OSCB
Oxfordshire
Safeguarding
Children Board

Oxfordshire multi-agency safeguarding arrangements for children

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Contents

Introduction to the Oxfordshire multi-agency safeguarding arrangements by the safeguarding partners

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John Campbell,
Chief Constable,
Thames Valley Police.

We are delighted to republish our multi-agency safeguarding arrangements on behalf of the children, young people and families in Oxfordshire and we remain fully committed to safeguarding children and promoting their welfare. The revised statutory guidance for Working Together 2018 required local areas to publish their multi-agency safeguarding arrangements by 29 June 2019 and we initially published ours in May 2019 and we have now undertaken our first review.

After 18 months in place we are really pleased to confirm that the new statutory requirement for the leadership of safeguarding arrangements to be at chief executive level across health, police and the local authority has significantly strengthened our collective approach to safeguarding children and young people. We remain responsible for and oversee these arrangements even where we may have delegated direct input to senior officers.

We would like to confirm our commitment to these statutory responsibilities locally which are ensuring the successful delivery of the arrangements outlined in Working Together 2018. We have undertaken a short survey with our relevant partners in order to inform this review, which has helped to confirm the success of the arrangements locally.

We are pleased that we decided to maintain and strengthen the Oxfordshire Safeguarding Children Board (OSCB) because it continues to be a high functioning, high challenge Board with a strong reputation and a long-standing commitment to partnership working. We are now a well-established Executive Group and meet regularly with the Independent Chair of OSCB and we work with our wider relevant partners through the OSCB under the leadership of the Independent Chair.

Frequency of our meetings has increased as a result of COVID-19 to bi-monthly to ensure we are on top of additional key safeguarding risks that have emerged as a result of the pandemic, as well as to manage our normal business. We oversee a multi-agency COVID-19 Opportunities and Risks Register to ensure we are sighted on new and emerging concerns.

The board continues to meet quarterly with clear reporting to and from our Executive Group.

Performance management and accountability for the Independent Chair lies with our Executive Group and challenging objectives have been revised for him after the first year.

We ensure that new and emerging safeguarding issues are identified and addressed and that there is no duplication across our system. To that effect we have asked the Independent Chair to convene a meeting with the chairs of the Health and Well-Being Board, the Safeguarding Adults Board and the Safer Oxfordshire Oversight Committee.

The geographical area covered by these arrangements continues to be Oxfordshire, with the exception of the child death review processes, which has successfully combined with Buckinghamshire in order to improve our learning from child deaths and to meet our statutory responsibilities.

We are fully committed to ensuring we have wide representation from across the sector to deliver our safeguarding priorities and the relevant partners who are part of OSCB are listed in Appendix 2. We are aiming to formalize and improve our operational relationships with the military locally by including military officers amongst our relevant partners in the coming year.

The arrangements for the Board being supported by a Business Group have worked well and it comprises of the Independent Chair, sub-group chairs and strategic leads for operational services. The purpose of the sub-groups is outlined on P.8. In addition, key safeguarding messages are disseminated to the wider workforce through existing local multi-agency groups focussing on specific safeguarding themes.

The Housing Network and close working with Oxfordshire Safeguarding Adult Board have remained integral to the new arrangements.

The voice of children and young people remains at the heart of our work and the Independent Chair works with existing children and young people's groups to ensure we effectively hear and respond to the voice of children and young people in the new arrangements. This included our 2020 annual conference on the Child's World which was co-led with children and young people. This will be an area for further development over the coming year.

We continue to work hard to promote the involvement of schools, colleges and other education providers which is key to the success of our local arrangements. This is an area in which we are keen to see further improvements during 2021. We also recognize the importance of the role of the third sector in our safeguarding arrangements and will continue to build on these links.

We take a lead role in ensuring our information sharing arrangements are clear and accessible to all and that our arrangements for dispute resolution are transparent. We are pleased to announce that we will be launching an online portal to collate Multi-Agency Chronologies in the new year which should significantly improve the efficiency and effectiveness of information sharing.

Independent scrutiny is crucial to the success of these arrangements and we make sure this is in place through the role of the Independent Chair and via the role of our board community/lay members. Our arrangements are being strengthened by establishing a peer review of our child safeguarding practice review work with Hampshire Safeguarding Children Board and through Oxfordshire County Council's Performance Scrutiny Committee and the equivalent functions in the Clinical Commissioning Group and Thames Valley Police.

We have reviewed our existing funding arrangements and partner contributions.

We have continued to report and implement local and national learning through the OSCB training, learning events and conferences.

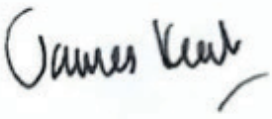
One of our key roles is to commission and publish child safeguarding practice reviews. Our arrangements for this are outlined in section 2. These include the responsibilities of the National Child Safeguarding Practice Review Panel and the criteria for decision making regarding local child safeguarding reviews. We undertake a rapid review of serious incidents and the Independent Chair reports the outcome to us and to the National Panel. The National Panel can now decide to undertake a national review if it considers that the serious child safeguarding case raises issues that are complex or of national importance and we have contributed to one of these reviews in relation to child criminal exploitation. We have published one review since May 2019. The responsibility for overseeing this work and disseminating the learning lies with the Child Safeguarding Practice Review Subgroup of OSCB. We are also keen to improve our processes in relation to Rapid Reviews over the coming year.

