

**EAST AYRSHIRE CHIEF OFFICERS GROUP: 3 JUNE 2009**

**JOINT AREA REVIEW HARINGEY CHILDREN'S SERVICES AUTHORITY AREA  
AND  
THE PROTECTION OF CHILDREN IN ENGLAND: A PROGRESS REPORT**

**1. PURPOSE**

- 1.1 To advise the Chief Officers Group of actions being taken to progress the recommendations of the above noted reports, in an East Ayrshire context.

**2. PROPOSALS**

2.1 The Protection of Children in England: A Progress Report

Following the tragic death of 'Baby P', The Lord Laming was commissioned on 17 November 2008, by the Secretary of State for Children, Schools and Families, the Rt Hon Ed Balls MP, to provide an urgent report on the progress being made across the country to implement effective arrangements for safeguarding children.

The Lord Laming was tasked to: evaluate the good practice developed since the publication of the Inquiry report following the death of Victoria Climbié; identify the barriers preventing good practice becoming standard practice, and; recommend actions required to make systematic improvements in safeguarding children across the country.

The report was published in April 2009 and the Lord Laming made 58 recommendations (appendix 1).

2.2 Joint Area Review Haringey Children's Services Authority Area

The report was published following the tragic death of Baby P, having been commissioned by Haringey Council. It contains a range of recommendations which are summarised in the attached appendix (appendix 2).

- 2.3 Both reports were considered by East Ayrshire Child Protection Committee on Tuesday 19 May 2009. The Performance and Audit Sub Group is currently giving detailed consideration to the recommendations and the specific delivery for East Ayrshire will be reported to the next Child Protection Committee.

### **3. RECOMMENDATION**

3.1 The Chief Officers Group is asked to:

- i) note the contents of this report.

**Susan Taylor**  
**Chair of Child Protection Committee**  
**25 May 2009**

**Report prepared by: Susan Taylor, Chair of Child Protection Committee**

## THE PROTECTION OF CHILDREN IN ENGLAND: A PROGRESS REPORT-MARCH 2009

### COMPLETE LIST OF RECOMMENDATIONS

1. The Home Secretary and the Secretaries of State for Children, Schools and Families, Health, and Justice must collaborate in the setting of explicit strategic priorities for the protection of children and young people and reflect these in the priorities of frontline services.

2. A National Safeguarding Delivery Unit be established to report directly to the Cabinet Sub-Committee on Families, Children and Young People. It should have a remit that includes:

- working with the Cabinet Sub-Committee on Families, Children and Young People to set and publish challenging timescales for the implementation of recommendations in this report;

- challenging and supporting every Children's Trust in the country to implement recommendations within the agreed timescales, ensuring improvements are made in leadership, staffing, training, supervision and practice across all services;

- raising the profile of safeguarding and child protection across children's services, health and police;

- supporting the development of effective national priorities on safeguarding for all frontline services, and the development of local performance management to drive these priorities;

- leading a change in culture across frontline services that enables them to work more effectively to protect children;

- having regional representation with expertise on safeguarding and child protection that builds supportive advisory relationships with Children's Trusts to drive improved outcomes for children and young people;

- working with existing organisations to create a shared evidence base about effective practice including evidence-based programmes, early intervention and preventative services;

- supporting the implementation of the recommendations of Serious

Case Reviews in partnership with Government Offices and Ofsted, and put in place systems to learn the lessons at local, regional and national level;

- gathering best practice on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drugs and alcohol misuse, and provide advice to local authorities, health and police on implementing robust arrangements nationally; and

- commissioning training on child protection and safeguarding and on leading these services effectively for all senior political leaders and service managers across those frontline services responsible for safeguarding and child protection.

## Leadership and accountability

3. The Cabinet Sub-Committee on Families, Children and Young People should ensure that all government departments that impact on the safety of children take action to create a comprehensive approach to children through national strategies, the organisation of their central services, and the models they promote for the delivery of local services. This work should focus initially on changes to improve the child-focus of services delivered by the Department of Health, Ministry of Justice and Home Office.

4. The Government should introduce new statutory targets for safeguarding and child protection alongside the existing statutory attainment and early years targets as quickly as possible. The National Indicator Set should be revised with new national indicators for safeguarding and child protection developed for inclusion in Local Area Agreements for the next Comprehensive Spending Review.

5. The Department of Health must clarify and strengthen the responsibilities of Strategic Health Authorities for the performance management of Primary Care Trusts on safeguarding and child protection. Formalised and explicit performance indicators should be introduced for Primary Care Trusts.

6. Directors of Children's Services, Chief Executives of Primary Care Trusts, Police Area Commanders and other senior service managers must regularly review all points of referral where concerns about a child's safety are received to ensure they are sound in terms of the quality of risk assessments, decision making, onward referrals and multi-agency working.

