Children & Lifelong Learning Scrutiny Panel	Agenda Item No. 6
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REPORT OF THE DIRECTOR OF CHILDREN'S SERVICES

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Report title:– Post Haringey Review of safeguarding - THE EFFECTIVENESS OF SAFEGUARDING ARRANGEMENTS IN PETERBOROUGH

1. PURPOSE

This report is in response to a letter dated 1st December 2008 from Ed Balls, Secretary of State for Children Schools and Families, asking all Directors of Children's Services to satisfy themselves as to the effectiveness of local safeguarding children arrangements. Directors are asked to use the Ofsted Joint Area Review on Haringey as "a clear and immediate challenge" against which those assessments are carried out.

2. RECOMMENDATIONS

That scrutiny panel considers, comments upon and endorses the report of the Executive Director of Children's Services.

LINKS TO CORPORATE PLAN, SUSTAINABLE COMMUNITY STRATEGY AND LOCAL AREA AGREEMENT

Safeguarding is a key judgement for the CAA and a priority in the Local Area Agreement.

3. BACKGROUND

3.1 Following the publication of the Serious Case Review [SCR] in respect of baby P in Haringey, a Joint Area Review [JAR] of safeguarding arrangements in that authority was undertaken at the end of November 2008. Its findings prompted the Secretary of State to request that all " *Local Authorities, with their partners take stock of the effectiveness of safeguarding practices in their own areas."* [Letter to Directors Dec 1st 2008].

3.2 The following is the action plan of Children's Services to undertake an assessment of it's arrangements against the findings and recommendations of the Haringey JAR. This has been compiled by Debbie Brayshaw.

3.3 In addition Local Authorities have been requested to Review Serious Case Reviews judged inadequate by Ofsted. This is being led by Maureen Phillips and a narrative of the priority action taken is also attached.

4. KEY ACTIONS

4.1 Immediately post-Haringey, the position of Head of Social Care reporting into a larger Family and Communities division was reviewed. To give safeguarding and social care a higher profile with direct accountability to the Director, the Head of Social Care has been designated a full member of DMT. In addition, within the developing Children's Trust Partnership Board (CTPB) structure, the staying safe partnership group will ensure that there is leadership within the trust of the Staying Safe Action Plan and will strengthen links between the CTPB and the Local Safeguarding Children's Board.

4.2 A review of safeguarding within social care has been conducted. One area for immediate action has been identified in relation to improving the quality of strategy meetings. Work is ongoing following recent audits to improve the quality of assessments, developing a best practice model, and a new audit programme is being developed to reflect the issues discovered in Haringey and ensure we remain compliant with the recommendations of the Climbie Inquiry of 2003.

4.3 Staff briefings have been held which reached over 100 staff and engaged them in learning lessons from the baby P case. Feedback was positive and was found to be supportive. Immediately post-Haringey, services experienced a 50% rise in referral rates and an increase in the number of admissions to care (18 in November against and average of 4 to 6 per month previously). The referral rate and admissions to care have reduced to nearer the norm in january 2009.

4.4 Currently, the capacity analysis conducted by Price Waterhouse Coopers in 2007 for qualified social workers still holds good. The vacancy rate is 12% and we are actively recruiting with confidence that the posts will be filled. Reliance on agency staff has reduced to a minimum and only being retained in business critical areas. There is one agency team manager and one agency social worker within the department presently.

4.5 The additional work to review the two serious case reviews deemed inadequate is complete and will report to DCSF at the end of February. All necessary changes to procedures had already been implemented.

4.6 The post-Haringey action plan was presented to Peterborough Safeguarding Children Board on 28th January. The full details of the Action Plan and the review of serious case reviews can be found at Appendix 1 and 2.

5.0 LEGAL AND FINANCIAL IMPLICATIONS

There are no legal and financial implications within this report.

6.0 HR IMPLICATIONS

In view of the very high profile nature of qualified social workers and their contribution to safeguarding, they have been excluded from the current opportunity for voluntary redundancy.

7.0 EXPECTED OUTCOMES

7.1 Implementation of the action plan will ensure that there is a robust infrastructure to deliver safeguarding services and monitor performance within the Department and with partner agencies. “Taking stock” against the measures in the Haringay JAR will also support preparation for future inspections.

7.2 Further improvements will be informed by the review of Lord Laming expected in the spring and will be responded to as required.

7.3 The changes in the process for management of Serious Case Reviews has already improved IMR report writers understanding and written contributions, and there is greater clarity of the Ofsted descriptors for evaluating the work. This should in the future reduce the possibility of a SCR evaluation as “inadequate.”

