WILTSHIRE COUNTY COUNCIL **AGENDA ITEM NO. 11**

Children's Services Scrutiny
29 January 2009

SUMMARY OF HARINGEY COUNCIL'S JOINT AREA REVIEW AND OUTLINE IMPLICATIONS FOR WILTSHIRE

PURPOSE OF THE REPORT

1. The Chairman of the Children's Services Scrutiny (who also sits as a member of the Performance Task Group), has requested this report for the committee to consider, mindful of the significance of the child protection issues arising from the Baby P case at Haringey Council.

CONTEXT

2. This is a summary report on Haringey's Joint Area Review re Baby P and outline implications for Wiltshire, compiled by Sarah Webb Head of Safeguarding WCC.

3. This report on Harringey's *JAR* follows the Head of Safeguardings previous Initial Summary report on Haringeys *SCR*, of which the main findings and recommendations are re-listed below;

- The pervasive belief that child A's injuries were caused by lack of supervision and his own behaviour and the lack of adequate re-assessment of the household following further injuries and bruising
- Need for all agencies to focus upon the child.
- Need to clearly state concerns and professional opinions in referrals
- The paediatric assessment was inappropriately limited (child cranky).
- Better Multi-agency involvement and attendance in discussions, meetings and conferences is needed
- Improved Administration required to support safeguarding (to include timing, accuracy, circulation of records and secure maintenance of such circulated records)
- Re Schools**;** Schools to transfer all child protection related documents to a child's new school or setting within five working days of it being identified. And, if a child subject to a child protection plan, changes school, a core group meeting should be convened at the new school within ten working days.
- Single and multi-agency training programmes should emphasise the need for all staff to:
    1. Be constantly vigilant
    2. Have an open and inquisitive approach, regardless of any assumptions arising from previous assessments
    3. Be aware of the need to re-assess following new and cumulative incidents and changes of circumstances (such assessment to include checking the accuracy of basic information e.g. household composition)
    4. Challenge colleagues within partner agencies

4. **Haringey JAR Summary judgement-**"The contribution of local services to improving outcomes for children and young people at risk or requiring safeguarding is inadequate and needs urgent and sustained attention.".

5. **Haringey JAR Main findings**

- Insufficient strategic leadership and management oversight of safeguarding of children from Haringey by elected members, senior officers and others within the strategic partnership.

- Managerial failure to ensure full compliance with some requirements re Victoria Climbie, such as the lack of written feedback to those making referrals to social care services.

- The local safeguarding children board (LSCB) fails to provide sufficient challenge to its member agencies.

- Social care, health and police authorities do 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, fail to identify those who are at immediate risk of harm and to address their needs.

- The quality of front line practice across all agencies is inconsistent and not effectively monitored by line managers.

- Child protection plans are generally poor.

- Arrangements for scrutinising performance across the council and the partnership are insufficiently developed and fail to provide systematic support and appropriate challenge to both managers and practitioners.

- The standard of record keeping on case files across all agencies is inconsistent and often poor.

- 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.

6. **Haringey JAR Recommendations**.

The Local Authority, working with its partners and in particular health and the police, should:

- improve governance of safeguarding arrangements. In particular, tensure full compliance with the guidance *'Working Together to Safeguard Children' 2006*.

- 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.

- establish more systematic monitoring of the quality of practice.
- 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 the decision making process.
- take steps to integrate individual service processes and systems across all agencies more effectively, so that all children are safeguarded.
- assure the competence of leadership and management in all areas of children's services and develop clear and effective accountability structures.
- 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 defined and monitored.
- make explicit to all staff and elected members the expectations and standards required of front line child protection practice.
- 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.
- 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.
- assure the competence of service and team managers in conducting rigorous and evaluative supervision and monitoring of safeguarding practice.
- appoint an independent chairperson to the local safeguarding children board (LSCB).
- ensure that all elected members have CRB checks and undertake safeguarding training.