7. All Directors of Children's Services who do not have direct experience or background in safeguarding and child protection must appoint a senior manager within their team with the necessary skills and experience.

8. The Department for Children, Schools and Families should organise regular training on safeguarding and child protection and on effective leadership for all senior political leaders and managers across frontline services.

9. Every Children's Trust should ensure that the needs assessment that informs their Children and Young People's Plan regularly reviews the needs of all children and young people in their area, paying particular attention to the general need of children and those in need of protection. The National Safeguarding Delivery Unit should support Children's Trusts with this work. Government Offices should specifically monitor and challenge Children's Trusts on the quality of this analysis.

## Support for children

10. Ofsted should revise the inspection and improvement regime for schools giving greater prominence to how well schools are fulfilling their responsibilities for child protection.

11. The Department for Children, Schools and Families should revise *Working Together to Safeguard Children* to set out clear expectations at all points where concerns about a child's safety are received, ensuring intake/duty teams have sufficient training and expertise to take referrals and that staff have immediate, on-site support available from an experienced social worker. Local authorities should take appropriate action to implement these changes.

12. The Department of Health and the Department for Children, Schools and Families must strengthen current guidance and put in place the systems and training so that staff in Accident and Emergency departments are able to tell if a child has recently presented at any Accident and Emergency department and if a child is the subject of a Child Protection Plan. If there is any cause for concern, staff must act accordingly, contacting other professionals, conducting further medical examinations of the child as appropriate and necessary, and ensuring no child is discharged whilst concerns for their safety or well-being remain.

13. Children's Trusts must ensure that all assessments of need for children and their families include evidence from all the professionals involved in their

lives, take account of case histories and significant events (including previous assessments) and above all must include direct contact with the child.

14. Local authorities must ensure that 'Children in Need', as defined by Section 17 of the Children Act 1989, have early access to effective specialist services and support to meet their needs.

15. The Social Work Task Force should establish guidelines on guaranteed supervision time for social workers that may vary depending on experience.

16. The Department for Children, Schools and Families should revise *Working Together to Safeguard Children* to set out the elements of high quality supervision focused on case planning, constructive challenge and professional development.

17. The Department for Children, Schools and Families should undertake a feasibility study with a view to rolling out a single national Integrated Children's System better able to address the concerns identified in this report, or find alternative ways to assert stronger leadership over the local systems and their providers. This study should be completed within six months of this report.

18. Whether or not a national system is introduced, the Department for Children, Schools and Families should take steps to improve the utility of the Integrated Children's System, in consultation with social workers and their managers, to be effective in supporting them in their role and their contact with children and families, partners, services and courts, and to ensure appropriate transfer of essential information across organisational boundaries.

## Interagency working

19. The Department for Children, Schools and Families must strengthen *Working Together to Safeguard Children*, and Children's Trusts must take appropriate action to ensure:

- all referrals to children's services from other professionals lead to an initial assessment, including direct involvement with the child or young person and their family, and the direct engagement with, and feedback to, the referring professional;
- core group meetings, reviews and casework decisions include all the professionals involved with the child, particularly police, health, youth services and education colleagues. Records must be kept which must include the written views of those who cannot make such meetings; and

- formal procedures are in place for managing a conflict of opinions between professionals from different services over the safety of a child.

20. All police, probation, adult mental health and adult drug and alcohol services should have well understood referral processes which prioritise the protection and well-being of children. These should include automatic referral where domestic violence or drug or alcohol abuse may put a child at risk of abuse or neglect.

21. The National Safeguarding Delivery Unit should urgently develop guidance on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drugs and alcohol misuse using current best practice. This should be shared with local authorities, health and police with an expectation that the assessment of risk and level of support given to such children will improve quickly and significantly in every Children's Trust.

22. The Department for Children, Schools and Families should establish statutory representation on Local Safeguarding Children Boards from schools, adult mental health and adult drug and alcohol services.

23. Every Children's Trust should assure themselves that partners consistently apply the Information Sharing Guidance published by the Department for Children, Schools and Families and Department for Communities and Local Government to protect children.

## **Children's workforce**

24. The Social Work Task Force should:

- develop the basis for a national children's social worker supply strategy that will address recruitment and retention difficulties, to be implemented by the Department for Children, Schools and Families. This should have a particular emphasis on child protection social workers;

- work with the Children's Workforce Development Council and other partners to implement, on a national basis, clear progression routes for children's social workers;

- develop national guidelines setting out maximum case-loads of children in need and child protection cases, supported by a weighting mechanism to reflect the complexity of cases, that will help plan the workloads of children's social workers; and

- develop a strategy for remodelling children's social work which delivers shared ownership of cases, administrative support and multi-disciplinary support to be delivered nationally.