Finally, we would like to take this opportunity to thank our entire children's workforce for your unstinting commitment to safeguarding children and families in Oxfordshire and to improving their outcomes. We have been delighted to recognize your successes through our commendation scheme and really look forward to being able to thank you in person in the future.

This is our first review of these arrangements and we are confident that they are working as well as they can locally.

We take our responsibilities to safeguarding children very seriously and are fully committed to ensuring that children and young people in Oxfordshire are kept safe and that all partner agencies work together to achieve this. We have found that the new arrangements have significantly strengthened our determination to actively address this priority.

Yvonne Rees,
Chief Executive of
Oxfordshire County Council



James Kent, Accountable Officer and
Executive Integrated Care System Lead,
Buckinghamshire, Oxfordshire and Berkshire
West Clinical Commissioning Group

John Campbell,
Chief Constable,
Thames Valley Police

SECTION 1:
Multi-agency arrangements

1.1 Three safeguarding partners

The Children and Social Work Act 2017 gave the option to replace Local Safeguarding Children Boards (LSCBs) with new flexible local safeguarding arrangements. The revised statutory guidance underpinning the Act, Working Together, came into force on 29 June 2018 and can be read here for guidance.

A definition of safeguarding is included in Appendix 1.

The Act establishes collective responsibility and accountability of these arrangements across chief officers in the county council, the clinical commissioning group and the police.

For Oxfordshire the safeguarding partners are:

- Yvonne Rees, Chief Executive of Oxfordshire County Council;
- James Kent, Accountable Officer and Executive Integrated Care System Lead, Buckinghamshire, Oxfordshire and Berkshire West Clinical Commissioning Group;
- John Campbell, Chief Constable, delegated to Timothy De Meyer, Assistant Chief Constable, Thames Valley Police

The three safeguarding partners have well established arrangements to work together as an Executive Group with overall accountability for safeguarding and promoting the welfare of children in our area. They work with relevant partners through the Oxfordshire Safeguarding Children Board (OSCB), under the leadership of an Independent Chair. The three safeguarding partners (Executive Group) have agreed on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents.

1.2 The purpose of these arrangements

The purpose of these local arrangements is to support and enable local organisations and agencies to work together in a system where:

- Children are safeguarded and their welfare promoted;
- Partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children;
- Organisations and agencies challenge appropriately and hold one another to account effectively;
- There is early identification and analysis of new safeguarding issues and emerging threats;
- Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice;
- Information is shared effectively to facilitate more accurate and timely decision making for children and families.

1.3 Strategic partnerships

The Independent Chair of OSCB will convene a bi-annual meeting with the chairs of the Health and Well- being Board, the Oxfordshire Safeguarding Adults Board, the Safer Oxfordshire Partnership Oversight Committee and Community Safety Partnerships to ensure new and emerging safeguarding issues are identified and addressed and to ensure there is no duplication across the system. This work will be supported by the Safer Oxfordshire Partnership Co-Ordination Group, which already holds a role in relation to this responsibility and this will strengthen safeguarding arrangements established in the Partnerships Protocol attached below.

1.4 Accountability and leadership

The Executive Group meets on a bi-monthly basis with the Director for Children's Services and the Independent Chair of the Board. Any of the three partners can meet with the Independent Chair for safeguarding briefings in between the bi-monthly meeting, as necessary.

The Executive Group has equal and joint responsibility for local safeguarding arrangements. In situations that require a clear, single point of leadership, the Executive Group will decide who will take the lead on issues that arise.

If the lead representatives delegate their functions, they remain accountable for any actions or decisions taken on behalf of their agency. The representative or those with delegated authority:

- Speaks with authority for the safeguarding partner they represent;
- Takes decisions on behalf of their organisation or agency and commits them on policy, resourcing and practice matters;
- Holds their own organisation or agency to account on how effectively they participate and implement the local arrangements.

The Independent Chair leads and implements the local safeguarding arrangements through the local partnership of relevant agencies, on behalf of the Executive Group. In order to retain partnership engagement and the well-established credibility of the OSCB, the name and branding has remained in place for the wider partnership. OSCB meetings are quarterly and key messages and issues are communicated between OSCB and the Executive Group.

Performance management and accountability for the Independent Chair is through the Executive Group at their bi-monthly meetings. His objectives have been reviewed and updated by the Executive Group.

1.5 Geographical area

The geographical area covered by these arrangements is Oxfordshire, with the exception of the Child Death Review arrangements which combine with Buckinghamshire. The Oxfordshire area is based on the current local authority boundary.

1.6 Co-ordination of services and relevant agencies

The oversight of the co-ordination of services is through the OSCB comprising of key relevant agencies who work together to safeguard and promote the welfare of children with regard to local need. Relevant partners are listed in Appendix 2 and have been chosen because of their key role in safeguarding children locally.