7.4 On-going Governance of the action plan will be provided through the Peterborough Safeguarding Children Board

APPENDIX 1: ACTION PLAN

THE EFFECTIVENESS OF SAFEGUARDING ARRANGEMENTS IN PETERBOROUGH: Post Haringey Action Plan

a. Following the publication of the Serious Case Review [SCR] in respect of baby P in Haringey, a Joint Area Review [JAR] of safeguarding arrangements in that authority was undertaken at the end of November 2008. Its findings prompted the Secretary of State to request that all "*Local Authorities, with their partners take stock of the effectiveness of safeguarding practices in their own areas."* [Letter to Directors Dec 1st 2008].

b. The following is the action plan of Children's Services to undertake an assessment of it's arrangements against the findings and recommendations of the Haringey JAR. This has been compiled by Debbie Brayshaw.

c. In addition Local Authorities have been requested to Review Serious Case Reviews judged inadequate by OFSTED. This is being led by Maureen Phillips and a narrative of the priority action taken is also attached.

	HARINGEY FINDING [F] /RECOMMENDATION [R]	**ACTION PROPOSED PETERBOROUGH**	**LEAD**	**TIMESCALE**
1	There is insufficient leadership and oversight of safeguarding by elected members, senior officers and the strategic partnership. **(F)** Improve governance arrangements **(R)** Assure the competence of leadership and management across children's services with effective accountability structures.**(R)**	The Children's Trust Partnership Board has established an executive board and partnership groups reflective of the ECM outcomes – one being dedicated to "staying Safe". This will strengthen oversight and accountability by all partners, and will be responsive to issues raised by the Peterborough Safeguarding Children Board (PSCB),	CTPB development, Elaine Fulton Chair of "staying safe" partnership group – Debbie Brayshaw	No additional action required
2	There is managerial failure to ensure compliance with requirements of Victoria Climbie (VC) Inquiry. **(F)**	Practice alert briefings to managers and staff [6 between Nov 2008 – Jan 2009] Sample file audits in R&A to ensure	Debbie Brayshaw	Audit – Feb 2009 Full QA programme April 2009.

	HARINGEY FINDING [F] /RECOMMENDATION [R]	ACTION PROPOSED PETERBOROUGH	LEAD	TIMESCALE
	Ensure full compliance with Working Together 2006 **(R)** Make explicit to staff and elected members the expectations and standards of frontline CP practice. **(R)** Assure competence of managers to provide rigorous and evaluative supervision. **(R)**	compliance with VC requirements on : - allocation - management decision - feedback to referrer - chronology - child's views [sec 53 CA 2004] - supervision This audit will form part of a comprehensive QA programme being developed in Children's Social Care. Briefing to elected members	John Richards	4th March Children and Lifelong Learning Scrutiny Panel
3	The LSCB fails to challenge agencies sufficiently, compounded by lack of independent chair. **(F)** Appoint an independent chair. **(R)**	PSCB operates with an independent chair. In the short term this role is being undertaken by the DCS as the existing Chair leaves and a new one is recruited. Evidence of challenge to be collated by the PSCB.	PSCB	March 2009
4	Social Care, Health and Police do not communicate and collaborate routinely and consistently to ensure effective assessment, planning and review of cases. **(F)**	A current SCR has prompted changes to arrangements for recording Strategy meetings with immediate effect. This will be followed with a Case file audit on: - robustness of strategy meetings	Debbie Brayshaw	Strategy meetings - Immediate

	HARINGEY FINDING [F] /RECOMMENDATION [R]	ACTION PROPOSED PETERBOROUGH	LEAD	TIMESCALE
	Establish clear procedures and protocols for communication between agencies. **(R)**	- the breadth of inquiries and information sharing at point of referral. A recent audit of assessment has highlighted some weaknesses in the multi agency component of these and a model of "good practice" is being rolled out to social care staff. Review of multi agency training to reflect this aspect of work.		Audit -February 2009 March 2009.
5	Too often assessments of children and young people in all agencies fail to identify those who are at immediate risk of harm and address their needs. **(F)** Establish more secure assessment and earlier intervention strategies. **(R)** Take steps to integrate individual service processes and systems to ensure safeguarding. **(R)**	Embedding integrated processes and use of the common assessment framework (CAF) throughout children's services through the 'delivering through localities' project. Pathfinders established from January 2009. Section 11 audit of all services to ensure that safeguarding is integral to integrated processes, ensuring that all staff fully understand how to use the vulnerability matrix.	Maureen Phillips PSCB	January 09 onwards April 2009
6	The quality of frontline practice is inconsistent and not effectively monitored by line managers. **(F)** Ensure managers and staff are accountable for casework	File audit as at 2 above	Debbie Brayshaw	Audit – Feb 2009 Full QA programme April 2009.