25. Children's Trusts should ensure a named, and preferably co-located, representative from the police service, community paediatric specialist and health visitor are active partners within each children's social work department.

26. The General Social Care Council, together with relevant government departments, should:

- work with higher education institutions and employers to raise the quality and consistency of social work degrees and strengthen their curriculums to provide high quality practical skills in children's social work;

- work with higher education institutions to reform the current degree programme towards a system which allows for specialism in children's social work, including statutory children's social work placements, after the first year; and

- put in place a comprehensive inspection regime to raise the quality and consistency of social work degrees across higher education institutions.

27. The Department for Children, Schools and Families and the Department for Innovation, Universities and Skills should introduce a fully-funded, practice-focused children's social work postgraduate qualification for experienced children's social workers, with an expectation they will complete the programme as soon as is practicable.

28. The Department for Children, Schools and Families, working with the Children's Workforce Development Council, General Social Care Council and partners should introduce a conversion qualification and English language test for internationally qualified children's social workers that ensures understanding of legislation, guidance and practice in England. Consideration should be given to the appropriate length of a compulsory induction period in a practice setting prior to formal registration as a social worker in England.

29. Children's Trusts should ensure that all staff who work with children receive initial training and continuing professional development which enables them to understand normal child development and recognise potential signs of abuse or neglect.

30. All Children's Trusts should have sufficient multi-agency training in place to create a shared language and understanding of local referral procedures, assessment, information sharing and decision making across early years, schools, youth services, health, police and other services who work to protect children. A named child protection lead in each setting should receive this training.

31. The General Social Care Council should review the Code of Practice for Social Workers and the employers' code ensuring the needs of children are paramount in both and that the employers' code provides for clear lines of accountability, quality supervision and support, and time for reflective practice. The employers' code should then be made statutory for all employers of social workers.

32. The Department of Health should prioritise its commitment to promote the recruitment and professional development of health visitors (made in *Healthy lives, brighter futures*) by publishing a national strategy to support and challenge Strategic Health Authorities to have a sufficient capacity of well trained health visitors in each area with a clear understanding of their role.

33. The Department of Health should review the Healthy Child Programme for 0–5-year-olds to ensure that the role of health visitors in safeguarding and child protection is prioritised and has sufficient clarity, and ensure that similar clarity is provided in the Healthy Child Programme for 5–19-year-olds.

34. The Department of Health should promote the statutory duty of all GP providers to comply with child protection legislation and to ensure that all individual GPs have the necessary skills and training to carry out their duties. They should also take further steps to raise the profile and level of expertise for child protection within GP practices, for example by working with the Department for Children, Schools and Families to support joint training opportunities for GPs and children's social workers and through the new practice accreditation scheme being developed by the Royal College of General Practitioners.

35. The Department of Health should work with partners to develop a national training programme to improve the understanding and skills of the children's health workforce (including paediatricians, midwives, health visitors, GPs and school nurses) to further support them in dealing with safeguarding and child protection issues.

36. The Home Office should take national action to ensure that police child protection teams are well resourced and have specialist training to support them in their important responsibilities.

## Improvement and challenge

37. The Care Quality Commission, HMI Constabulary and HMI Probation should review the inspection frameworks of their frontline services to drive improvements in safeguarding and child protection in a similar way to the new Ofsted framework.

38. Ofsted, the Care Quality Commission, HMI Constabulary and HMI Probation should take immediate action to ensure their staff have the appropriate skills, expertise and capacity to inspect the safeguarding and child protection elements of frontline services. Those Ofsted Inspectors responsible for inspecting child protection should have direct experience of child protection work.

39. The Department for Children, Schools and Families should revise *Working Together to Safeguard Children* so that it is explicit that the formal purpose of Serious Case Reviews is to learn lessons for improving individual agencies, as well as for improving multi-agency working.

40. The Department for Children, Schools and Families should revise the framework for Serious Case Reviews to ensure that the Serious Case Review panel chair has access to all of the relevant documents and staff they need to conduct a thorough and effective learning exercise.

41. The Department for Children, Schools and Families should revise *Working Together to Safeguard Children* to ensure Serious Case Reviews focus on the effective learning of lessons and implementation of recommendations and the timely introduction of changes to protect children.

42. Ofsted should focus its evaluation of Serious Case Reviews on the depth of the learning a review has provided and the quality of recommendations it has made to protect children.

43. The Department for Children, Schools and Families should revise *Working Together to Safeguard Children* to underline the importance of a high quality, publicly available executive summary which accurately represents the full report, contains the action plan in full, and includes the names of the Serious Case Review panel members.