The list of relevant agencies is reviewed annually and the intention is to include local representatives from the armed forces in 2021.

All relevant agencies are aware of the purpose of these arrangements and expectations and were consulted with in their development to make sure they took into account each agency's structure and statutory obligations. Consultation was originally managed through two board workshops in 2016 and 2018 and in accordance with the timetable outlined in Appendix 3. A survey was undertaken in September 2020 to review these arrangements and the revised version approved by the Executive Group in February 2021 and the OSCB in March 2021.

The designated doctor and designated nurse for Oxfordshire are board members to ensure clinical expertise of designated health professionals is secured.

The Board is supported by a Business Group, which is chaired by the Independent Chair and brings together the strategic leaders of operational services and chairs of sub-groups, to problem solve, identify key emerging concerns, escalate issues as appropriate and inform the Board and Executive Group. Please see Structure Chart in Appendix 4.

The purpose of the sub-groups is outlined below:

- Performance, Audit and Quality Assurance – to review safeguarding data and intelligence to test the effectiveness of services including early help and complete multi-agency and single agency audits and the annual self-assessment by all agencies.
- Child Safeguarding Practice Review – to undertake rapid reviews of serious incident notifications, oversee and supervise all child safeguarding practice reviews and identify themes, actions and learning from serious incidents (see section 2 for detailed arrangements).
- Training – to commission, monitor and oversee the delivery of training and to provide an annual conference and learning summaries and events from key themes that are identified locally and nationally on behalf of the OSCB and the Oxfordshire Safeguarding Adults Board.
- Child Exploitation – to ensure a co-ordinated multi-agency approach is in place for all child exploitation concerns and emerging issues.
- Safeguarding in Education – to ensure staff in pre-schools, schools, colleges and other education providers are aware of key safeguarding issues and are also able to escalate their concerns to the Board and Executive Group and influence the strategic development of services.
- Procedures – to ensure all practitioners and managers across the children's workforce have up-to-date guidance and procedures on all key safeguarding issues via the OSCB website.
- Local Child Death Review Panel/Joint Thematic Group with Buckinghamshire – to ensure local oversight of all child deaths in the area and ensure that lessons are learnt and action taken as appropriate to the circumstances and any themes are identified and addressed (see section 3 for detailed arrangements).

- Disabled Children – to ensure the safeguarding needs of disabled children are addressed and high-quality services are delivered to this group.
- Health Advisory Group – to bring together health partners and alert the Board and Executive Group to key safeguarding gaps and concerns from the health sector.

Thematic Task and Finish Groups are set up as required and the current example is the Neglect Strategy Group, which was established to ensure all services work together to identify neglect early and take effective action through a consistent approach.

Dissemination of key safeguarding messages to the wider workforce is through individual relevant agencies and to existing multi-agency local groups e.g. self-harm networks, child exploitation networks, schools/settings, neglect practitioner forums etc.

A dedicated Housing Network of providers and city and district councils is in place with Oxfordshire Safeguarding Adults Board (OSAB) to ensure housing providers can raise issues and concerns, access training and support, understand pathways and thresholds and can hear key messages from the Board and the Executive Group.

The Independent Chair currently seeks the views of children and young people through the Voice of Oxfordshire Youth (VOXY) and the Children We Care For Council. The aspiration remains to work with a range of children and young people's groups to establish a robust mechanism to effectively understand and respond to current safeguarding issues, so that the voice of children and young people is at the heart of the implementation and ongoing work of these arrangements.

Joint Board meetings with OSAB have been suspended during the pandemic but will be reviewed later in 2021 and joint priorities will continue to be agreed so that we work together on shared issues of concern. The current joint priority is housing.

Together with the OSAB, an annual self-assessment is undertaken to ensure each relevant agency has robust safeguarding policies and procedures in place in accordance with section 11 of the Children Act 2004.

Organisations and agencies who are not named in the relevant agency regulations (see P.76 of the guidance), whilst not under a statutory duty, should nevertheless cooperate and collaborate with the safeguarding partners.

The Oxfordshire Threshold of Needs Matrix was re-issued in 2019 and is again under review and is used to ensure all local agencies have consistent criteria for action and understand how decisions are made, in accordance with Working Together 2018 Guidance.

1.7 How schools, colleges and other education providers will be included

Schools, colleges and other education providers have a pivotal role to play in safeguarding children and promoting their welfare. All schools includes academies, independent and private schools as well as those that remain the responsibility of the local authority. A representative from primary, secondary and special schools have been identified as relevant agencies. In addition the Safeguarding in Education Sub Group of the board continues to ensure wider representation from schools, colleges and other education providers. A termly Safeguarding Newsletter goes out to all schools, colleges and other education providers to ensure engagement and inclusion in these safeguarding arrangements.

Locally all schools and settings are required to complete an annual S157 or S175 self-assessment of their safeguarding arrangements which is reported to OSCB and arrangements are in place to review safeguarding arrangements in language schools.

During 2021 we will be seeking to further strengthen these relationships.