	HARINGEY FINDING [F] /RECOMMENDATION [R]	ACTION PROPOSED PETERBOROUGH	LEAD	TIMESCALE
	decisions. **(R)**			
7	Child protection plans are generally poor. **(F)**	No current evidence to support this is the case in Peterborough. Compliance with procedure strong and after initial conference subsequent reports are multi-agency constructed within the core group implementing the plan. Introduction of CP co-ordinator monitoring form to strengthen QA monitoring	Debbie Brayshaw	No action February 2009
8	Arrangements for scrutinising performance across the council and partnership are insufficiently developed and fail to provide systemic support and challenge. **(F)** Establish rigorous arrangements for management of performance across all agencies. **(R)**	This role will be strengthened through the new partnership structure as at 1 above. The QA group within the safeguarding Board needs to develop a performance monitoring tool. CSC are building a performance management framework CSC have developed a QA programme to be implemented	PSCB QA group	No additional action. April 2009.
9	The standard of record keeping across agencies is inconsistent and poor**. (F)**	Case file audit as at 2 above. Interrogation of RAISE to support file creation processes.	Debbie Brayshaw	April 2009
10	There is too much reliance on quantitative data without analysis of quality. **(F)**	QA programme in CSC will be focussed on quality tracking the “story of the child” from files and tasks alongside monitoring “safe environments” measuring against	Debbie Brayshaw	April 2009.

	HARINGEY FINDING [F] /RECOMMENDATION [R]	ACTION PROPOSED PETERBOROUGH	LEAD	TIMESCALE
	Establish more systematic monitoring of the quality of practice. **(R)**	national minimum standards. Quantitative data is monitored through performance monitoring framework.		
11	Ensure all elected members have CRB checks. **(R)**	The only councilors that are CRB checked are the ones involved with CS committee, scrutiny panel, cabinet member etc. Consideration will be given to extending this to others	John Richards Debbie Brayshaw	
12	Ensure all elected members undertake safeguarding training. **(R)**	Free safeguarding training available for all councilors. Greater efforts will be made to ensure awareness and attendance at such training	Debbie Brayshaw Jo Bramwell	

APPENDIX 2: PRIORITY ACTION ON SERIOUS CASE REVIEWS

1. Background

1.1 The requirement to undertake a serious case review (SCR) in certain circumstances is contained within Working Together to Safeguard Children 2006. Essentially, a SCR is required where a child dies and abuse or neglect is known or suspected. A SCR must also be considered where: -

- a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
- a child has been subjected to particularly serious sexual abuse; or
- a parent has been murdered and a homicide review is being initiated; or
- a child has been killed by a parent with a mental illness; or
- the case gives rise to concerns about inter-agency working to protect children from harm.

1.2 The purpose of the review is to:-

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and agencies work together to safeguard children;
- Identify clearly what these lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence,
- Improve inter-agency working and better safeguard children.

1.3 On 16th December, Beverley Hughes, Minster of State for Children, Young People and Families wrote to all chairs of LSCBs and Directors of Children's Services clarifying the action that should be taken in relation to any serious case reviews judged as inadequate by Ofsted. The action involves convening a panel, independently chaired which examines: -

- How process issues which may have contributed to the judgement of 'inadequate' have been acted upon in subsequent SCRs;
- Whether or not it was purely the process which led to an inadequate judgement of whether the actual findings and conclusions of the review need revisiting;
- Whether the panel has confidence in the integrity of the conclusions of the SCR and have they led to tangible improvements through the implementation of the action plan.

2. Peterborough serious case reviews judged inadequate by Ofsted:

2.1 Two serious case reviews were judged inadequate in 2008. Both conducted within the same timescale. The first case[1] was submitted to Ofsted three weeks before publication of their new evaluation criteria on 1st April. The second case (the executive summary of which is published on the Peterborough Safeguarding Children Board website as 'child a 2008') relating to a child adopted by her foster carers and discovered in August 2007 to have been sexually abused by the male carer, was close to completion at this stage. Peterborough Safeguarding Children Board delayed submission of the 'child A' report and pending an independent review of the SCR against the Ofsted criteria, taking steps to clarify certain individual management reports before finally submitting to Ofsted. In addition, a full review of Peterborough's SCR process was

[1] This case has, although completed, cannot yet been published on PSCB website due to circumstances beyond the safeguarding board's control and therefore details of the case are not covered in this report.

undertaken immediately following the judgement in the first case, resulting in fully revised procedures for subsequent SCRs.