44. Local Safeguarding Children Boards should ensure all Serious Case Review panel chairs and Serious Case Review overview authors are independent of the Local Safeguarding Children Board and all services involved in the case and that arrangements for the Serious Case Review offer sufficient scrutiny and challenge.

45. All Serious Case Review panel chairs and authors must complete a training programme provided by the Department for Children, Schools and Families that supports them in their role in undertaking Serious Case Reviews that have a real impact on learning and improvement.

46. Government Offices must ensure that there are enough trained Serious Case Review panel chairs and authors available within their region.

47. Ofsted should share full Serious Case Review reports with HMI Constabulary, the Care Quality Commission, and HMI Probation (as appropriate) to enable all four inspectorates to assess the implementation of action plans when conducting frontline inspections.

48. Ofsted should share Serious Case Review executive summaries with the Association of Chief Police Officers, Primary Care Trusts and Strategic Health Authorities to promote learning.

49. Ofsted should produce more regular reports, at six-monthly intervals, which summarise the lessons from Serious Case Reviews.

## Organisation and finance

50. The Department for Children, Schools and Families must provide further guidance to Local Safeguarding Children Boards on how to operate as effectively as possible following the publication of the Loughborough University research on Local Safeguarding Children Boards later this year.

51. The Children's Trust and the Local Safeguarding Children Board should not be chaired by the same person. The Local Safeguarding Children Board chair should be selected with the agreement of a group of multi-agency partners and should have access to training to support them in their role.

52. Local Safeguarding Children Boards should include membership from the senior decision makers from all safeguarding partners, who should attend regularly and be fully involved as equal partners in Local Safeguarding Children Board decision making.

53. Local Safeguarding Children Boards should report to the Children's Trust Board and publish an annual report on the effectiveness of safeguarding in the local area. Local Safeguarding Children Boards should provide robust challenge to the work of the Children's Trust and its partners in order to ensure that the right systems and quality

of services and practice are in place so that children are properly safeguarded.

54. The Department for Children, Schools and Families, the Department of Health, and the Home Office, together with HM Treasury, must ensure children's services, police and health services have protected budgets for the staffing and training for child protection services.

55. The Department for Children, Schools and Families must sufficiently resource children's services to ensure that early intervention and preventative services have capacity to respond to all children and families identified as vulnerable or 'in need'.

56. A national annual report should be published reviewing safeguarding and child protection spend against assessed needs of children across the partners in each Children's Trust.

## Legal

57. The Ministry of Justice should lead on the establishment of a system wide target that lays responsibility on all participants in the care proceedings system to reduce damaging delays in the time it takes to progress care cases where these delays are not in the interests of the child.

58. The Ministry of Justice should appoint an independent person to undertake a review of the impact of court fees in the coming months. In the absence of incontrovertible evidence that the fees had not acted as a deterrent, they should then be abolished from 2010/11 onwards.

Ref: <http://publications.everychildmatters.gov.uk/eOrderingDownload/HC-330.pdf>

**APPENDIX 2**

**EAST AYRSHIRE CHILD PROTECTION COMMITTEE**

**PERFORMANCE AND AUDIT SUB GROUP**

**JOINT AREA REVIEW HARINGEY CHILDREN'S SERVICES AUTHORITY AREA**

**EAST AYRSHIRE CHIEF OFFICERS GROUP – 2 JUNE 2009**

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## **CIRCUMSTANCES OF BABY P'S DEATH**

On 03.08.07 at approximately 11.30am Ms A (mother of baby P - a White child of Irish ethnic origin) called the London Ambulance Service. Attending paramedics took the apparently lifeless body of baby P (aged seventeen months) to the North Middlesex University Hospital.

In spite of efforts by Ambulance and hospital staff to revive him, baby P was pronounced dead at 12.10pm. A post mortem completed on 06.08.07 offered as a provisional cause of death 'a fracture / dislocation of the thoraco-lumbar spine'.

At the time of his death, baby P was subject of a multi-agency child protection plan.

Police enquiries established that at the time of baby P's death, Ms A's boyfriend Mr H lived at her address and Mr G, his three children and a fifteen year old female whom he described as his girlfriend had been staying there since 17.07.07.

Ms. A, Mr H and Mr G were charged with murder and causing or allowing the death of a child. On 11 November 2008 Mr H and Mr G were convicted of causing or allowing the death of baby P. Mrs A had already pled guilty to this charge.

