Thurrock LSCB Annual Report on the Effectiveness of Safeguarding Children in Thurrock

April 2010 to March 2011

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Section 1

Introduction

1. Background

1.1 The Annual Report on the Effectiveness of Safeguarding

Thurrock LSCB is required to publish an annual report on the effectiveness of safeguarding in the local area (Working Together to Safeguard Children, HM Govt 2010). This requirement was laid out in the Apprenticeships, Skills, Children and Learning Act 2009. This is the report for the period 1st April 2010 until 31st March 2011.

1.2 Thurrock and its children

	Southend	Essex	Thurrock	SET
Live Births 2006	2,102	15,368	2,138	19,608
Children aged 0-4 years % of total population	9,500 5.9%	76,000 5.6%	9,900 6.6%	95,400 6%
Children aged 0-19 years % of total population	38,600 24.1%	328,900 24.2%	39,600 26.6%	407,100 24.9%
% of children living in poverty	23.9%	16.3%	20.6%	20.2%

Source: ERPHO Child Health Profile, September 2008 (reproduced from Southend, Essex Thurrock SET Child Death Review Annual Report 2009/10)

Thurrock has a population of roughly 152,000 people and it is growing faster than the national average. 49% of its children are girls, 51% boys. The ethnicity of the child population is rapidly becoming more diverse, with approximately 22% of children between 5 and 16 years coming from an ethnic group other than White British. Black African children of school age now make up 8% of the school population, the largest minority group.

1.3 Chair's Commentary

This has been a very positive year for the LSCB with considerable activity in place and a continuing strong commitment by all partners to the LSCB's work.

2010/11 was a year of transition for the Board. There were a number of changes to senior personnel from key partners during the year. Strategic and/or operational changes in core agencies such as Thurrock Council, NHS South West Essex, Essex Police, NSPCC and others resulted in a much more fluid LSCB membership than has been the case in earlier years. Our long-standing Business Manager left but has continued to support the Board on a part-time basis.

Nevertheless, the LSCB continued to undertake its core responsibilities and provide an analysis of, and challenge to, local children's workforce in Thurrock.

All of the sub-groups of the LSCB have been well supported by partner agencies with good attendance and strong commitment to the work. The Management Executive continued to receive and scrutinise reports from key partners and partnerships on a range of local and national safeguarding issues. The Audit Group continued to develop its practice of independent audit analysis of child protection practice amongst partners.

In February 2011 the LSCB arranged an Awayday to review how effective it was in relation to local arrangements, such as its relationship with the Children and Young People's Partnership, as well as revisions announced by the new Government and changes implemented to national guidance, such as those revisions announced in Working Together to Safeguard Children (2010). The discussions centred on the need to ensure the LSCB remained fit for purpose in relation to its core role not in directly providing safeguarding to the local children's workforce, but in ensuring that what is provided is effective and safe for the children of Thurrock.

The Board and its partners began implementation of the action plan arising from this Awayday and have made a number of improvements to the way the Board undertakes its role. This will be reported on more fully in the Annual Report for 2011-12.

It was reassuring to note that the Safeguarding Peer Review of September 2010 reported that the LSCB was well regarded by most agencies and that "the LSCB has demonstrated that it is an active forum for both challenge and issue resolution". They also reaffirmed that the roles of both the LSCB and the Children and Young People's Partnership Board "have been well defined and are undoubtedly understood at a strategic level".

However a number of challenges remain. Both the Peer Review and the Ofsted Unannounced Inspection in December 2010 highlighted safeguarding areas that require attention by partners. Recommendations for change arising from these analyses, along with the LSCB's own findings and the output of the LSCB Awayday have been assimilated into an action plan for local partners to implement during the coming year.

Issues such as the local response to domestic violence, particularly against women and girls, and the need for better communication of safeguarding information to Thurrock children, young people and families, requires our greater attention in 2011/12. For this reason, it has remained a key priority for the LSCB.