1.8 Information sharing and information requests

All relevant agencies have signed up to the OSCB Information Sharing Protocol, which was reviewed and approved in September 2020. Safeguarding partners may require any person or organisation or agency to provide them with specified information even if they are not a relevant agency. This is information which enables and assists the Executive Group to perform its functions to safeguard and promote the welfare of children in Oxfordshire, including as related to local and national child safeguarding reviews and child death reviews. In accordance with Working Together, the safeguarding partners may take legal action against an organisation or person that does not comply with such a request and will act in accordance with the guidance provided by the Information Commissioner's Office when issuing and responding to requests for information.
https://ico.org.uk/for-organisations/guide-to-freedom-of-information/receiving-a-request/

1.9 Independent scrutiny

The role of independent scrutiny is to provide assurance in judging the effectiveness of the multi-agency arrangements in working with children and families, as well as practitioners and how well the Executive Group is providing strong leadership.

The local independent scrutiny is fulfilled in a range of ways:

- Through the appointment of an Independent Chair who provides external scrutiny and challenge;
- By extending the reciprocal peer review agreement with Hampshire, which is currently reviewing our child safeguarding practice review arrangements;
- Through the two community/lay members who are independent members of the OSCB;
- As necessary by commissioning peer reviews on relevant safeguarding issues;
- Through Oxfordshire County Council's Performance Scrutiny Committee which receives the OSCB Annual Report, the Performance, Audit and Quality Assurance Annual Report and the Child Safeguarding Practice Review Annual Report. The Committee also scrutinises child safeguarding practice reviews at the point of publication;
- Alongside Thames Valley Police's Service Improvement Team, which undertakes thematic and geographic reviews, a Recommendations Panel has been established, which oversees the implementation of recommendations from child safeguarding practice reviews and other similar reviews.

- Through the Oxfordshire Clinical Commissioning's (OCCG) Quality Committee, Executive and Governing Body meetings where safeguarding board annual reports, child death review annual report and briefings on issues and emerging themes are presented for scrutiny and discussion. OCCG also provides a quarterly assurance report for NHS England as part of the external scrutiny and assurance framework for the NHS. This will change during 2021 as the Integrated Care System governance process emerges for Buckinghamshire, Oxfordshire and Berkshire West.
- As part of the wider system of independent inspection of individual agencies and Joint Targeted Area Inspections.

An evaluation of these independent scrutiny arrangements will be included in the OSCB annual report and any changes to the plans will be recommended on at least an annual basis.

1.10 Funding

Funding contributions from relevant agencies are included in Appendix 5 and have been reviewed by the Executive. Costs incurred by OSCB include training and development, administration of board business and local child safeguarding practice reviews. They do not include the commissioning or delivery of services, which is outside the remit of the board.

1.11 Dispute resolution

The Executive Group and relevant agencies work together to resolve any disputes locally. Public bodies that fail to comply with their obligations under law are held to account through a variety of regulatory and inspection activities. In extremis, any non-compliance would be referred to the Secretary of State for the non-compliant organisation. OSCB procedures on escalating concerns and resolving disputes should be used by all partners and are available on the OSCB website.

1.12 Reporting and implementing local and national learning

The Executive Group publishes an annual report on the OSCB website outlining what they have done as a result of the arrangements, including child safeguarding practice reviews and how effective these arrangements have been in practice. The report also includes:

- Evidence of the impact of the work on outcomes for children and families, from early help to children we care for and care leavers;
- An analysis of any areas where there has been little or no evidence of progress on agreed priorities;
- A record of decisions and actions taken by partners in the report period to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements;
- Ways in which partners have sought and utilised feedback from children and families to inform their work and influence service provision.
- Any updates to the published arrangements, including reviewing the list of relevant partners and the proposed timescale for implementation;
- The effectiveness of the arrangements for independent scrutiny.

The report is also sent to the Child Safeguarding Practice Review Panel and What Works Centre for Children's Social Care within 7 days of being published. An Annual Business Plan is also produced outlining key priorities and actions for the next year.

The Executive Group holds an annual safeguarding conference and two learning events per year to promote key local and national themes and emerging issues in relation to safeguarding. These will be held virtually for 2021. They also ensure that multi-agency training is delivered across the children's workforce in Oxfordshire.

SECTION 2:
Arrangements for commissioning and publishing child safeguarding practice reviews

2.1 Purpose

The purpose of child safeguarding practice reviews at both local and national level is to identify improvements to be made to safeguard and promote the welfare of children.

2.2 Responsibility

Responsibility for learning lessons from serious incidents lies at a national level with the Child Safeguarding Practice Review Panel (National Panel) and with the Executive Group in Oxfordshire implemented through the Independent Chair and the Child Safeguarding Practice Review Sub-Group of OSCB. The National Panel maintains oversight of the system of national and local reviews and judges how effectively it is operating.

2.3 Serious harm and notifications

16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states:

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if:

(a) The child dies or is seriously harmed in the local authority's area, or

(b) While normally resident in the local authority's area, the child dies or is seriously harmed outside England.

The notification must be within 5 days of becoming aware of the incident. The local authority should also report this to OSCB.