## KEY ISSUES

1. Baby P had been subject to a child protection plan from 22 December 2006, following concerns that he had been abused and neglected. He was still subject to this plan when he died.
2. Agencies did not know the full details of the child's living circumstances in relation to who was living in the house/having frequent contact and what was known about these individuals.
3. Baby P was the fourth child in his family group – there had been no previous concerns in respect of the children prior to December 2006. (Parents separated 6 months before initial child protection concern raised)
4. Family friend was utilised as part of child protection plan and there was insufficient assessment, monitoring and review of her role and performance.
5. Mother's description of child as active, clumsy and with a high pain threshold seemed plausible as workers observed the child throwing himself around. A paediatric assessment was commissioned to investigate this but was delayed and when Baby P was seen (2 days before death) he was judged unwell and a follow up appointment made.
6. Re-assessment did not take place following new or repeated concerns; instead these were interpreted alongside original assessment.
7. The lack of an identified perpetrator contributed to lack of action in relation to child protection procedures.
8. Mother's overt co-operation and observed positive parenting led to high degree of trust.
9. Legal services advised case did not meet criteria for formal care proceedings.
10. During the last month of his life the mother presented her son to health professionals eight times. In his last week he was seen both by a social worker and by a paediatrician. None of these professionals identified major concerns about his health and well-being.

A special joint area review was commissioned in November 2008 by the Secretary of State for Children, Schools and Families. It was commissioned following the death of Baby P in Haringey and the subsequent findings of the serious case review, which examined the circumstances of the baby's death and the role of each of the services involved with the family.

The inspection commenced on 13 November 2008 and was completed by 26 November 2008. It was carried out by a multi-disciplinary team of seven

Inspectors from Ofsted, the Healthcare Commission and Her Majesty's Inspectorate of Constabulary.

Ofsted has judged the quality of the serious case review relating to Baby P to be inadequate. The terms of reference are insufficiently comprehensive, lack clarity, and were not finalised until 12 December 2007. This was four months after the serious case review process began, and when the writing of the individual management reviews by the relevant agencies had already been completed. This resulted in some important aspects not being adequately considered, such as the capacity of front line services, the effectiveness of provision for other children in the family, and the reasons why agencies failed to discover the two men living in the household. There was insufficient independence of the serious case review panel; the panel was chaired by the director of the children and young people's service, who also chairs the local safeguarding children board.

## **MAIN FINDINGS**

The main findings of this inspection, described below, point to significant weakness in safeguarding and child protection arrangements in Haringey. They also show that the arrangements for the leadership and management of safeguarding by the local authority and partner agencies in Haringey were inadequate.

- There was insufficient strategic leadership and management oversight of safeguarding of children and young people from Haringey by elected members, senior officers and others within the strategic partnership.
- There was a managerial failure to ensure full compliance with some requirements of the inquiry into the death of Victoria Climbié, such as the lack of written feedback to those making referrals to social care services.
- The local safeguarding children board (LSCB) failed to provide sufficient challenge to its member agencies. This was further compounded by the lack of an independent chairperson.
- Social care, health and police authorities did not communicate and collaborate routinely and consistently to ensure effective assessment, planning and review of cases of vulnerable children and young people.
- Too often assessments of children and young people, in all agencies, failed to identify those who are at immediate risk of harm and to address their needs.
- The quality of front line practice across all agencies was inconsistent and not effectively monitored by line managers.
- Child protection plans were generally poor.

- Arrangements for scrutinising performance across the council and the partnership were insufficiently developed and failed to provide systematic support and appropriate challenge to both managers and practitioners.
- The standard of record keeping on case files across all agencies was inconsistent and often poor.
- There was too much reliance on quantitative data to measure social care, health, and police performance, without sufficiently robust analysis of the underlying quality of service provision and practice.

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## KEY RECOMMENDATIONS

The Department for Children, Schools and Families should provide immediate appropriate support and challenge to the local authority to ensure that comprehensive and effective safeguarding arrangements for children and young people are established.

RECOMMENDATION	Circumstance in Haringey	CHILD PROTECTION COMMITTEE	SINGLE AGENCY	TIMESCALE
<p>1. Improve governance of safeguarding arrangements. In particular, they should ensure full compliance with the guidance contained within 'Working Together to Safeguard Children' 2006 and embed the London protocol for inter-agency working to improve outcomes for children and young people</p>		<ul style="list-style-type: none"> <li>• East Ayrshire Child Protection Guidelines are in place and are known to staff and used</li> <li>• The West of Scotland Chairs consortium have commissioned the re writing of the Child Protection Procedures. The CPC are awaiting the production of these to incorporate them into new East Ayrshire Child Protection Procedures</li> </ul>		<p>Date to be confirmed 2009 for West of Scotland Procedures</p>