Overall though, the Thurrock LSCB is pleased with the progress made locally during this period and will continue to be vigilant in providing a level of challenge to partners responsible for keeping Thurrock children and young people safe.

I would like to thank all those who have contributed to the LSCB's work this year for all their hard work and commitment. I would particularly like to thank our administrator, Frances and our Business Manager, David for supporting me to keep the LSCB operating smoothly.

AMY WEIR
Independent LSCB Chair

Section 2

Summary Assessment on the Effectiveness of Safeguarding Children in Thurrock

2. Summary assessment of safeguarding effectiveness in Thurrock

2.1 During the 2010/11 period the quality of safeguarding children in Thurrock was externally assessed on two separate occasions. A safeguarding peer review process was undertaken on 6-10th September 2010 and Ofsted undertook an unannounced inspection of safeguarding and looked after children on 9-10th December 2010.

2.2 **Safeguarding Peer Review** – This was undertaken by Local Government Improvement and Development (LGID) with a review team consisting of members from a range of English councils and partner agencies, including Gateshead, Norfolk, Brent and Southend-On-Sea.

2.3 The findings from this review were overall very positive. The team commented on the fact that everyone they met "appeared to be highly motivated and committed to delivering improvements in their service area". They also mentioned the fact that "Officers at all levels have a strong and passionate commitment to the safeguarding of children and young people".

2.4 They found many examples of effective practice and cited three in particular:

- the joint work between the police child abuse investigation team and the children's social care service
- the recent improvement in joint work between the Council's legal and children's social work teams (these developments were prompted by LSCB recommendations arising from an earlier serious case review)
- the work undertaken by the Multi-Agency Groups (MAGs), which appears to be delivering a practical and successful multi-agency approach to supporting children and families as they come off child protection, whilst retaining the ability to re-refer if escalation becomes necessary.

2.5 The team also cited good examples of children and young people participating in decisions and in developing service policy; strong links to the voluntary sector and emerging good practice linked to the changing demographics of Thurrock; and the innovative work of the Therapeutic Foster Care team as an example of best practice.

2.6 There were areas of challenge identified that required attention and some key priorities agreed:

- Single quality assurance strategy and approach

- Developing the partnership to ensure the new structures deliver effective safeguarding, ensuring that all partners share a common understanding

- The management of risk – via the enforcement of safeguarding thresholds across the partnership – dependent upon a clear and shared understanding of individual partner agencies responsibilities

2.7 **Ofsted Unannounced Inspection** – Carried out on 9th and 10th December 2010.

2.8 The Government directed Ofsted inspection identified no priority areas for action and was once again acknowledged by local partners as reflecting a positive perspective on local safeguarding arrangements.

2.9 Inspectors commented on the fact that referrals were responded to promptly, there were no unallocated cases and practice and procedures complied with statutory requirements and ensured children were protected.

2.10 In addition, children identified as suffering or at risk from harm received an immediate response with child protection enquiries carried out by suitably qualified and experienced practitioners. Assessments are clear and include some analysis.

2.11 Out-of-hours duty arrangements were clear, provided effective safeguarding and well linked to daytime services.

2.12 The Inspectors were also very complimentary of the positive approach shown by officers to external scrutiny and challenge and “have used this to enhance their understanding of the service”.

2.13 There were also areas requiring development, including the following:

- Safeguarding thresholds are not consistently adhered to by all referring agencies resulting in some unnecessary referrals.
- Referral information provided by partner agencies is not of a consistently good quality, particularly so in respect of notifications of incidents of domestic violence with a lack effective protocol in responding to incidents of domestic abuse
- Case audit information not systematically analysed and used to inform service improvement.

2.14 In addition to the external scrutiny, Thurrock LSCB continued its practice of requesting and evaluating reports from partners about the quality of safeguarding from its partners in the local children’s workforce. The LSCB Management Executive received a total of 19 reports on a range of safeguarding issues. In addition the LSCB Audit

Group undertook a number of audits on a range of key safeguarding issues. A summary of these findings are noted in Section 4 below.