3. The 'first case'

3.1 There was no social care involvement in this case. Individual management reviews (IMRs) were conducted in relation to health, early years and primary school involvement. Four individual management reviews were deemed inadequate in that they were regarded as having gaps in information or were insufficiently analytical.

3.2 The SCR panel convened a meeting with Ofsted in which all areas of concern were fully discussed. This resulted in one addition to the recommendations.The inspector also recognised that gaps in information contained within the IMRs had been addressed within the SCR panel process. However, as Ofsted does not include in the evaluation the SCR panel minutes, this information was not taken into account. Amendments to process have now rectified this issue and in future all additional information will be contained within the IMR.

4. Child A 2008

4.1 The 'child A 2008' SCR judged three IMRs to be inadequate, one conducted by NSPCC who had been independently commissioned on behalf of children's social care, one conducted by another branch of the NSPCC on its own behalf in relation to their historical involvement and one conducted by the Learning and Skills Division. The SCR panel met with the inspector in November 08. The inspector stated that he had been greatly reassured by the information he heard and that the evaluation of inadequate in the main was attributed to process issues. Panel also felt that the inspector's judgement contained matters of factual inaccuracy which were subsequently raised with Ofsted formally. However, although Ofsted has acknowledged partial inaccuracies, it has declined to change the overall judgement and it is not felt that to challenge the matter further would not be appropriate.

5. The Peterborough Safeguarding Children Board SCR panel process

5.1 Unlike Haringey, Peterborough's SCR process has always been rigorously independent. The SCR panel is chaired by the independent chair of the safeguarding board. As is required within Working Together to Safeguard Children 2006, overview writer is appointed at the outset with responsibility for collating and summarising all the information contained in the IMRs into a single report with recommendations. Authors of IMRs present their reports to the panel which is also attended by an overview writer, who has the opportunity to directly question the IMR authors. A number of IMRs deemed to be wholly inadequate have been rejected and re-submitted. Minor gaps in information have been clarified within the panel and contained within the minutes. Amendments to this process will therefore ensure that in future all additional information is contained within the IMR. The newly drafted procedure also includes more explicit guidance for IMR authors and all are expected to attend an initial briefing. Improvements in the confidence of IMR authors and in the quality of initial reports have been evidenced in the most recent SCR (PS, a 6 week old baby who was killed by his father in September 2008), for which the SCR panel received IMRs on 16th January 09.

6. Lessons learned

6.1 In each of the SCRs resulting in judgements of inadequate, the independence and integrity of the reviews and overall recommendations were not in question. The issues were therefore substantially different from the issues relating to the Haringey process. Nevertheless, there have been lessons learned. Improvements in guidance and process had already been implemented. The quality of analysis in IMRs has improved and authors are more confident in

the process. Governance of SCRs has improved with chief officer sign off now standard across all agencies, again evidenced in the quality of the most recent IMRs. Whilst monitoring implementation remains the responsibility of the individual agency at chief officer level, the LSCB has developed smarter mechanisms for ensuring that actions are on track and evidenced.

7. The post Haringey review of the inadequate SCRs

7.1 The SCR panel met on 14th January to examine both SCRs against the criteria set out in Beverley Hughes' letter. Prior discussions had been held with Ofsted and with GO East, both of which confirmed that Peterborough's review of each SCR following the judgements had gone some considerable way to fulfilling what was required. Nevertheless, the meeting chaired by Barbara Trevanion, former independent chair of the safeguarding board, painstakingly addressed the criteria. It was agreed that none of the IMRs required being re-done.

7.2 Letters went out to all agencies to confirm the latest information on implementation of the actions in order to collate information and produce a report within the designated timescale. That report is currently in draft and will be agreed by PSCB members and the in dependent chair of the on 26th February. The report sets out details of the process undertaken to review the two cases and the actions take subsequently. Those actions relate to two key areas: -

- Improvements to the SCR process to strengthen individual agencies' governance of their IMRs and to ensure that all evidence in future SCRs is fully reflected in the IMRs and the overview report submitted to Ofsted;
- