EAST AYRSHIRE COUNCIL

EDUCATION COMMITTEE: 4 FEBRUARY 2004

Report of the Caleb Ness Inquiry – Implications for East Ayrshire

Report by the Director of Educational and Social Services

1. PURPOSE OF REPORT

1.1 This report informs members of the recommendations made about Child Protection practice detailed in the Report of the Caleb Ness Inquiry and advises of the position in East Ayrshire in respect of each recommendation.

2. BACKGROUND

2.1 On 18 October 2001, Caleb Alexander Ness was admitted to the Royal Hospital for Sick Children, Edinburgh and pronounced dead. It was immediately suspected that the baby had been the victim of non-accidental injury and an autopsy was carried out. There was evidence of very widespread focal fresh haemorrhage in all the compartments of the brain. The findings suggested rapid death following traumatic injury, probably caused by rough shaking of the baby. There was also evidence of 14 definite rib fractures, with three categories of age relating to those fractures. Some were new, probably sustained during the course of the morning of 18 October; some fractures were approximately one week to 10 days old; and one fracture was several weeks old. It was concluded that there had been at least three separate episodes of trauma to the chest, probably caused by gripping and shaking. Caleb had been born on 30 July 2001 and was 11 weeks old at the time of his death.

2.2 The baby's mother had been a drug addict for over 20 years, and was taking methadone by prescription throughout her pregnancy. She had a long history of prostitution, and many criminal convictions. Her two children had ended up by being taken into care, after many unsuccessful efforts had been made to end her addiction. News of her pregnancy in 2001 only reached the social work department by chance.

2.3 The baby's father, Alexander Ness, went to trial charged with assault and murder. Eventually, in February 2003, he pled guilty to culpable homicide. It was accepted that he could establish diminished responsibility caused by brain injuries he had sustained some months before the baby was born. He had met the mother, Shirley Malcolm in the autumn of 2000, soon after being released from prison on licence after serving most of a

five year sentence for drug related offences. His earlier criminal history included a conviction for very serious assault of an adult.

2.4 A Child Protection Case Conference was held while the baby was still in hospital on 9 August 2001. Caleb was put on the Child Protection Register. Later, he went home with his mother. It was well known that his father would be visiting often, although he was not actually living with the mother. No further decision or formal review of risk took place before the baby died.

2.5 The Inquiry reached the conclusion that this was an avoidable child death and that neither parent should have had unsupervised care of Caleb.

2.6 The findings and recommendations of the Report are discussed in section 4 of this report.

2.7 A copy of the Executive Summary Report is lodged in the Members Information Point.

3. WIDER CONTEXT

3.1 In November 2002 the Scottish Executive published the report of its audit and review of child protection services in Scotland entitled *It's Everyone's Job to make sure I'm Alright.* The review had been commissioned in response to the death of the child Kennedy McFarlane in Dumfries and Galloway and made 17 recommendations focusing on seven areas for improvement. A report on the audit and review was presented to Social Work Committee on 27th March 2003.

3.2 Many of the recommendations contained in the report are mirrored in the Caleb Ness Inquiry Report.

3.3 Following publication of the audit and review a national implementation team was established to support local agencies in improving child protection arrangements. The team is currently developing National Standards in relation to what children in need of protection can expect from agencies.

3.4 A report into the death of Carla Nicole Bone in Aberdeen was published by the North East Scotland Child Protection Committee in November 2003. Some of the key themes in the report correlate with these in the Caleb Ness Inquiry Report.

3.5 Prior to the publication of the Caleb Ness Inquiry Report significant developments in Child Protection practice in East Ayrshire had already taken place. These were described in a report to Education Committee on

11 November 2003 (*Child Protection Policy and Practice developments – Progress Statement*).

3.6 In that same report, it was recommended that a further report on the implications of the Caleb Ness report be presented to the next meeting of the Education Committee, following the Inquiry Report being considered at the East Ayrshire Child Protection Committee on 26 November 2003. The present report fulfils that recommendation.

4. FINDINGS OF THE CALEB NESS INQUIRY

4.1 The Executive Summary of the Inquiry Report highlights 14 fundamental factors contributing to Caleb's death and makes 35 recommendations. Some of these recommendations relate to the specific situation in Edinburgh and the Lothians, but many have implications for child protection practice throughout Scotland.

4.2 Key Themes included:-

- A failure by all concerned to take account of background information about both parent's and Caleb's older siblings which was readily available.

- The whole Child Protection Case Conference process was flawed, with important information not being made available and a detailed Child Protection Plan not being agreed.

- There was a failure on the part of workers to undertake a rigorous assessment of risk and to co-ordinate regular home visits.

- There was a lack of supervision of staff and a lack of management involvement.