The local authority must also notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is suspected.

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain.

Any notification of an incident referred to the Panel is also referred to the Child Safeguarding Practice Review Sub Group for a local decision on whether the circumstances:

- meet the criteria for a Child Safeguarding Practice Review
- raise issues which are complex or of national importance

The Executive Group holds an annual safeguarding conference and two learning events per year to promote key local and national themes and emerging issues in relation to safeguarding. They also ensure that multi-agency training is delivered across the children's workforce in Oxfordshire.

2.4 The rapid review

When a serious incident becomes known to the OSCB, the CSPR sub-group promptly undertakes a rapid review of the circumstances. According to the guidance the Independent Chair should report the outcome to the National Panel within 15 working days. Whilst we seek to comply with this if possible, in practice, we have informed the National Panel that we aim to report within 30 days in order to manage the process effectively, bearing in mind the importance of ensuring there must be a thorough multi-agency investigation to inform robust decision making. The aim of the review is to enable the OSCB to:

- gather the facts about the circumstances, as far as they can be readily established at the time, through comprehensive chronologies from each of the partner agencies;
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately;
- consider the potential for identifying improvements to safeguard and promote the welfare of children;
- decide what steps we should take next, including whether to commission a child safeguarding practice review.

As soon as the rapid review is complete, the OSCB:

- Sends a copy to the Child Safeguarding Practice Review Panel setting out the case for the decision made.
- Shares with the Panel where issues which are complex or of national importance have been raised, such that a national review may be appropriate, and on whether we plan to carry out a child safeguarding practice review.
- Makes the Child Safeguarding Practice Review Panel, the Department for Education and Ofsted aware of the decision to initiate/publish child safeguarding practice reviews.

In practice, there may be a dialogue between the OSCB and the Panel to support the decision- making process and the OSCB can be required to share further information with the Panel.

If the Panel does decide to undertake a national child safeguarding practice review, the OSCB takes this into account when making a final decision on whether to undertake a local child safeguarding practice review of any child's circumstances covered by a national review.

After 18 months of operation the Rapid Review process locally is under review in order to ensure it is as effective as possible and to further clarify requirements of partners.

2.5 Decisions regarding local child safeguarding practice reviews

The criteria below is used by the Child Safeguarding Practice Review Sub Group (CSPR) in order to determine whether to carry out a local child safeguarding practice review by considering whether the circumstances:

- Highlight or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- Highlight or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.
- Highlight or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.

Further criteria include concern about the actions of one agency; the lack of any agency information; situations which involve a number of authorities where families have moved around and concern about the welfare of children in institutional settings.

Recommendations on whether to undertake reviews will be made by the CSPR sub-group and the final decision rests with the OSCB Independent Chair on behalf of the Executive Group. Child safeguarding practice reviews are a standing item at the Executive Group's bi-monthly meetings. If it is considered that the circumstances raise issues that are of national importance then the Executive Group is informed in between the bi-monthly meetings. Decisions are made transparently and the rationale communicated appropriately, including to families.

2.6 Local reviews

On behalf of the safeguarding partners, the CSPR sub-group takes responsibility for commissioning and supervising reviewers for local reviews. In each situation the CSPR sub-group takes into account whether the reviewer has the appropriate professional knowledge, understanding of relevant research, recognition of the complex circumstance in which practitioners work together, understanding of practice at the time rather than using hindsight, effective communication skills and whether there is a conflict of interest.

The CSPR sub-group determines the methodology and ensures the review is proportionate and focuses on learning. The sub-group also takes responsibility for overseeing the quality of the review, ensuring practitioners are fully involved and that families have the opportunity to contribute. The President of the Family Division's guidance (May 2017) covering the role of the judiciary in serious case reviews is also noted.

https://www.judiciary.uk/publications/presidents-guidance-judicial-cooperation-with-serious-case-reviews/

The final report includes a summary of recommended improvements and an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report. In addition, for surviving children a 'later- life' letter explaining the review and its findings and learning is produced by the reviewer on behalf of the Independent Chair for all children who are subject to a review. Dependent on the age and understanding of the child the letter is shared with them and/or given to an appropriate parent or carer to share with them in later life.

Published reports are available on the OSCB website for at least one year. In preparation for publication the CSPR sub-group carefully considers how best to manage the impact of publication on children, family members, practitioners and those closely affected by the circumstances.

A copy of the full report is sent to the National Panel, Ofsted and the Secretary of State for Education no later than seven working days before the date of publication. Where the safeguarding partners decide only to publish information relating to improvements to be made these are also submitted within seven working days.

Guidance states that the report should be completed and published no later than six months from the date of the decision to initiate the review. Where other processes (such as a criminal investigation) may have an impact on or delay publication the Independent Chair informs the National Panel and the Secretary of State of the reasons for the delay. Where a decision may be made not to publish the full report, the justification is communicated to the Panel and the Secretary of State.

Learning is disseminated and corrective action is taken at the earliest point and we do not wait until publication or completion of the review.

2.7 National Panel responsibilities for national reviews

The National Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance.

