

9. Safeguarding Children

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The focus on child safeguarding intensified with the publication of reports about the death of Baby Peter. As with the case of Victoria Climbié (HM Government, 2003), many of the failings were again due to poor communication between professionals, and the ability of those involved with the cases to recognise the severity of the risks to the child. These risks cannot always be mitigated, but by making safeguarding training and awareness a priority among staff, the risk of child abuse or death may be reduced. Review of serious case reviews in Devon (and nationally) has shown that there are some themes which recur, and these include parental substance misuse, mental health problems and domestic abuse and violence.

9.1 Safeguarding and promoting the welfare of children

Safeguarding and promoting the welfare of children is the process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care, which is undertaken so as to enable children to have optimum life chances and enter adulthood successfully.

All who come into contact with children and young people have a duty to safeguard and promote the welfare of children and young people and should know what to do if they have any concerns. Standards for practice, assessment tools and guidelines to assist practitioners in the field of child protection have been developed across the United Kingdom.

The legislative framework is set out in the 1989 and 2004 Children Acts, and “Every Child Matters”. There are also Joint Chief Inspectors Reports and Biennial Reports on Serious Case Reviews. “Working Together to Safeguard Children” (HM Government, 2006) sets out the expectations of public sector bodies in accordance with their statutory duties. A range of additional actions has been published by the Lord Laming in his recent review (2009).

Devon Local Safeguarding Children Board, the statutory body responsible for ensuring partner organisations fulfil their duties, has a three-year Business Plan (2008-11). This can be accessed at www.devon.gov.uk/lscb-businessplan0811.pdf

In the last year, there has been a major review of the Local Safeguarding Children Board function and structure:

- Devon Safeguarding Children Board now has an independent chair.
- The Board will continue to meet four times a year, addressing policies and processes including child death and serious case reviews; communicating and raising awareness; monitoring and evaluation (including audit); effective learning and workforce development; participation in commissioning and planning.

- The newly-formed Executive Group, chaired by the Director of Early Years and Child Care Services, will ensure Devon Safeguarding Children Board operates strategically and effectively in delivering its Business Plan – by working with the Board's subgroups to evidence successful outcomes for children, ensuring priorities and objectives are achieved, that targets and performance data including audit findings are available to the Board within agreed timescales, and any areas for further improvement are identified. Health representation on the Executive includes a Consultant in Public Health and the Chair of the Devon Safeguarding Children Board's Health Subgroup.
- Subgroups, at present nine including the Health Subgroup, agree and deliver specific action plans for delivery of the Board's Business Plan within agreed timescales, and provide the Executive Subgroup with progress reports, audit findings and performance information, including proposals for new development and improvement.
- Devon Safeguarding Children Board crosses the commissioning/provider interface in partner agencies, such as Health and Education, and has a 'critical friend'/scrutiny role with Devon Children's Trust.

The Health Subgroup has been reconstituted with revised terms of reference and is chaired by the Designated Doctor for Child Protection. The Subgroup is responsible for the implementation of the health action points in the Devon Safeguarding Children Board business plan. Membership includes the Named and Designated Health professionals, Trust Executive leads and NHS commissioners.

The governance and reporting arrangements for Serious Case Reviews (known as SCRs) following death or serious injury where there has been concern about child protection practice, are now very strict. Central government has taken a proactive role in raising standards and the scrutiny role is now taken by Ofsted (the Office for Standards in Education). Feedback from Serious Case Reviews is through debriefs within individual Health Trusts and through training offered by the Learning and Workforce Development Subgroup. Three Devon Safeguarding Children Board Serious Case Reviews which were graded as inadequate by Ofsted have been revised and resubmitted.

Following the implementation of the 2004 Children Act all child deaths, from birth up to the 18th birthday, including neonatal deaths, are now notified to the joint Local Safeguarding Children Board Peninsula Child Death Overview Panel (CDOP) Office. The Child Death Overview Panel will report to the four separate Peninsula Local Safeguarding Children Boards (Devon, Torbay, Plymouth and Cornwall) on outcomes arising from the analysis of preventable factors, especially in unexpected deaths.

All NHS Trusts in Devon are up to strength in the establishment of Designated and Named Health professionals. Governance and accountability for child protection has been agreed at meetings of Devon Primary Care Trust's Child Protection Committee. The Designated and Named Health professionals play a major role in Local Safeguarding Children Board training programmes.