RECOMMENDATION	Circumstance in Haringey	CHILD PROTECTION COMMITTEE	SINGLE AGENCY	TIMESCALE
<p>2. Establish more secure assessment and earlier intervention strategies which ensure that, in all cases where concerns about children are identified, agencies can intervene and assess risks of significant harm to children in a timely manner.</p>	<ul style="list-style-type: none"> <li>• Inconsistencies in the application of the thresholds for access to children in need and child protection services.</li> <li>• Following referral, arrangements for gathering information from relevant and involved parties was generally poor. The requirement that referrers be informed in writing of action taken in response to the referral was not routinely met.</li> <li>• All children's social care cases were allocated a social worker. However, workloads were heavy and some staff reported that they are unable to action all cases effectively as a result. Some allocations of cases within social care services were made electronically and without discussion with social workers.</li> </ul>	<ul style="list-style-type: none"> <li>• GIFREC referral meeting</li> <li>• Performance and audit sub group completing self evaluation of assessing risks and need.</li> <li>• Management information for CPC to include information in relation to staffing levels to highlight workload capacity issues in Social Work and other services such as Health Visiting</li> <li>• All child protection referrals, referrer sent a standard letter</li> <li>• IAF process agreed implementation plan being developed</li> </ul>	<ul style="list-style-type: none"> <li>• Risk Assessment training to all front line social workers completed</li> <li>• Social Work Eligibility criteria agreed and distributed.</li> <li>• No electronic allocation of SW cases in East Ayrshire. Case prioritisation process in place and weekly allocation meetings. Review of caseloads currently underway, and subject to regular monitoring.</li> </ul>	<p>Current plan ongoing from April 2009.</p> <p>Agencies to submit staffing level information on 6 monthly basis to CP Co-ordinator. Report to CPC October 2009.</p> <p>IAF Implementation plan to be agreed May 2009</p>

RECOMMENDATION	Circumstance in Haringey	CHILD PROTECTION COMMITTEE	SINGLE AGENCY	TIMESCALE
<p>3. Establish more systematic monitoring of the quality of practice.</p>	<ul style="list-style-type: none"> <li>• Case file recording for individual children and young people was inadequate. There was insufficient evidence of managerial oversight and decision-making on case records in children's social care services, police and health services. There was limited evidence of thorough, analytical and reflective supervision to ensure individual casework is carried out effectively.</li> <li>• Police and health service files were often poorly organised and the process and planning of individual cases is difficult to follow.</li> <li>• Not all children's social care files had a chronology of the individual case.</li> <li>• While some files demonstrate that children and young people were seen and spoken to and their views taken into account, this was not</li> </ul>	<ul style="list-style-type: none"> <li>• Agencies to provide details of the mechanisms in place for monitoring the quality of practice to the Performance and Audit sub group/ Child Protection Co-ordinator</li> <li>• Key agencies to provide CPC with information in relation to the outcomes of the monitoring of Practice.</li> <li>• Training calendar to include course on record keeping and report writing in child protection.</li> <li>• All Child Protection files include chronology</li> <li>• Staff supervision tool being developed to assist</li> </ul>	<ul style="list-style-type: none"> <li>• Agencies responsible for monitoring quality of practice and submit details to performance and audit sub group</li> </ul>	<p>Agencies to submit details of mechanisms by September 2009.</p> <p>Outcome monitoring to be submitted to Performance and Audit on annual basis</p> <p>Tool developed June 2009 and piloted in Social Services.</p>

RECOMMENDATION	Circumstance in Haringey	CHILD PROTECTION COMMITTEE	SINGLE AGENCY	TIMESCALE
	<p>consistently demonstrated in assessments. Where the child had not been seen alone, there was limited evidence of managers addressing the reasons for this and enabling the child's voice to be heard.</p> <ul style="list-style-type: none"> <li>• There were frequent unacceptable and extreme delays in distributing to partner agencies the minutes of key meetings, such as child protection conferences, core groups and statutory reviews of looked after children and young people.</li> <li>• Assessment and care planning were poor overall.</li> </ul>	<p>self evaluation- one area focus recording of views of the child</p> <ul style="list-style-type: none"> <li>• Business Object reports to be created in relation to monitoring the timescales of distribution of CPCC minutes. Information to be included in the management information reports for CPC</li> </ul>		<p>Information available for CPC from October 2009.</p>
<p>4. Ensure that managers and staff at all levels are accountable for casework decisions, and that they draw as necessary on the expertise of partner agencies to inform</p>	<ul style="list-style-type: none"> <li>• Inter-agency cooperation in child protection work was inadequate. The majority of child protection strategy discussions on files read during the inspection only involve staff from children's social care services and the police.</li> <li>• Relevant information from</li> </ul>	<ul style="list-style-type: none"> <li>• CPC/Performance and audit sub group to collate partner agencies accountability frameworks.</li> <li>• Performance and audit sub group self evaluation of assessing risks and</li> </ul>		<p>October 2009</p> <p>Refer to assessing risks and needs self</p>