The National Panel considers if the circumstances could highlight improvements, lead to legislative changes, highlight recurrent themes and have regard for children not educated in school; who die whilst in the care of the local authority or subject to a Child Protection Plan and for circumstances that involve a range of types of abuse or cover issues that relate to the welfare of children in institutional settings.

The National Panel considers evidence from inspection reports (Ofsted, Her Majesty's Inspection of the Constabulary, Care Quality Commission, Joint Targeted Inspections, Ofsted thematic reviews).

If the Panel does determine to do a national review the OSCB and families will be contacted promptly.

There is further guidance about how the National Panel should approach, complete and publish national reviews on P. 87/88 of the guidance.

SECTION 3:
Arrangements for child death reviews

3.1 Context and statutory information

Child death review partners consist of local authorities and clinical commissioning groups. Oxfordshire and Buckinghamshire have combined areas for the child death review process. The child death review partners are:

- Yvonne Rees, Chief Executive for Oxfordshire County Council
- James Kent, Accountable Officer, Accountable Officer and Executive Integrated Care System Lead, Buckinghamshire, Oxfordshire and Berkshire West Clinical Commissioning Group
- Rachael Shimmin, Chief Executive for Buckinghamshire County Council

The designated doctors for child deaths are:

- Alison Shefler, Designated Doctor for Child Death, Oxford University Hospitals
- Craig McDonald, Designated Doctor for Unexpected Child Deaths in Childhood, Buckinghamshire Healthcare NHS Trust

The purpose of the review and analysis is to identify any matters relating to the death that are relevant to the welfare of children in the area or to public health and safety and to consider what action should be taken. There is also a requirement to ensure coordinated care and support of the family and community is prioritised.

Child deaths are reported to the CSPR sub-group at its monthly meetings so that there is regular oversight and scrutiny and any themes can be taken into account alongside other serious incidents.

3.2 Responsibilities of child death review partners

In line with statutory requirements the child death review partners for Oxfordshire have agreed the following:

- A structure and process to review all child deaths of children normally resident in the area and if appropriate and agreed by the partners, the deaths of children not normally resident in the area but who have died here (see 3.4 below).
- That the arrangements include analysis of information from all deaths reviewed.
- That we prepare and publish reports on what we have done as a result of the child death review arrangements in our area and how effective these arrangements have been in practice.
- Funding is through the Clinical Commissioning Group (see Appendix 5).
- The core representation of the panel structures includes public health; the Oxfordshire Designated Doctor for child deaths; children's social care; Thames Valley Police; the designated doctor/nurse for safeguarding; GP/health visitor; nursing/midwifery; community/lay representative and any others relevant to the local area.
- The geographical area is Oxfordshire and Buckinghamshire. This takes into account networks of NHS care, organisational boundaries and reflects the integrated care and social networks in the area, as the two counties work closely together. Oxfordshire has approximately 40 deaths a year and Buckinghamshire has approximately 30 deaths, which together exceeds the required minimum of 60 deaths in an area covering the child death review arrangements. Both areas use the same electronic system.
- The designated doctor for child deaths is notified of each child death and is sent relevant information by the Child Death Overview Panel (CDOP) administrator using eCDOP.
- That the child death review arrangements were reviewed after a year in operation and are working effectively.

3.3 Responsibilities of other organisations and agencies

All local organisations or individual practitioners that have had involvement in the child's circumstances co-operate in the child death review process and have regard for the guidance issued.

Specific responsibilities for registrars and coroners including timescales for notifications are outlined on P.97 & 98 of the guidance.

3.4 Responding to the death of a child: the child death review

Immediate decision making and notifications and investigation and information gathering

Practitioners work together to respond in a thorough, sensitive and supportive manner. The aims of the response are to:

- Establish, as far as possible, the cause of the child's death;
- Identify any modifiable contributory factors;
- Improve ongoing support to the family by identifying a key worker who is the single, named point of contact and provide a leaflet to help understand the child death review process;
- Learn lessons to reduce risks to other children;
- Ensure that all statutory obligations are met;
- Identify whether the death meets the criteria for a Joint Agency Response (P.100 of guidance);
- Identify whether a Medical Certificate of Cause of Death can be issued, or whether a referral to the coroner is required;
- Identify whether the death meets the criteria for a serious incident investigation from any agency.

As an immediate response, practitioners in all agencies notify the Oxfordshire CDOP administrator of the death of a child using the notification form. The CDOP administrator notifies the child's GP and other professionals via the 'Child death notification form' and the Child Health Information System, the relevant CDOP and the National Child Mortality Database automatically by eCDOP.

Allied to the child death review process, if there is a criminal investigation, the police are responsible for collecting and collating all relevant information and practitioners consult the lead police investigator and Crown Prosecution Service to ensure their enquiries do not prejudice any criminal proceedings.

If the results of any investigations suggest evidence of abuse or neglect as a possible cause of death, the paediatrician is responsible for informing CDOP and the OSCB Business Manager and the National Panel immediately.

Child death review meeting

Every child's death is discussed at a child death review meeting. This is the final multi-agency professional meeting that takes place prior to the CDOP meeting and involves practitioners who were directly involved in the care of the child and the investigation into their death and is not limited to medical staff.