2.15 These areas for improvement have been summarised in an action plan for the LSCB and Children and Young People's Partnership to work on during 2011/12 and will form the basis of the next LSCB Business Plan.

2.16 **From the evidence noted both internally and externally, the Thurrock LSCB is satisfied to report that safeguarding arrangements for children and young people continue to be effective in Thurrock.**

Section 3

Governance and Accountability Arrangements – effectiveness of the LSCB

3. Governance and Accountability Arrangements

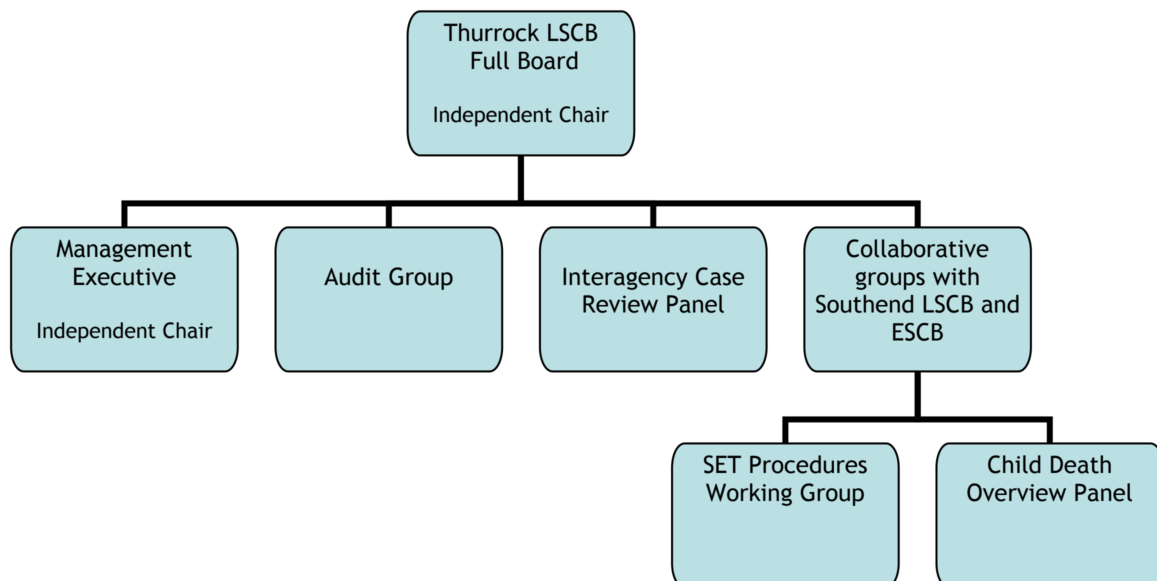
3.1 Role, Function and Structure of the Board and Sub Groups

The role of the LSCB is:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in Thurrock; and
- To ensure the effectiveness of what is done by each such person or body for that purpose.

The functions undertaken by the LSCB reflect the requirements of the Children Act 2004, and are based upon the objectives set out in Chapter 3 of 'Working Together to Safeguard Children (2010)'.

3.2 The Board structure has been further streamlined for 2010/11 to ensure that the LSCB concentrates on its core business as outlined above.



3.3 Relationship to Thurrock Children's and Young People Partnership

A protocol has been developed between the Thurrock LSCB and the Thurrock Children's and Young People Partnership, to ensure that there was a clear understanding of the distinct roles played by each multi-agency partnership in this vital area.

The LSCB has more clearly defined its responsibilities in providing the challenge and scrutiny of local partners' abilities to effectively safeguard and protect children and young people in the Thurrock area. The Children's and Young People Partnership has developed its action plan on the commissioning, coordination and delivery of services to these groups, including effective safeguarding.