- Individual agencies were not working together effectively, with no single person holding a knowledge of all the facts and with information being collected in a piecemeal fashion.

- Professionals in all agencies made assumptions about the knowledge, training and actions of others and there was an identified gulf of collective professional responsibility for child protection.

- Several workers felt constrained from sharing information because of a perceived duty of confidentiality to Caleb's parents and a lack of knowledge about the relevant guidance on sharing confidential information in a Child Protection context.

- Child Protection Training was seen as a major requirement before services could be improved.

- There was an absence of clear accountability for Child Protection within Health agencies.

5. IMPLICATIONS FOR EAST AYRSHIRE

5.1 Health

- Protocol to be established to improve the treatment and care of babies born with neonatal abstinence syndrome. Additionally, that an automatic referral be made to Social Work of any baby born with neonatal abstinence syndrome who has not been identified pre-birth.

- Advice to staff at all levels on the extent to which a patient's right to medical confidentiality can be breached when a child is at risk. To include the expectation that health care professionals will notify Social Work Department if they anticipate there may be a risk after birth for a child still in utero, even if it means breaching confidentiality of either mother or father and that this is included in file.

- Clear lines of accountability to be identified.

5.2 Child Protection Guidelines

East Ayrshire Guidelines need to be updated to reflect this and other inquiry reports. Additions from this report will include:

- Explicit discussion and decisions as to whether or nor the child should be discharged to the care of the parent should always be part of a Child Protection Case Conference (CPCC) for a newborn baby.

- Expectation that health care professionals will notify Social Work if they anticipate there may be risk after birth for an unborn child, even if it means breaching the duty of confidentiality owed to mother or father.

5.3 Social Work

The recommendations made in this report aimed at Social Work comprise the following points:

- Chairperson of CPCC to sign the minute.

- Invitation to CPCC for police to contain relevant information so that their records can be checked prior to CPCC.

- Checklist of invitees for CPCCs to be established.

- Child Protection Reviewing Officer to chair all CPCCs.

- Reporter to be invited to all initial CPCCs.

- Team Leader to attend CPCC along with case worker.

- Core Groups to take place on monthly basis.

- Weekly visits and reporting to senior management.

- Training has been identified as a high priority within this report, as well as other inquiry reports.

5.4 An audit of current practice and procedures in East Ayrshire has been undertaken and it has been established that local practice and procedures already comply with the main recommendations made in the report. 5.5 In particular, the following progress has been made:

- With the appointment of Child Protection Co-ordinator, Child Protection Reviewing Officer and Child Protection Advisor LHCC procedures already introduced have been implemented fully, with effective management of the Case Conference System and Quality Assurance audit of practice.

- The other two major developments are in the development of a training package for all staff who are involved with families. The training is multi-agency and includes staff from housing, early years, social work, health and addiction services. Approximate numbers to benefit from this training in 2004 will be 2700. This figure however does not currently include the voluntary sector.

- The Health Advisor LHCC is also involved in this training, as well as developing and facilitating specific training for health staff. This post also involves peer support and supervision of staff who are involved in Child Protection work.

- Within East Ayrshire Child Protection Guidelines there is very clear guidance on complex issues like confidentiality and the referral process for Child Protection concerns. However, the challenge for the future is to ensure full implementation of the guidelines so that a culture which encompasses the Scottish Executive's vision for Scotland's children

can be developed. In particular, it is important to establish robust joint agreements with Health to ensure that children receive the highest level of protection achievable.

5.5 Appendix 1 describes the position in East Ayrshire relative to each of the recommendations of the Inquiry Report and indicates where appropriate what further action is required by agencies in East Ayrshire. The action plan will be considered by East Ayrshire Child Protection Committee when it meets on 21 January 2004.

6. LEGAL IMPLICATIONS

NIL

7. FINANCIAL IMPLICATIONS

7.1 The cost of Child Protection service improvements are funded from the allocation of Changing Children's Services Fund monies which the Council has received for the period 2003-2004 to 2005-2006. Consideration will need to be given in due course to sustainability beyond the term of that funding.

8. PERSONNEL IMPLICATIONS

8.1 The importance of Child Protection practice underpins a number of the revised arrangements for strengthening frontline social work services, on which a separate report is presented for members' consideration elsewhere on the present agenda.

9. RECOMMENDATIONS

9.1 Committee is requested to:

(i) note of the implications for East Ayrshire arising from the Caleb Ness Inquiry Report and the progress being made in addressing those implications;

(ii) note that the report will also be considered by the Social Work Committee when it meets on 29 January 2004;

(iii) instruct the Director of Educational and Social Services to present further progress reports to Committee as appropriate.