RECOMMENDATION	Circumstance in Haringey	CHILD PROTECTION COMMITTEE	SINGLE AGENCY	TIMESCALE
<p>the decision making process.</p>	<p>ViSOR was not currently obtained to inform decision-making and risk assessment.</p> <ul style="list-style-type: none"> <li>• Not all children and young people who attended accident and emergency services were checked against the list of those subject to child protection plans.</li> <li>• Child protection plans were generally poor. Insufficient involvement of key staff from health and other agencies to ensure plans take full account of the child's needs.</li> <li>• In many cases there was a lack of clarity about what needs to be done, and by whom, to reduce identified risk and there is little evidence of the impact on improving the safety or welfare of the child.</li> <li>• In some cases, children and young people are not consulted in order to establish their views about their child protection plan. While attendance at child protection</li> </ul>	<p>needs will look at multi agency working and impact on decision making</p> <ul style="list-style-type: none"> <li>• Current A&amp;E does not check all children if on CPR.</li> <li>• A&amp;E does not have access to live CPR would need to contact local keepers of register or standby</li> <li>• Multi agency child protection plans in place</li> <li>• CPC to consider the implementation of a monitoring system for children and young people's attendance at Child Protection Case Conference and the recording of their views. Detailed in Self evaluation action</li> </ul>	<ul style="list-style-type: none"> <li>• Health to consider a system to ensure A &amp; E staff able to easily access child protection register information.</li> </ul>	<p>evaluation plan.</p> <p>November 2009</p> <p>Refer to assessing risks and needs self evaluation plan.</p>

RECOMMENDATION	Circumstance in Haringey	CHILD PROTECTION COMMITTEE	SINGLE AGENCY	TIMESCALE
	<p>conferences by children, young people, parents, carers, was monitored, the information was not collated and analysed by the local safeguarding children board, which limits its oversight and impedes improvement of the process.</p>			
<p>5. Take steps to integrate individual service processes and systems across all agencies more effectively, so that all children and young people are safeguarded.</p>	<ul style="list-style-type: none"> <li>• Staff expressed concern to the inspectors about the quality of some foster families and the lack of robust arrangements to ensure that the views of placing social workers were sought to inform the annual foster carer review.</li> <li>• There are indications that police child abuse investigation teams were not always receiving required information in domestic violence cases</li> </ul>	<ul style="list-style-type: none"> <li>• GIFREC referral meeting</li> <li>• IAF development</li> <li>• The views of social workers requested for all carers' reviews. Robust system being put in place to follow up if SW views are not submitted. Concerns raised are investigated and outcomes recorded for the Care Commission. Social workers are</li> </ul>		<p>In place</p> <p>IAF Implementation plan being developed</p>

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		<p>routinely asked suitability of the placement at each child's LAAC review.</p>		
<p>6. Assure the competence of leadership and management in all areas of children's services and develop clear and effective accountability structures.</p>	<ul style="list-style-type: none"> <li>The work of the local safeguarding children board was insufficiently robust. Whilst it maintained a focus on the wider safeguarding agenda, the impact of this work on making life safer and more secure for children and young people is not well evidenced.</li> </ul>	<ul style="list-style-type: none"> <li>Agencies to give CPC reassurance in relation to the accountability structures within their organisation and processes in place to ensure competence of leadership and management.</li> </ul>	<ul style="list-style-type: none"> <li>Single agencies responsible for ensuring competence of leadership and management</li> </ul>	<p>October 2009 and ongoing</p>
<p>7. Establish rigorous arrangements for management of performance across all agencies, which ensure that the quality of practice is evaluated and reported regularly and reliably, and that accountability for each action is</p>	<ul style="list-style-type: none"> <li>Performance management arrangements across agencies were insufficiently robust. The reliance on national and local performance indicators was too great and did not enable understanding of the quality and effectiveness of service provision on the ground.</li> <li>Insufficient attention was given to evaluating the quality</li> </ul>	<p>Recent HMle report should provide a basis of the standard of practice.</p> <p>Planned programme of self evaluation will provide evidence of improvement.</p> <p>Performance and audit sub group reviewing the format of the management information provided to the</p>		<p>Plan developed implemented from May 2009.</p> <p>Revised Management information to CPC from</p>

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defined and monitored.	<p>of front line practice and quantifying the impact of services upon children.</p> <ul style="list-style-type: none"> <li>• There was a failure to use the outcomes from qualitative audit activity to critically self evaluate and to report on the actual outcomes for children and young people.</li> </ul>	<p>child protection committee to ensure that multi agency information is available</p>		October 2009.
8. Make explicit to all staff and elected members the expectations and standards required of front line child protection practice.	<ul style="list-style-type: none"> <li>• Child protection training was mandatory for all health services staff.</li> <li>• Police training provision was compliant with the Victoria Climbié recommendations.</li> <li>• Staff in schools reported that the quality of child protection training is good, with very useful advice and support provided by Child Protection advisers.</li> </ul>	<ul style="list-style-type: none"> <li>• Single/Multi agency Child protection training (4 tiers). Multi agency calendar currently being further developed.</li> <li>• Child protection procedures in place and awaiting review</li> <li>• CPC Practitioners Forum meets 4 times a year</li> <li>• Child Protection Web pages</li> <li>• Prominence of work of Child Protection Committee</li> </ul>		Ongoing