For sudden unplanned deaths, a rapid review meeting is held to agree support arrangements for the family and confirm any investigations processes required.

For expected deaths, existing relevant health-led meetings have been expanded to ensure wider information is available and to include other agencies who may have had an involvement. Responsibility for convening the meetings lies with the lead clinician supported by the CDOP co-ordinator. An additional meeting is required only in the unusual circumstances of the expected death of a child with a previous health issue, following a defined period of illness and where the death occurred at home.

Child death overview panel

This multi-agency panel at a senior level is the final, independent scrutiny of a child's death by professionals with no responsibility for the child during their life. The panel meets on a quarterly basis. At this meeting the consolidated child death review form is considered and the child death analysis form is finalised and signed off. Oxfordshire and

Buckinghamshire continue to convene the CDOP for their own area to review the death of all children normally resident in their area and also where appropriate, the deaths of non-resident children. The panel also identifies modifiable factors that could be altered to prevent future deaths.

Oxfordshire and Buckinghamshire joint thematic child death review panel

Oxfordshire and Buckinghamshire joint thematic panel meetings are held three times a year. These meetings involve professionals who have had no involvement in the children under discussion and who can identify thematic system changes in order to learn lessons for the prevention of future child deaths. This panel is chaired by Public Health.

3.5 Publishing a report

Child death review partners publish an annual report that forms part of the OSCB Annual Report. The CDOP report is produced jointly by Oxfordshire and Buckinghamshire based on the learning and analysis of the Joint Thematic Child Death Review Panel. The report includes:

- local patterns and trends in child deaths,
- any lessons learnt and actions taken;
- the effectiveness of the wider child death review process and any revisions to be made to the process.

APPENDICES

Appendix 1: Definition of safeguarding

Safeguarding is the action that is taken to promote the welfare of children and protect them from harm. Safeguarding means: protecting children from abuse and maltreatment, preventing harm to children's health or development, ensuring children grow up with the provision of safe and effective care. (NSPCC definition).

In addition, in Oxfordshire we are taking into consideration contextual safeguarding (P. 23 of Guidance). This refers to extra-familial threats that might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/online. These threats can take a variety of different forms and children can be vulnerable to multiple threats including exploitation by criminal gangs and organised crime groups such as county lines; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation.

Appendix 2: Relevant agencies

Oxfordshire County Council
- Director of Children's Services
- Deputy Director Children's Social Care
- Deputy Director Safeguarding
- Deputy Director for Education
- Deputy Director Adult Social Care
- Director of Public Health
- Principal Solicitor
- Assistant Chief Fire & Rescue Service
- Cllr for Children and Family Services
- Cllr for Education

Thames Valley Police
- Nominated Local Police Area Commander* (currently deputy chair)
- Detective Chief Inspector, Protecting Vulnerable People

*There are three Local Police Area Commanders in Oxfordshire and one commander represents all three, historically Oxford City commander.

Clinical Commissioning Group
- Deputy Director of Quality/Lead Nurse

Oxford Health NHS Foundation Trust
- Director of Nursing and Clinical Standards
- Service Director

Oxford University Hospitals
- Chief Nurse
- Safeguarding Children Lead and Patient Experience

Designated Health Professionals
- Designated Doctor, Safeguarding Consultant
- Designated Nurse

Oxford City Council
- Assistant Chief Executive

South and Vale District Council
- Head of Housing and Environment

West Oxfordshire District Council
- Group Manager

Cherwell District Council
- Assistant Director: Communities

Thames Valley Community Rehabilitation Company
- Head of Operations

National Probation Service
- Senior Operational Support Manager

Schools
- Headteacher Warriner School
- Headteacher Windmill Junior School
- Headteacher Mabel Prichard (special school)

Armed Forces
- Regional Manager South, SSAFA
- Governance and Patient Safety, Defence Primary Health Care

CAFCASS
- Senior Service Manager

Housing Representative
2 Voluntary Sector representatives
2 Lay/Community Members

Appendix 3: Timetable for agreement to the arrangements

- September 2016: OSCB Full Board and Executive Subgroup workshop on Wood Review
- June 2018: OSCB Full Board and Executive Subgroup workshop on Working Together arrangements
- January 2019: OSCB Full Board, Executive Group, OSCB overview of arrangements and proposed way forward
- February 2019: CSPR subgroup review proposals for child safeguarding practice reviews. Oxfordshire Child Death Overview Panel and Buckinghamshire Child Death Overview Panel review detailed proposals for child death
- March 2019– April 2019: Full Board, Health and Well-being Board and Executive approval of arrangements and governance
- May 2019: Publish and launch new arrangements
- September 2020: Survey to relevant partners and Executive Group to review arrangements.
- February 2021: Approval of revised arrangements by Executive Group
- March 2021: Approval of revised arrangements by Full Board