John Mulgrew
Director of Educational and Social Services
5th January 2004

For further information on this report, please contact John Alexander, Principal Officer (Quality and Planning), Civic Centre, John Dickie Street, Kilmarnock. (Tel 01563 576978).

IMPLEMENTATION OFFICER: JACKIE DONNELLY, HEAD OF SOCIAL WORK

List of Background Papers:

1. Report of the Caleb Ness Inquiry

APPENDIX 1

REPORT TO EAST AYRSHIRE CHILD PROTECTION COMMITTEE ON CALEB NESS INQUIRY REPORT – IMPLICATIONS FOR EAST AYRSHIRE.

Recommendations of Report	Response in East Ayrshire	Timescale	Responsibility
1. RECOMMEND that the CPCC minute format is changed, so that the Chairperson has an opportunity and obligation to sign the Minutes	Established practice currently		
2. RECOMMEND that an explicit discussion and decision as to whether or not the child should be discharged to the care of the parent should always be part of a CPCC for a newborn baby	(a)Establish protocol for discharge of babies where there are CP concerns. (b) Protocol to be added to CP Guidelines	January 2004 April 2004	All agencies- Health Advisor LHCC to co-ordinate Educational & Social Services Quality and Planning
3. RECOMMEND that a Joint Working Party prepares a Joint Protocol to inform the treatment and care of babies born with neonatal abstinence syndrome.	Currently such babies would be referred to SW through Interagency CP Procedures prior to discharge. Rec. 2 will also address this.		
4. RECOMMEND automatic referral to the Social Work Department of any baby born with neonatal abstinence syndrome, who has not been identified pre-birth.	As above.		
5. RECOMMENDATION that the Trust organises and funds mandatory child protection training, as identified by their own specialist	Programme of CP training is currently being formulated for both primary and acute trust. NHS A&A Action Team to consider making training mandatory.	March 2004	NHS Action Team
6. RECOMMEND that the Trust reviews its record keeping systems to facilitate effective information sharing	Currently under review as part of NHS A&A Child Protection action plan.	Current	NHS Action Team

Recommendations of Report	Response in East Ayrshire	Timescale	Responsibility
7. RECOMMEND that Lothian Primary Care Trust urgently allocated resources and skilled staff at all levels, which must include advice on the extent to which a patient's right to medical confidentiality can be breached when a child is at risk.	PCT Data Protection & Caldicott training is mandatory. Will be reinforced through training and rec. 6. NHS A&A currently has a Designated Paediatrician & Nurse for child Protection and 3 Child Protection Advisers available for staff to contact for advice on child protection issues, including confidentiality. Trust guidance advises staff to seek advice and provides contact numbers to do so.	Ongoing	NHS Action Team
8. RECOMMEND that the pro-forma invitation issued by Social Work Departments throughout the City should be reviewed, in consultation with the Police, and a new pro-forma drawn up, which offers the Police far more information.	Currently in place and will continue to be monitored		CP Reviewing Officer
9. RECOMMEND that the Police review the detail of their approach to physical and sexual abuse in collaboration with Child Protection specialists from outside the Police. Thereafter, we recommend that they re-examine their internal procedures for allocating cases.	Established within CP Guidelines. Consider evaluation of practice	Summer 2004	CP Reviewing Officer/ DI Family Protection Unit

Recommendations of Report	Response in East Ayrshire	Timescale	Responsibility
10. RECOMMEND that a clear understanding is reached between the Police and Social Workers on information sharing prior to the CPCC.	Established practice will continue to be monitored		CP Reviewing Officer
11. RECOMMEND that the Social Work Department refrains from interviewing witnesses where an inquiry has been set up.	Noted		
12. RECOMMEND that the Housing Department of the City of Edinburgh reviews what happened here, with a view to streamlining and supporting applications by people suffering from brain injury.	EA has in place Tenancy Support Teams who offer support to vulnerable families Officers of the Department of Homes and Technical Services to participate in CP training as appropriate	Ongoing	HATS
13. RECOMMEND that Lothian Primary Care Trust facilitates the registration with GPs of brain injury patients with a view to providing them with appropriate care outside the hospital.	NHS A&A should review systems to ensure all vulnerable children are registered with a GP and that adults who are perceived to be of danger to children are flagged.	To be decided	NHS Action Team

