistent agency attendance evidences agency commitment to safeguarding & promoting the welfare of children & young people.
Roles and responsibilities of MKSCB members are reviewed in response to revised guidance, new legislation and national reviews such as Munro.	MKSCB membership meets the requirements of revised guidance, new legislation & national reviews & provides effective partnership work, improved communication, better understanding of roles and an improved ability to safeguard children through collaboration.
Receive and interpret multi-agency safeguarding children data	Data reports assist MKSCB in monitoring safeguarding practice, identifying trends and therefore inform policy and practice trends
MKSCB budget is monitored, and additional/ extraordinary expenditure agreed	A transparent budget monitoring and expenditure process is in place and reported to MKSCB.
THEMATIC REVIEW **All partners participate in the MKSCB thematic reviews identified for 2011/12 of the impact on children of:** **Parental mental ill-health** **Parental substance misuse** **Domestic abuse**	**Inter-agency work around the three safeguarding themes improves safeguarding for children affected by these issues**

Objective 2: Information is made available to children and young people, their parents, professionals and communities on how children can be safeguarded and their welfare promoted **MKSCB Lead Responsibility: Communications Sub-Group**	
Activity	**Outcome**
Review the MKSCB Communication Strategy.	Up to date and relevant Communication Strategy is in place and available on the MKSCB website.
Information about safeguarding children and the work of MKSCB is available to professionals, children and young people and their families and the community.	Information is made available to assist a better understanding of safeguarding and what to do if concerned, inter-agency working, and MKSCB work.
Develop engagement opportunities with existing groups.	MKSCB work is informed by feedback from local engagement forums.
MKSCB will address the specific publicity/media needs of MKSCB in response to MKSCB initiatives/events/issues (such as Serious Case Reviews).	There is a co-ordinated response to publicising safeguarding issues and MKSCB work.
Communication links between the MKSCB, agencies and the community are developed and maintained via the MKSCB website.	MKSCB website is kept up to date with relevant and appropriate safeguarding information and promotes the work of the MKSCB.
THEMATIC REVIEW Specifically raise awareness within Milton Keynes of the impact on children of: **Parental mental ill-health** **Parental substance misuse** **Domestic abuse**	Information is made available to professionals, children and young people, and the public of inter-agency work and sources of advice

Objective 3: Safeguarding training is provided effectively to the children's workforce and promotes the objectives of MKSCB **MKSCB Lead Responsibility: Training and Development Sub-Group**	
Activity	**Outcome**
Implement agreed inter-agency safeguarding training strategy and delivery programme, to meet demand from the workforce for safeguarding-children training across MK	Training Needs Analysis demonstrates the availability of safeguarding children training and how that is meeting the identified needs of the children's workforce
Design implement and evaluate MKSCB safeguarding training, in response to course evaluations, Training Needs Analysis (TNA), Section 11 audits and national and local developments.	MKSCB training provision is up to date and relevant and MKSCB is assured that training is effective
The training sub-group is responsive to the needs of other MKSCB sub groups.	The work of the MKSCB is supported by training
THEMATIC REVIEW **MKSCB Training Programme and awareness-raising events include the impact on children of:** **Parental mental ill-health** **Parental substance misuse** **Domestic abuse** **and implications for inter-agency working** **Incorporate areas of thematic review into the 2011 Annual Conference**	Specific knowledge and practice improvements are made by the workforce in these three areas.

Objective 4: Safe recruitment and workforce practices are in place across all services and agencies. **MKSCB Lead Responsibility: Safer Workforce Sub-Group**	
Activity	**Outcome**
Complete a scoping exercise across organisations (including commissioning organisations) to test 'compliance' in Recruitment, Induction/Guidance, Safe working culture and monitoring	Audit demonstrates that all relevant settings are practicing safe recruitment
Review guidance regarding safer employment in line with changes in national policy, paying particular attention to ISA & CRB and ensure this is widely publicised	Managers and Workforce are made aware of the changes and relationship between CRB and ISA
Raise awareness of processes for responding to allegations against staff and volunteers in all organisations working with children & young people	Referrals are made and processes go ahead without conflict or misunderstanding