The Stay Safe group of the Children's and Young People Partnership continues to work on identified safeguarding priorities in Thurrock and provides the LSCB with periodic progress reports.

This work was further strengthened at the LSCB Awayday in February 2011.

3.4 Membership and Attendance

Membership of the Full Board of the LSCB and attendance for 2010/11 can be broken down as follows:

Member Agency/Organisation	%
Independent Chair	**100**
Thurrock Council Children's Services	**100**
Thurrock Council Adult and Community Services	**50**
Essex Probation Trust	**100**
Essex Police	**100**
NHS South-West Essex	**100**
Thurrock Primary Heads Association	**0**
NHS South Essex Partnership Foundation Trust	**25**
NHS Basildon and Thurrock University Hospitals NHS Foundation Trust	**50**
Thurrock Youth Offending Service	**75**
Thurrock Association of Secondary Heads	**0**
Thurrock Racial Unity Support Taskgroup (TRUST)	**25**
NSPCC	**0**
CAFCASS	**50**
Essex County Fire & Rescue Service	**100**
East of England Ambulance NHS Trust	**0**
Palmers College	**25**
South Essex College of Further and Higher Education	**50**

It has been recognised that a number of partners went through a number of personnel changes during this period, resulting in reduced attendance from some, NSPCC and East of England NHS Trust in particular. It was of particular concern to the Board that there was no representation from the Association for Primary or Secondary schools. Given that education representation is of vital importance to effective safeguarding in Thurrock this has been subsequently addressed. The Board were pleased to welcome further education representatives for the first time during 2010/11.

The Management Executive met on nine occasions during 2010/11. Membership of the Management Executive meetings can be broken down as follows:

Member Agency/Organisation	**%**
Independent Chair	**78**
Thurrock Council	**89**
Essex Probation Trust	**33**
Essex Police	**78**
NHS South-West Essex	**100**
NHS South Essex Partnership Foundation Trust	**56**
NHS Basildon and Thurrock University Hospitals NHS Foundation Trust	**67**
Thurrock Youth Offending Service	**44**
Thurrock Racial Unity Support Taskgroup (TRUST)	**22**
NSPCC	**78**
East of England Ambulance NHS Trust	**0**

Again, due to personnel changes membership was more erratic during 2010/11. In fact only NHS South West Essex representatives were able to attend 100% of the meetings and they are to be commended for their commitment to the Thurrock LSCB.

3.5 Role of Lead Member and Scrutiny by Council Members

- Periodic reports are provided to the Children's Services Overview and Scrutiny committee within Thurrock Council.
- In addition, the elected Councillor and Portfolio holder for Children's Services is invited to attend and observe the quarterly LSCB Full Board meetings.

During 2010/11 the Member for Children's Services attendance was 100% and this close involvement has been positively acknowledged by partners.

3.6 Appointment of Lay Advisors

The Board has deferred its decision to appoint Lay Advisors until more guidance on the appointment process has been provided by the Government.

3.7 Finances

Funding for the LSCB comes from its key partners, Thurrock Council, Essex Police, NHS South West Essex, Essex Probation Trust and a small contribution from CAFCASS.

Income for 2010/11, including the brought forward surplus from 2009/10, totalled £123.1k. The percentage of contributions by partner was as follows:

Thurrock Council:	61%
NHS South West Essex	14%
Essex Police	14%
Essex Probation Trust	10%
CAFCASS	1%

Expenditure for the period was £66.1k. This is broken down as follows:

Independent chairing of all meetings:	30%
Administration including Business Manager costs:	58%
Contribution to Child Death Review administration:	8%
Other expenses including licences:	4%

The Board has a surplus of £70.8k carried forward at the end of the period. This is to cover expected costs in 2011-12 such as the work planned for conducting a multi-agency case review using the Social Care Institute of Excellence (SCIE) methodology. In addition the Children's Partnership Training Group has not yet used their allocation of funds and this will be made available during 2011-12.