Recommendations of Report	Response in East Ayrshire	Timescale	Responsibility
14. RECOMMEND that the section of the Child Protection Guidelines is amended to reflect the expectation that health care professionals will notify the social work department if they anticipate there may be risk after birth for a child still in utero, even if it means breaching the duty of confidentiality owed to either mother or father.	Already supported through Interagency Child Protection Procedures. Integrated Assessment Framework will ensure consistency.	Summer 2004	
15. RECOMMEND that a file entry is made when information is shared in this way, and in particular when liaison workers pass that information out beyond the hospital.	All files should contain a common chronology of events-to be audited on a regular basis. Will be reinforced through training and rec. 6. Arrangements for updating files and monitoring to be agreed	To be established by summer 2004	All agencies
16. RECOMMEND that the LUH Trust Reviews the accuracy of its record keeping for at risk children.	Will be reviewed under action identified for Rec 6		
17. RECOMMEND that serious dialogue is undertaken to clarify the role of the Trusts' Child Protection Services within the interagency context.	NHS A&A Child Protection Action Team to provide framework of accountability which will detail roles and responsibilities within the health services. (See also recommendation 34)	Ongoing	NHS Action Team

Recommendations of Report	Response in East Ayrshire	Timescale	Responsibility
18. RECOMMEND that Lothian Health ensures that its various Trusts fund the training requirements identified by their own senior staff with management responsibility for Child Protection.	Will be addressed through NHS A&A Child Protection Action Team (See also recommendation 5)		NHS Action Team
19. RECOMMEND that the best means of triggering early reviews or immediate action in response to health visitors' concerns be investigated, and improved upon, as a matter of urgency.	This will be addressed via the integrated assessment framework.	Spring 2004	All agencies
20. RECOMMEND that steps are taken to clarify when medical duties of confidentiality towards a patient who is caring for a child can be waived.	Current Trust Child Protection Guidance supports this. PCT Data Protection & Caldicott training is mandatory. Information sharing protocol will reinforce this as will training. (See also recommendations 7 & 14)	Current	
21. RECOMMEND that Children and Families and Criminal Justice social work services review their joint working practices in this area as a matter of urgency.	To be considered via training days and briefing sessions with all staff groups	January 2004	Educational & Social Services
22. RECOMMEND that a checklist of invitees for CPCCs is compiled as an aid for social workers in the future.	Currently in place		

Recommendations of Report	Response in East Ayrshire	Timescale	Responsibility
23. RECOMMEND that all agencies make it a priority to collaborate and put in place effective risk assessment processes to underpin decision making.	See recommendation 19		
24. RECOMMEND that the use of Senior Practitioners as Chairpersons of Case Conferences is discontinued.	Dedicated CP Reviewing Officer now in post		
25. RECOMMEND that formal training in how to chair a CPCC is introduced for all new Chairpersons.	Child Protection Reviewing Officer will attend formal training.	February 2004	CP Reviewing Officer
26. RECOMMEND that the CDPS provides information for the use of CPCCs about the inferences which can be drawn from the factual information they are providing.	Review of interface of existing addiction services currently in progress.	Due to be completed March 2004	EAC Children and Families and Quality & Planning Section.
27. RECOMMEND that Social Workers involved with CPCCs in Lothian are encouraged to refer to the Reporter, where there is a history of previous children who have been taken into care, unless the circumstances are exceptional.	Practice in EA is to invite Reporter to all CPCC and a minute is sent which in effect constitutes a referral. This referral procedure requires to be formalised.	Immediate	Social Work
28. RECOMMEND that the CPCC Chairs, in discussion with the Reporter, agree appropriate referral criteria.	As Recommendation 27		

Recommendations of Report	Response in East Ayrshire	Timescale	Responsibility
29. RECOMMEND that resources are allocated for the employment and training of administrative staff to take and type up Minutes relating to CPCCs	Dedicated admin staff are in post and minute taking training will be implemented for C&F and Q&P staff	Current and ongoing	
30. RECOMMEND that the pro forma Minutes are changed slightly, to include a section for signature by the Chair of the relevant CPSS.	Established practice		
31. RECOMMEND that the supervising Senior Social Worker should attend Child protection Case Conferences along with the case worker from the Children and Families Team.	Established practice		
32. RECOMMEND that consideration should be given to this model of a "core group", as a means of developing and implementing the Child Protection plan.	Established practice with monthly core groups taking place		
33. RECOMMEND that senior managers with responsibility for child protection practice have appropriate training to discharge that responsibility, in every agency.	Audit of training needs of senior managers	Spring 2004	CP Co-ordinator, Health Advisor LHCC , Designated Nurse CP and Lead Clinician to CP
34. RECOMMEND that the Chief Executives and Medical Directors give urgent consideration to lines of accountability.	NHS A&A Child Protection Action Team to provide a framework of accountability in health services. (See recommendation 17)	Immediate action	All agencies

Recommendations of Report	Response in East Ayrshire	Timescale	Responsibility
35.RECOMMEND that an independent audit of Child Protection cases is carried out.	Full audit completed by CP Reviewing Officer. Rolling programme of monthly quality audit established	Ongoing	CP Reviewing Officer