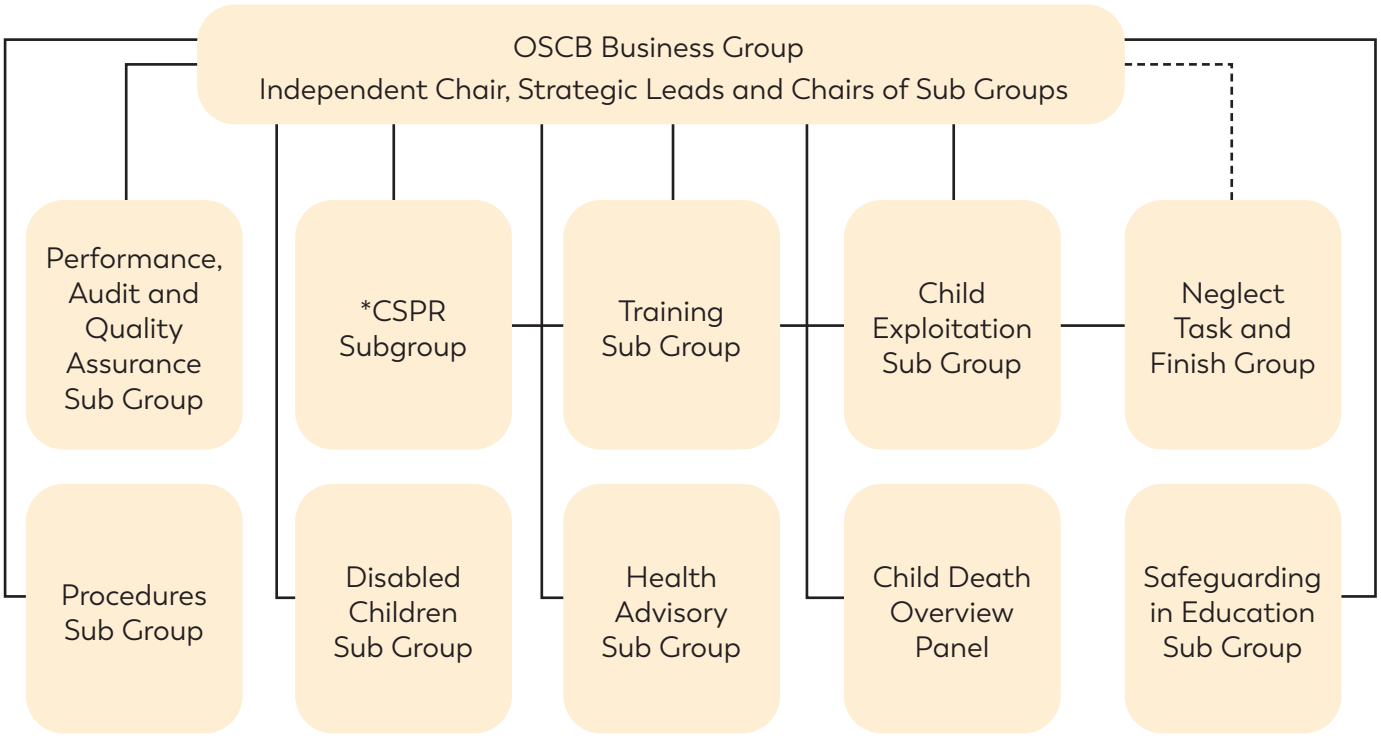
Appendix 4: Structure Chart

Oxfordshire Multi-Agency Safeguarding Arrangements

Structure Chart

Executive Group
Chief Executive Officer, Oxfordshire County Council
Assistant Chief Constable Thames Valley Police, Accountable Officer, Clinical Commissioning Group

Oxfordshire Safeguarding Children Board
Independent Chair and Relevant Partners



*Child Safeguarding Practice Review Group

Appendix 5: Budgeted finances for the year 2020/21

Funding streams

Public Health	-£30,000.00

Income

Foster carer training	-£2,500.00
Non-attending delegates	

Contributions

OCC Children, Education & Families	-£201,100.00
OCC Dedicated schools grant	-£64,000.00
NHS OCCG*	-£60,000.00
Thames Valley Police	-£21,000.00
National Probation Service	-£1,410.00
CRC	-£2,500.00
Oxford City Council	-£10,000.00
Cherwell DC	-£5,000.00
South Oxfordshire DC	-£5,000.00
West Oxfordshire DC	-£5,000.00
Vale of White Horse DC	-£5,000.00
Cafcass	£0.00
Public Health (see above)	£0.00
Total income	**-£412,510.00**

Expenditure

Independent Chair	£36,000.00
Business unit	£273,000.00
L & I work	£17,000.00
Training & learning	£51,000.00
Subgroups	£10,510.00
All case reviews	£25,000.00
Total	**£412,510.00**

Other contributions

(not including partner time to support ongoing board activity.)

- Oxfordshire County Council re-accommodation and employment of staff in OSCB Business Unit.

Premises	16,000.00
Employment	26,110.00
Total	**42,110.00**

- Clinical Commissioning Group re child death review processes for Oxfordshire

eCDOP	11,650.00
Staffing including Designated Doctor time	88,920.00
Total	**100,57.00**

OSCB
Oxfordshire
Safeguarding
Children Board

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