Section 4

Monitoring and Quality Assurance Activity

4. Monitoring and Quality Assurance Activity

4.1 The LSCB Business Plan identified three key priority areas for consideration during 2010/11:

- **To ensure agencies work effectively together to safeguard Thurrock children**
- **To provide a specific focus on those children at risk from domestic abuse**
- **To better communicate child safeguarding messages in Thurrock**

4.2 The LSCB monitored performance in these and other areas required under LSCB regulations using four key methods:

a) Periodic reports providing an update position from relevant agencies and/or local partnerships,
b) By the work of the LSCB Audit Group in scrutinising a random sample of cases
c) By analysing self –evaluation audits into Section 11 (Children Act 2004) compliance.
d) Information arising from external inspections.

4.3 The Management Executive reviewed 19 key reports during the period in line with the LSCB Business Plan.

4.4 Inter-agency training

During this period the LSCB Inter-Agency Training Group was disbanded, passing responsibility for delivery of training to the Children and Young People Partnership Stay Safe training sub-group, to more closely align the delivery work of that group with training requirement.

4.5 Unfortunately, this new training group encountered a number of challenges in 2010 establishing itself, agreeing a training strategy and ensuring the right membership to facilitate effective delivery.

4.6 Inter-agency training for this period has therefore been restricted to two sessions of Inter-agency Child Protection training and two sessions of serious case review messages training, with the support of the Council Workforce Development team.

4.7 The Training group has a more extensive programme of events planned for 2011-12 and this will be evaluated during the year to assess whether the delivery has proven effective to meet the needs of the local children's workforce with regard to safeguarding training.

4.8 **Audit Group activity**

During the period the Audit Group undertook a range of multi agency case audits on local cases, analysing the quality of practice in areas such as referral and assessment of cases deemed to meet the threshold of child protection and child in need criteria. They also reviewed cases taken to child protection conference to assess the effectiveness of this process and undertook an audit of domestic abuse referrals.

4.9 **Introduction**

The LSCB Audit Group's remit for 2010/11 was to conduct multi agency case audit reviews of a random sample of cases referred to key partner agencies (Thurrock Children's Social Care, Essex Police and NHS South West Essex).

These case samples were reviewed against current local SET Child Protection procedures. The experience and knowledge of the Audit Group members then was used to consider, analyse and assess the level of adherence to procedures and safe practice. Above all, the group has focused on assessing whether children's safeguarding had been effectively promoted and positive outcomes achieved for the children concerned.

During the period April 2010 to March 2011 the Group reviewed the follow case types:

- S47 investigation;
- Child In Need (CIN) activity;
- those referred to Child Protection Conference (CPC);
- and it also undertook a random sample of domestic violence cases requiring police attendance.

If the group has positive comments to make about practice these are recorded and passed on to the relevant senior manager. By the same token, if there are concerns about safeguarding or apparent lack of progress in a case, then this is also raised with managers and responses come back to the group at its next meeting.

4.10 Group Membership

The Group was well attended. It was chaired during 2010/11 by the LSCB Chair. During the year staff from the following agencies contributed to the work of the Audit Group.

- **Essex Police**
- **Essex Probation Service**
- **Thurrock Children's Social Care**
- **Thurrock Young People's Service / Youth Offending Service**
- **Basildon Hospital - BTUH**
- **SW Essex PCT**
- **NSPCC**

4.11 Details of Activity 2010/11

The Audit Group met on seven separate occasions, at approximately six weekly intervals.

The Group was chaired by Amy Weir, Independent Chair on six of the seven meetings held. The Audit Group comprised six partner agencies and attendance percentage over the year was as follows:

NHS SW Essex:	100%
Thurrock Council CEF:	86%
Essex Police:	71%
NSPCC:	71%
Youth Offending Service:	57%
Essex Probation:	29%

4.12 Summary Findings

Random Section 47 Audits

During the period the Group reviewed 18 cases that had been subject to a S47 referral and subsequent enquiry, ranging in age from a few months old to 16 years. These cases were chosen at random from the existing list of Social Care referrals, with no preference for age, gender or ethnicity.