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<p>9. Establish rigorous procedures to audit and monitor the quality of case files across all partner agencies and ensure processes are in place to deliver improvement.</p>	<ul style="list-style-type: none"> <li>The existing social care electronic recording system operated by the council lacked sufficient flexibility and, although this impeded effective practice by social workers, there was insufficient priority given to resolving this issue by managers.</li> </ul>	<ul style="list-style-type: none"> <li>First performance and audit case file audit completed 2008.</li> <li>Performance and Audit sub group set up a file auditing group to complete a tiered approach to case file auditing including auditing a number of cp1s</li> </ul>		<p>Ongoing from June 2009.</p>
<p>10. Establish clear procedures and protocols for communication and collaboration between social care, health and police services to support safeguarding of children, and ensure that these are adhered to.</p>	<ul style="list-style-type: none"> <li>The high turnover of qualified social workers in some social care teams had resulted in heavy reliance on agency staff, who make up 51 of 121 established social worker posts. This resulted in lack of continuity for children and their families and of care planning.</li> <li>There was limited evidence of the priorities and policies of the children and young people's plan being robustly put into practice on the ground.</li> </ul>	<ul style="list-style-type: none"> <li>East Ayrshire Information Sharing Protocol in place and recently reviewed- self evaluation and case file audit to evidence its usage.</li> <li>GIFREC/IAF processes</li> <li>JiIT interviews</li> <li>Tripartite discussions</li> <li>Corporate Parenting plan</li> </ul>		

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	<ul style="list-style-type: none"> <li>Corporate parenting arrangements are underdeveloped and there is currently a lack of shared responsibility across the council for this function.</li> </ul>	<p>developed and roll out of we can and must do better to be completed</p>		December 2009
<p>11. Assure the competence of service and team managers in conducting rigorous and evaluative supervision and monitoring of safeguarding practice.</p>	<ul style="list-style-type: none"> <li>Individual case files in all agencies showed too little evidence of management oversight and decision-making. A high priority was given to ensuring regular supervision of staff, and most staff across all services report that they received regular supervision and felt well supported by their line managers. However, records of case discussions were not routinely placed on service users' files. This is unacceptable.</li> <li>There were some good policies, but they are often not acted upon, such as the social care supervision policy, with the result that outcomes for children and young people</li> </ul>	<ul style="list-style-type: none"> <li>All agencies to provide the CPC evidence that supervision systems are in place and being implemented effectively</li> <li>CPC seek confirmation of the mechanisms in place to monitor supervision practices</li> <li>CPC consider an audit of supervision notes/ supervision monitoring</li> <li>Supervision to be of a high quality and focus on case planning, constructive challenge and professional</li> </ul>		Agency reassurance and details of monitoring submitted by September 2009

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	are seriously compromised.	development.		
12. Appoint an independent chairperson to the local safeguarding children board (LSCB).	<ul style="list-style-type: none"> <li>• The management arrangements within the council and across the partnership did not facilitate sufficient independent challenge on safeguarding matters. The local safeguarding children board was chaired by the director of the children and young people's service.</li> <li>• The management arrangements for independent reviewing officers, with senior management responsibility resting with the deputy director of the children and young people's service, were insufficiently independent of operational line management in social care.</li> </ul>	<ul style="list-style-type: none"> <li>• Chair of CPC is operational manager of social services. Child Protection Committee members to consider current chairing arrangements and whether appointment of an independent chair should be explored</li> <li>• Independent chairperson of child protection case conferences in place but managed by Service Manager Children and Families (adoption and fostering). Child Protection</li> </ul>		CPC to discuss chairing options for the CPC at development day 22.06.09.

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		committee members to consider any possible restrictions this may place on independence.		

Whilst not a mandatory requirement, it would be good practice for the Local Authority to:

Ensure that all elected members have CRB checks	<ul style="list-style-type: none"> <li>Not all elected members had CRB check</li> </ul>	<ul style="list-style-type: none"> <li>To ensure that all elected members receive child protection training</li> </ul>		October 2009.
Ensure that all elected members undertake safeguarding training.	<ul style="list-style-type: none"> <li>Some elected members had not received child Protection or safeguarding training</li> </ul>	<ul style="list-style-type: none"> <li>To ensure that all elected members have undertaken child protection training</li> </ul>		October 2009