EAST AYRSHIRE CHILD PROTECTION COMMITTEE

PERFORMANCE AND AUDIT SUB GROUP

JOINT AREA REVIEW HARINGEY CHILDREN'S SERVICES AUTHORITY AREA

APRIL 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.

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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

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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 Climbie, 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.

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- 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
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		• East Ayrshire Child Protection Guidelines are in place and are known to staff and used • 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		Date to be confirmed 2009 for West of Scotland Procedures

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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.	• Inconsistencies in the application of the thresholds for access to children in need and child protection services. • 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. • 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.	• GIFREC referral meeting • Performance and audit sub group completing self evaluation of assessing risks and need. • 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 • All child protection referrals, referrer sent a standard letter • IAF process agreed implementation plan being developed	• Risk Assessment training to all front line social workers completed • Social Work Eligibility criteria agreed and distributed. • 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.	Current plan ongoing from April 2009. Agencies to submit staffing level information on 6 monthly basis to CP Co-ordinator. Report to CPC October 2009. IAF Implementation plan to be agreed May 2009

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3. Establish more systematic monitoring of the quality of practice.	• 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. • Police and health service files were often poorly organised and the process and planning of individual cases is difficult to follow. • Not all children's social care files had a chronology of the individual case. • While some files demonstrate that children and young people were seen and spoken to and their views taken into account, this was not	• 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 • Key agencies to provide CPC with information in relation to the outcomes of the monitoring of Practice. • Training calendar to include course on record keeping and report writing in child protection. • All Child Protection files include chronology • Staff supervision tool being developed to assist	• Agencies responsible for monitoring quality of practice and submit details to performance and audit sub group	Agencies to submit details of mechanisms by September 2009. Outcome monitoring to be submitted to Performance and Audit on annual basis Tool developed June 2009 and piloted in Social Services.

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	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. • 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. • Assessment and care planning were poor overall.	self evaluation- one area focus recording of views of the child • 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		Information available for CPC from October 2009.
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	• 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. • Relevant information from	• CPC/Performance and audit sub group to collate partner agencies accountability frameworks. • Performance and audit sub group self evaluation of assessing risks and		October 2009 Refer to assessing risks and needs self

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the decision making process.	ViSOR was not currently obtained to inform decision-making and risk assessment. • Not all children and young people who attended accident and emergency services were checked against the list of those subject to child protection plans. • 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. • 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. • 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	needs will look at multi agency working and impact on decision making • Current A&E does not check all children if on CPR. • A&E does not have access to live CPR would need to contact local keepers of register or standby • Multi agency child protection plans in place • 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	• Health to consider a system to ensure A & E staff able to easily access child protection register information.	evaluation plan. November 2009 Refer to assessing risks and needs self evaluation plan.

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	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.			
5. Take steps to integrate individual service processes and systems across all agencies more effectively, so that all children and young people are safeguarded.	• 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. • There are indications that police child abuse investigation teams were not always receiving required information in domestic violence cases	• GIFREC referral meeting • IAF development • 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		In place IAF Implementation plan being developed

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		routinely asked suitability of the placement at each child's LAAC review.		
6. Assure the competence of leadership and management in all areas of children's services and develop clear and effective accountability structures.	• 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.	• 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.	• Single agencies responsible for ensuring competence of leadership and management	October 2009 and ongoing
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	• 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. • Insufficient attention was given to evaluating the quality	Recent HMIe report should provide a basis of the standard of practice. Planned programme of self evaluation will provide evidence of improvement. Performance and audit sub group reviewing the format of the management information provided to the		Plan developed implemented from May 2009. Revised Management information to CPC from

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defined and monitored.	of front line practice and quantifying the impact of services upon children. • 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.	child protection committee to ensure that multi agency information is available		October 2009.
8. Make explicit to all staff and elected members the expectations and standards required of front line child protection practice.	• Child protection training was mandatory for all health services staff. • Police training provision was compliant with the Victoria Climbie recommendations. • Staff in schools reported that the quality of child protection training is good, with very useful advice and support provided by Child Protection advisers.	• Single/Multi agency Child protection training (4 tiers). Multi agency calendar currently being further developed. • Child protection procedures in place and awaiting review • CPC Practitioners Forum meets 4 times a year • Child Protection Web pages • Prominence of work of Child Protection Committee		Ongoing

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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.	• 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.	• First performance and audit case file audit completed 2008. • 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		Ongoing from June 2009.
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.	• 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. • 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.	• East Ayrshire Information Sharing Protocol in place and recently reviewed- self evaluation and case file audit to evidence its usage. • GIFREC/IAF processes • JIIT interviews • Tripartite discussions • Corporate Parenting plan		

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	• Corporate parenting arrangements are underdeveloped and there is currently a lack of shared responsibility across the council for this function.	developed and roll out of we can and must do better to be completed		December 2009
11. Assure the competence of service and team managers in conducting rigorous and evaluative supervision and monitoring of safeguarding practice.	• 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. • 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	• All agencies to provide the CPC evidence that supervision systems are in place and being implemented effectively • CPC seek confirmation of the mechanisms in place to monitor supervision practices • CPC consider an audit of supervision notes/ supervision monitoring • Supervision to be of a high quality and focus on case planning, constructive challenge and professional		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).	• 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. • 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.	• 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 • Independent chairperson of child protection case conferences in place but managed by Service Manager Children and Families (adoption and fostering). Child Protection		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	• Not all elected members had CRB check	• To ensure that all elected members receive child protection training		October 2009.
Ensure that all elected members undertake safeguarding training.	• Some elected members had not received child Protection or safeguarding training	• To ensure that all elected members have undertaken child protection training		October 2009

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