The Integrated Children System record was interrogated in each case via the laptop / projector link. This record was considered alongside paperwork provided by partners.

The focus of this audit was to review whether there had been a sufficiently holistic multi-agency response to the allegation or concern which had been made. Then, the task was to consider and form a judgement about whether appropriate action to investigate had been taken to safeguard the child and to follow up the information which had been gathered.

The findings were as follows:

- Poor/incomplete/confusing recording was identified across the files (both ICS and partner agencies) in 4/18 cases (22%). This sometimes made it difficult to see whether appropriate action had been taken.
- Appropriate child protective action had been taken according to the recording viewed in 10 of the 18 cases (55%). This may be an underestimate as poor recording made it difficult to see what had been done in some cases.
- Other issues in particular cases included difficulty in arranging a medical examination; a perceived lack of progress in another case to progress to initial child protection conference; an apparent premature closure of a case.

Where issues of concern regarding practice from whichever agency were identified, the Chair made immediate enquiries to the appropriate senior manager and sought assurance that each case be reconsidered to ensure the ongoing safety of the child. We are pleased to report that follow up information provided showed that the Group's concerns were taken seriously and any deficiencies addressed.

Although this was only a small sample, findings showed that appropriate actions were taken in a timely way in the majority of cases reviewed. Where there were concerns, these were immediately followed up and the remedial action was reported to the Audit Group.

4.13 Child Protection Conference Process

Six cases were reviewed during the period, although only three subsequently met the criteria for a Child Protection Conference. Due to the small number of cases reviewed, it is difficult to draw any firm conclusions from the findings.

One case had a good core group attendance and clear actions, but some of the child protection plan was not completed within timescales and the production of minutes was significantly delayed. In another case there were no core group meetings recorded at all, nor real evidence of progress. Further investigation upon request by the Chair showed that core group activity had taken place but had not been recorded in the right place within ICS. The third case showed that CP procedures had been followed and procedural timescales met. However the Group were concerned about the level of ‘drift’ in the case over many years and the subsequent degree of harm that the children may have experienced.

Overall, the level of actual practice in these cases was of a good or at least adequate standard but recording did not always represent accurately or in a timely way what had actually been done.

4.14 Child in Need (CIN) process

Again, due to the focus on S47 cases only a small number of CIN cases were reviewed. In addition, on several occasions, the cases chosen had not met the criteria for selection or the family had subsequently moved out of the area. Three CIN cases were considered during this period. Of these, one had been managed and recorded appropriately, showing a clear reason for de-escalation from child protection. The other two were weaker, one case showed that a core assessment was overdue; the other did not have a clear CIN plan or review structure on file.

4.15 Domestic Violence audits

Two separate audits were undertaken by the Group during the period. Each time a random seven day period was chosen and the police provided a summary of the police reports involving children and young people during that time.

In total 83 (28 from Mar 11, 55 from Sep 10) incidents were analysed by the Police, Health and Social Care.

The Group were pleased to find that the reporting by police had improved in the quality of the documentation. However, there was a delay in the inputting of police reports from the first audit in July 2010 and in both audits there were discrepancies between the incidents input and the paper documentation provided to both Health and Social Care.

The Audit Group was therefore concerned to see a continuation of the inconsistency of information provided and that separate processes are still being undertaken in each agency to assess whether action should be taken.

4.16 Section 11 Audits

A range of S11 audits from Thurrock Council departments were reviewed during the period, as well as a resubmission by Basildon and Thurrock University Hospital NHS Trust (BTUH). The Group were pleased to note the level of improvement in the evidence provided by BTUH, given that this was previously assessed as Inadequate. During 2011-12 the LSCB will evaluate the evidence of action plan implementation from those partners who submitted an audit.