Objective 5: Effective quality assurance systems are in place across and within all partners and scrutiny systems across agencies are in place and MK children's workforce actively learns from QA processes. **MKSCB Lead Responsibility: Quality Assurance Sub-Group**	
Activity	**Outcome**
Monitor the effectiveness of organisations' implementation of their duties under section 11 of the Children Act 2004, and identify areas within organisations that MKSCB should monitor and address to enable effective safeguarding.	MKSCB ensured that partner agencies functions are discharged with regard to the need to safeguard and promote the welfare of children.
Evaluate the effectiveness of safeguarding practice in partner agencies with audit and other QA activities.	Audits and other QA activities identify strengths as well as areas for development around safeguarding children practice
Receive multi-agency safeguarding children data from Business Management Group to inform audit and other QA activity	Data reports assist MKSCB in monitoring safeguarding practice, identifying trends and therefore inform policy and practice
Partner agencies report safeguarding-children audits, QA and inspection activity within their organisation to MKSCB	MKSCB monitors the effectiveness of agency systems for quality-assuring their safeguarding practice
THEMATIC REVIEW **Carry out joint audit of cases involving:** **Parental mental ill-health** **Parental substance misuse** **Domestic abuse**	Evaluate multi-agency working and identify the quality of practice and lessons to be learnt in practice. The MKSCB actively learns from audits undertaken.

Objective 6: Effective arrangements are in place to determine when to hold a serious case review, to ensure the review is carried out in an efficient and independent manner, and to ensure that learning from the review is disseminated across partner agencies and wider and leads to improved practice. **MKSCB Lead Responsibility: Serious Case Review Sub-Group**	
Activity	**Outcome**
Review the SCR process and resources in line with the Munro review and other national and local developments	SCRs take place in line with national good practice
Appropriate training is made available to those staff identified by agencies to undertake individual management reviews	Managers and staff in all agencies understand what is needed when a SCR takes place
Refresh the process for commissioning Overview Report writers, in line with regional/national initiatives as required	Overview reports for SCRs that take place are graded as good or better
Gather and disseminate national and local learning from SCRs and near misses to the workforce and evaluate learning and actions for Milton Keynes	Learning is reported to partners and changes in practice take place where identified as required
To discuss any serious incidents/cases/ near misses that cause inter-agency concern to consider what learning and further actions are required from them	Agencies actively learn from serious concerns and near misses and disseminate the lessons
Receive and analyse the CDOP annual report	Learning is reported to partners and changes in practice take place where identified as required
THEMATIC REVIEW **Review SCR national data relating to Domestic Abuse/ Substance Misuse/ Mental Ill-Health**	Learning is reported to partners and changes in practice take place where identified as required
Identify those serious incidents/cases/near misses that cause inter-agency concern, and action and promulgate any learning identified	Agencies actively learn from serious concerns and near misses and disseminate the lessons, and promulgate to partner agencies

Objective 7: Multi-agency safeguarding policies and procedures are up to date and easily accessible to staff across agencies **MKSCB Lead Responsibility: Policy & Procedures Sub-Group**	
Activity	**Outcome**
Lead on development and review of MKSCB inter-agency Child Protection Policy & Procedures in light of new and revised national guidance and legislation	Policies are clear, accessible, easy to understand, and up to date.
Advise and support Milton Keynes agencies in the development of their child protection policies and procedures if required and signpost to relevant sources of support.	Individual agencies are enabled to develop current, accurate and accessible child protection policies which are in line with MKSCB inter-agency policies and procedures.
THEMATIC REVIEW **Develop and update local policies, procedures and guidance documents regarding parental substance misuse, parental mental ill-health and domestic abuse**	Policies in place are clear and easy for practitioners to use and follow

Objective 8: MKSCB reviews all deaths of children normally resident in the Milton Keynes area, in line with statutory Working Together guidance **MKSCB Lead Responsibility: Child Death Overview Panel**	
Activity	**Outcome**
Collect and analyse available information on all deaths of children normally resident in the Milton Keynes area with a view to identifying any case giving rise to the need for a serious case review, any matters that may affect the safety and welfare of children in the area and any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.	Systems are in place for the reviewing of the deaths of children normally resident in Milton Keynes and for making any local or national recommendations arising out of the findings of the reviews.