7. IMPLICATIONS FOR WILTSHIRE'S LOCAL SAFEGUARDING CHILDREN'S BOARD

a) CONTEXT

Our recent Joint Area Review found LSCB work to be good, but received an overall outcome of Adequate due to low number of CAFs and area inconsistency in assessments. "Children and young people say they feel safe and receive good quality information to inform them of potential dangers. Despite this, too few are benefiting from early intervention and prevention services as a result of insufficient use of the Common Assessment Framework (CAF). There is too much variability in the timely identification and completion of initial and core assessments. "

"All children with child protection plans have reviews that are carried out within the required timescales and are allocated to qualified social workers" with "rigorous, independent chairing of child protection conferences "

"The arrangements for agencies to collaborate in safeguarding children are good. The LSCB works well to ensure that actions are in place to safeguard children and young people and the accountabilities and responsibilities of partner agencies are well understood. The board carries out an annual review of its functions against Working Together to Safeguard Children requirements both internally and externally. Leadership is effective and meetings are well attended by partners who provide effective challenge and monitoring. "

The above JAR findings must be considered in the light of other findings such as those referred to regarding Process, below at c).

b) ACTIONS

Extraordinary meetings of key LSCB leads from across the main safeguarding agencies were held in December and January. These meeting reviewed the main SCR and JAR findings from Haringey, together with the national NSPCC Baby Recommendations and agreed a draft LSCB response to Lord Lamings questions. Although some Haringey JAR recommendations and NSPCC criteria are already covered in Wiltshire, others require audit, progress or improvement. The full LSCB Board will consider the Baby P Action Plan on February 18th, and a report will be made to Wiltshire's Trust Board.

Early actions decided by Wiltshire LSCB include;

Training- the LSCB Training group Chair and WCC CP Training Manager requested to incorporate the Haringey JARs findings into all CP training courses for 2009 onwards-*this training update work has now been started.*

Child focus- all agencies to focus upon the child, *by reminder in supervision and training by managers of all agencies*

Challenge across agencies- Re-issue and upload onto Wiltshires LSCB website www.wiltshirelscb.org, the Escalation/Disagreement Policy, and review need for LSCB to have an Independent Chair. *The former has been done, the latter is scheduled for Feb LSCB.*

Supervision- Strengthened rigorous and challenging supervision is needed across agencies. *ASMs in WCC are keeping a close check on CP cases, and the LSCB should consider a protocol for supervision.*

Agencies responses to Baby P- A template with checklist from NSPCC and recommendations from the Haringey and Wiltshire Jars to be compiled by LSCB and used by agencies-***29 areas of practice have been considered and collated by a multi-agnecy group, and overall shows a "Green to Amber" assessment (15 Green, 14 Amber) with areas identified for progress by LSCB and S11 groups.***

Strategy discussions- Need for a standard checklist on standard format for each case.

Health, and Education for school aged, must be part of all these. Police and WCC to clarify thresholds for both agencies to ensure conformity.

LSCB QA sub-group audit of strategy discussions re compliance with procedures. *This work has begun by Head of Area Services, WCC and Police Inspector.*

Recources/capacity –Social work capacity must be reviewed.

Written feedback from LA to referrers must be given *–this is being drafted by the Head of Safeguarding in a standard template of referral and feedback for all agencies.*

CAF numbers to be increased, and outcomes to be reported to the LSCB-*this has been included in the LSCB Scorecard, and is being reported within the S175 audit with schools*

Quality Assurance- All agencies to be asked to report outcomes of their auditing of CP cases on a regular basis to the LSCB. LSCB to ensure qualitative as well as quantitative measures are incorporated into its balanced scorecard reporting system-*the LSCB Chair is commissioning additional independent auditing work of multi-agency child protection practice.*

c) PROCESS

All agencies responses re Baby P need to be co-ordinated through the LSCB, via the Chair. Any decisions regarding our response to Baby P should also take into account various related national and local processes, including;

- Ofsted's 'Evaluations of serious case reviews 2007-8' which found;

  "the single most significant practice failing throughout the majority of the serious case reviews – the ***failure of all professionals to see the situation from the child's perspective and experience***; to see and speak to the children; to listen to what they said, to observe how they were and to take serious account of their views"

- HM Govt report Dec 2008, 'Safeguarding the young and Vulnerable, the Govts response to the 3rd Joint Chief Inspectors report on arrangements to safeguard children.', which includes re-iteration of a S11 Children Act duty to "clarify the chain of accountability and responsibilities for child protection from the front line to their most senior level", and the need for LSCBs to "ensure robust QA processes are in place to monitor compliance by agencies to support safe recruitment."

- Governments national LSCB stocktake, 2009.
- NSPCC's audit questions for LSCBs re Baby P
- Our Wiltshire JAR finding on Safeguarding ,APA, and Wiltshire LSCB's most recent SCR, Child F.

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