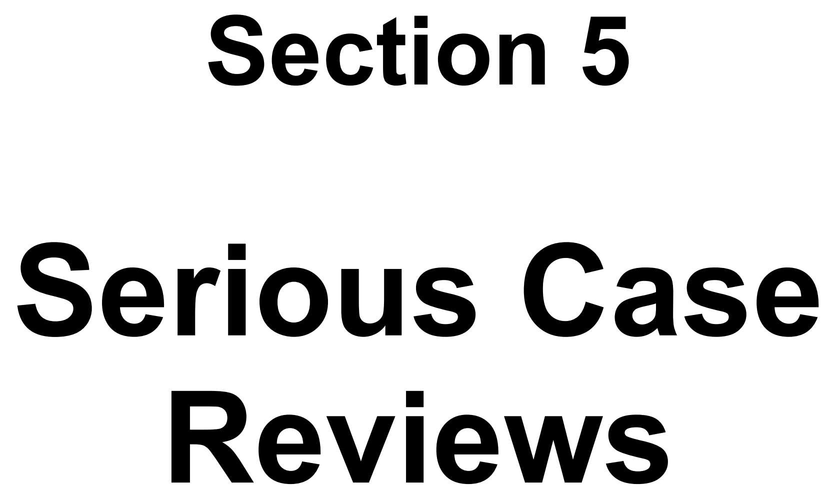
4.17 Summary

The Audit Group continues to focus on the quality of recorded evidence of safeguarding practice amongst key partners. However, the amount of time required to analyse each case in sufficient detail presents significant time challenges and therefore the work of the Group will continue to be in the nature of a 'dip' sample. This is still regarded by all the group members as a useful exercise.

As well as providing an opportunity to test safeguarding in practice, the group also provides a positive and fertile learning environment for its members to gain a better understanding of safeguarding processes in each agency.

The Group also plans to undertake a number of **field visits** to partner premises during 2011/12 to review electronic records in situ, alongside its existing audit programme. Consideration will also be made to reviewing the current process driven analysis to improve the quality of auditing being undertaken.

Amy Weir
Chair of Audit Group
Thurrock LSCB



Section 5

Serious Case Reviews

5. Serious Case Reviews (SCRs)

5.1 The LSCB is pleased to report that once again no new serious case reviews were identified during 2010/11.

5.2 The Board have reviewed recommendations arising from reviews undertaken since 2005 and were satisfied that partners have provided sufficient evidence of implementation. Many of the actions required have been superseded by innovations in practice since the time of the review, although any such changes would have been informed by LSCB recommendations.

5.3 During the 2010/11 period Thurrock received feedback from Ofsted in relation to a complex and complicated serious case review undertaken in another area and where there had been historical Thurrock agency involvement (1998-2002). In total the family had been involved with agencies from six LSCB areas during the period under scrutiny. This review was commenced in the autumn of 2009.

5.4 The analysis of Individual Management Reviews submitted by Thurrock agencies to the review process in Sandwell ranged from inadequate to outstanding. Where deficiencies in the IMR report were identified those agencies responsible have noted these and implemented changes in their processes, but Thurrock Council were commended for their outstanding contribution by Ofsted.

5.5 Ofsted also complimented Thurrock's LSCB chair for her useful synopsis of involvement and actions identified, recommending it as a good practice method for future complex reviews.

5.6 Due to the fact that no serious case reviews had been undertaken in the period, the Case Review Group identified local cases that in their opinion warranted inter-agency scrutiny and might progress safeguarding learning for partners.

5.7 A number of cases were considered by this SCR / Interagency Panel. One case in particular has led to developments to improve communication and joint working between adult mental health and children's services.

Section 6

Child Death Overview Panel

6. Child Death Overview Panel

6.1 A child death review includes collecting information about the circumstances of a death, identifying if there were any modifiable factors and determining lessons to be learnt to reduce future child deaths. Following the publication of Working Together to Safeguard Children, as outlined in chapter 7, from 1st April 2008 there is a requirement to report the death of any child aged under 18 years, whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community, to Local Safeguarding Children Boards (LSCBs). LSCBs are responsible for establishing procedures and processes to support the review of and response to such deaths.