References

H M Government (2003). The Victoria Climbie Enquiry. Report of an Inquiry by Lord Laming

Royal College of Paediatrics and Child Health (2008). The Physical Signs of Child Sexual Abuse: evidence based review

The Protection of Children in England: A Progress Report - The Government's response to Lord Laming CM 7589 (2009)

Wales Systematic Review Group (2008). Evidence on various injuries in relation to child abuse [on line]. Available from: www.core-info.cf.ac.uk

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9.2 Prevention of unintended injuries

Unintentional injury is a leading cause of death and illness among children aged one to 14 years and causes more children to be admitted to hospital each year than any other reason. It represents a serious risk to the health and wellbeing of children. Crucially, many of these injuries are preventable (Audit Commission, 2007).

In 2007, unintentional injury led to 197 deaths among children aged one to 14 years in England and Wales: the majority (114) of these involved a road injury; 19 involved drowning or submersion; 29 were other accidental threats to breathing and 10 by exposure to smoke, fire and flames (Office for National Statistics, 2008). Children under five years of age carry a disproportionate burden of injuries from falls and fires. They suffer nearly 45% of all severe burns and scalds. About 50% of these happen in the kitchen and approximately 50% of all injuries to the under-fives occur in the home. In 1997 and 1998, children under five years of age represented 71% of childhood fatalities from fire (Audit Commission, 2007).

Around two million children and young people visit UK accident and emergency departments each year as a result of non-fatal injuries, at a cost of approximately £146 million to the NHS. In England alone in 2006–07, unintentional injuries resulted in over 100,000 children aged 0–14 being admitted to hospital (Audit Commission, 2007).

Children and young people from lower socio-economic groups are more likely to be affected by unintentional injuries (Towner and Dowswell, 2001). Residential areas with higher proportions of lower socio-economic groups have higher rates of unintentional injury. Children of parents who have never worked, or who are long-term unemployed, are 13 times more likely to die from unintentional injury and 37 times more likely to die as a result of exposure to smoke, fires or flame than children of parents in higher managerial and professional occupations (Edwards et al, 2006). In England, children in the 10% most deprived wards are three times more likely to be hit by a car than children in the 10% least deprived wards. Fatality is twice as likely in boys as girls, a gap that increases with age (Towner and Dowswell, 2001).

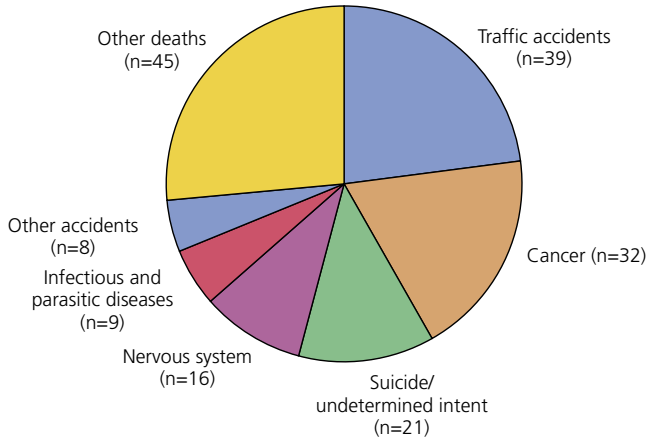
In Devon there were a total of 170 deaths in children and young people over the 2001-07 year period. Of these 170 deaths, 47 were deaths resulting from an accident of which 39 deaths were from traffic accidents (Figure 9.1).

Of the 47 deaths by accidents, 29 were in the 17-18 age group and a further 12 were in the 12-16 age group. The majority (25) of the accidents in the 17-19 age group were due to road traffic accidents.

The main types of injury resulting in admission to hospital in the Devon area during April 2005 to March 2008 are shown in Figure 9.2. This is similar to the national picture of unintentional injury across the 0-14 age group resulting in admission to hospital. There were a total of 5,207 admissions for the period April 2005 to March 2008, with the highest admissions for falls (1985) followed by transport accidents.

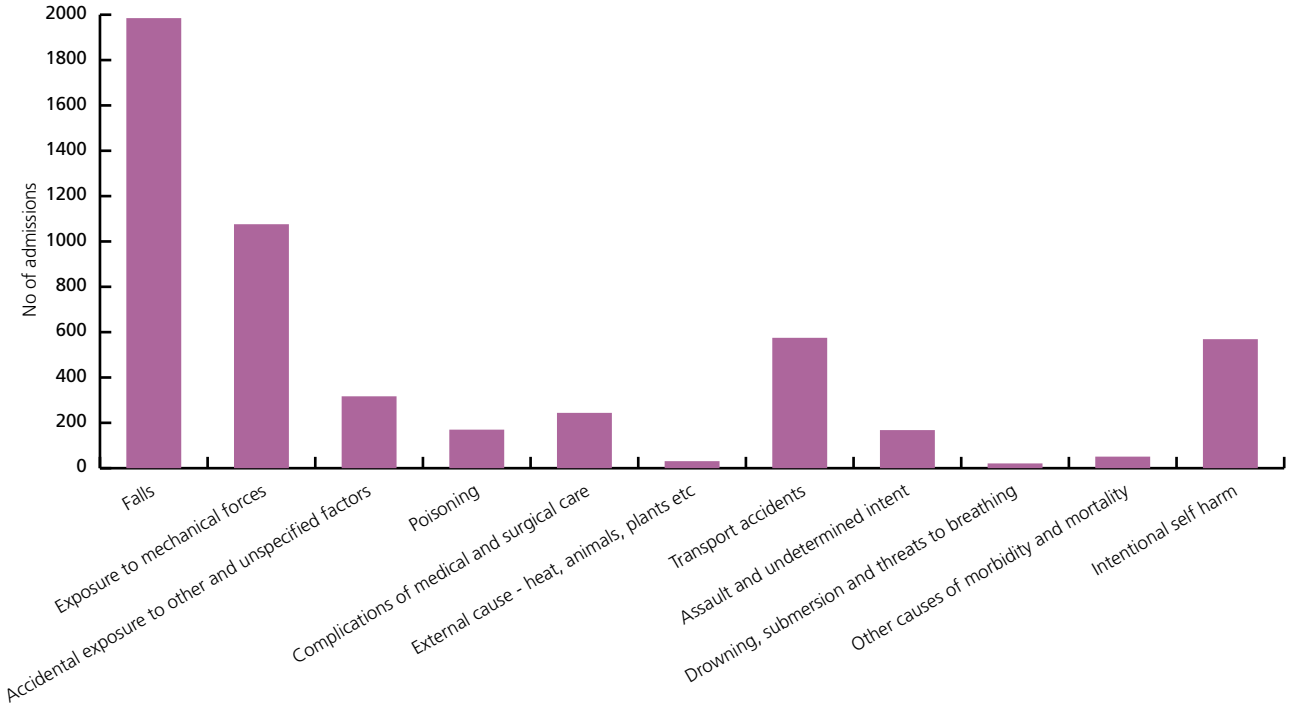
Causes of serious unintentional injury vary with age (Figure 9.3).

Figure 9.1: Cause of deaths in children and young people in Devon for the period 2001–07



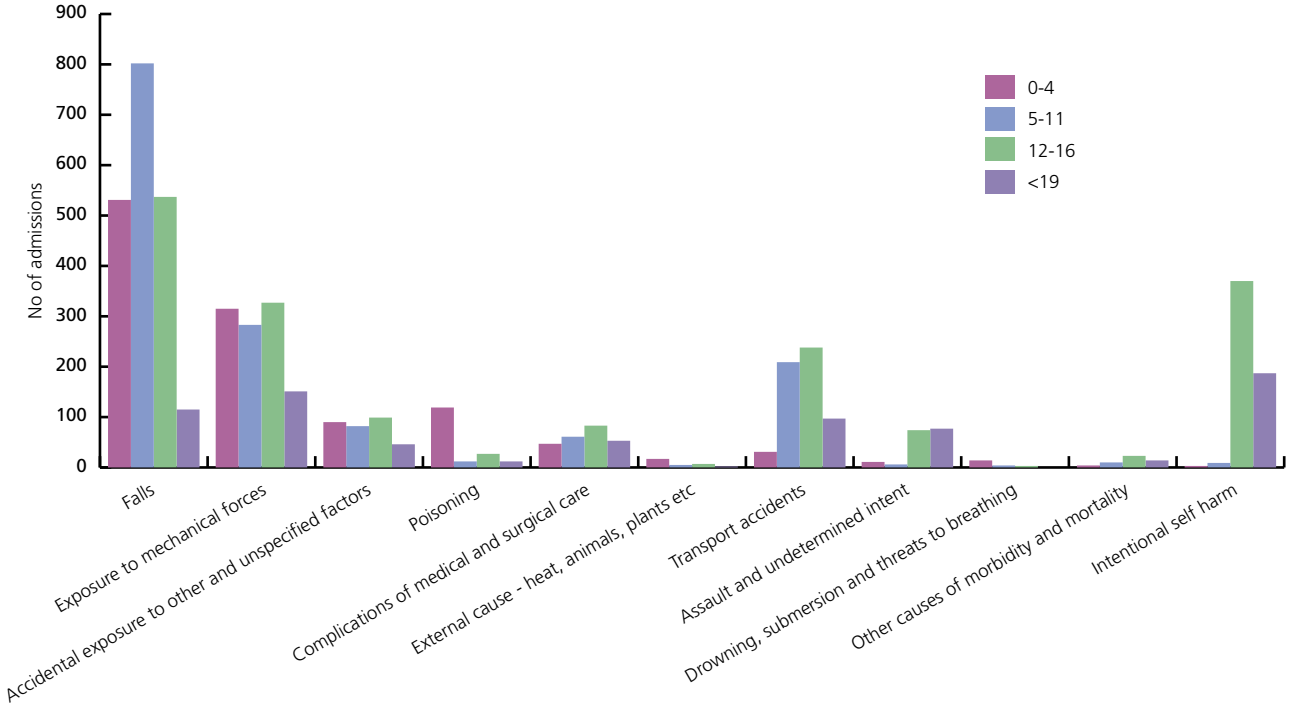
Source: Office for National Statistics, Crown Copyright, 2008