- The SET CDR procedures were revised to reflect the changes in Chapter 7 of Working together to Safeguard Children. The key changes were in relation to:

- The definition for modifiable factors **'…modifiable factors may have contributed to the death. These factors are defines as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.'**

- The definition of an unexpected death **'….and unexpected death is defined as the death of an infant or child (less than 18 years old) which: was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.'**

Sudden Unexpected Death in Infancy (SUDI)	All unexpected deaths of infants up to 1 year of age at the point of presentation. Description rather than a diagnosis. Following investigation, will be divided into those with a clear diagnosis (explained SUDI) and those with no diagnosis (SIDS)

6.2 Between 1st April 2010 and 31st March 2011 a total of **115** deaths were notified for review in SET. This compares to 116 in 2009-2010 and 108 in 2008-2009, totalling 339 child deaths in the three years. The majority of these deaths occurred in Essex for all three years (78%) with Southend and Thurrock each accounting for 11% of all deaths.

6.3 In SET, modifiable factors have been identified in 20% of the child deaths that have been reviewed. Factors have been identified as follows:

- Maternal Smoking
- Co-sleeping and other risk factors in SUDI death
- Service provision factors in deaths classified as infection, chronic and acute medical conditions and neonatal deaths
- Non-intentional injury in the age ranges of 1 – 4 years where supervision and home safety have been factors identified
- Driver behaviour, particularly in young drivers and RTC

6.4 Maternal smoking is considered to be a key risk factor for premature birth and death. In SET a history of smoking either during pregnancy or after birth was recorded in 19% of the neonatal deaths.

The smoking status is not always recorded on the data-collection forms so the percentage of mothers recorded as smokers could actually be higher than this. It is acknowledged that paternal smoking is also a risk factor and although the data collections forms request data relating to this, information is rarely provided. From April 2011 however, the national data collection forms have

6.5 Sudden Infant Death Syndrome (SIDS) is defined as the sudden unexpected death of an infant less than one year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, such deaths may also be called cot death or unascertained. Nationally, the number and rate of SIDS have been decreasing since 1989 but the fall was most marked in 1991 and 1992, when the 'reduce the risk' campaign was launched. There has been a slower decline since then and numbers appear to have stabilised.

Evidence from a very large number of studies worldwide consistently demonstrates that maternal smoking during pregnancy increases the risk of SIDS. The risk appears to be dose related with the risk increased with bed-sharing. In SET maternal smoking was identified as a factor in 67% of deaths classified as SUDI and identified as a modifiable factor in 60% of deaths classified as SUDI.

In SET co-sleeping was recorded as a factor in 47% of deaths classified as SUDI and 13% occurred in children born before 37 weeks gestation (31 weeks and 25 weeks gestation. Alcohol misuse by parent or carer was identified as a factor in 26% of the deaths classified as SUDI and as a modifiable factor in 13% of deaths classified as SUDI.

Section 7

Priorities for 2011/12

7. Looking Forward / Priorities for 2011 to 2012

7.1 It has been decided by the Thurrock LSCB that its Business Plan for 2011-12 will be a one year plan.

7.2 **The LSCB Partners have identified four key LSCB priorities for 2011/12. They are:**

1. **To ensure agencies work effectively together to safeguard Thurrock children and to deliver the core statutory functions of the LSCB.**

2. **To focus on violence against women and girls specifically considering the needs of those children and young people at risk from domestic abuse, child sexual abuse and exploitation or trafficking.**

3. **To implement changes resulting from the Government response to the Munro Review as required including ensuring there is effective provision of local early help services for Thurrock children, young people and families.**

4. **To communicate child protection and safeguarding messages effectively in Thurrock.**

REPORT ENDS