Figure 9.2: Admission to hospital by cause (Devon Primary Care Trust, April 2005 to March 2008, under 19 years of age)



Source: SUS, Devon PCT admissions April 2005-March 2008

Figure 9.3: Admission to Hospital by age and cause (Devon Primary Care Trust, April 2005 to March 2008)



Source: SUS, Devon PCT admissions April 2005-March 2008

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Approaches to preventing unintentional injuries range from education (providing information and training) to product or environmental modifications and enforcement (regulations, legislation). The most effective strategies use a combination of these approaches (British Medical Association, 2006). Experience from countries with the best safety records show that positive leadership, together with widespread efforts to provide safer physical and social environments, can reduce unintentional injuries (Sethi et al, 2006).

In summary, unintentional injury presents a significant risk to the health and wellbeing of children. Although the mortality rates due to unintentional injuries are declining, there is still an issue around injuries, many of which are preventable. Partnership working is central to addressing this issue.

References

Audit Commission/Healthcare Commission (2007). Better safe than sorry: preventing unintentional injury to children. London: Audit Commission

British Medical Association (2001). Injury prevention. London: British Medical Association Board of Science and Education

Edwards, P., Roberts, I., Green, J. et al (2006). Deaths from injury in children and employment status in family: analysis of trends in class specific death rates. BMJ 333: 119-121

Office for National Statistics (2008). Mortality statistics: deaths registered in 2006. ICD10 codes V01–X59. Review of the Registrar General on deaths in England and Wales [online]. Available from: www.statistics.gov.uk

Sethi, D., Racioppi, F., Baumgarten, I. et al (2006). Injuries and violence in Europe: why they matter and what can be done. Copenhagen: WHO Regional Office for Europe

Towner, E. and Dowswell, T, (2001). What Works to Prevent Unintentional Injury Amongst Children? A report prepared for the HAD. University of Newcastle

Recommendations

9.1 NHS Devon and Devon County Council, through their commissioning and public health functions, should continue to support the development of good practice in child safeguarding including the prevention of unintentional injury and the appropriate multi-agency management of child protection concerns. Child protection will always be a high risk activity for commissioning and provider functions.

9.2 To establish a multi-agency partnership group, with appropriate membership and terms of reference, to oversee the implementation of the recommendations and facilitate regular reporting on progress.

9.3 To ensure processes are in place to analyse the National Institute for Health and Clinical Excellence (NICE) guidance and recommendations on unintentional injury and ensure these are reflected in local action plans.

9.4 To agree a data sharing protocol between partner agencies to ensure a consistent approach to data collection.

9.5 To agree and develop a minimum dataset drawn from data held by partner agencies.

9.6 To collect routinely and review data on a regular basis (quarterly) to provide a clear understanding of the rates and types of unintentional injury across Devon, to enable actions and resources to be directed accordingly.

9.7 To produce a multi-agency evidence-based implementation plan for unintended injuries.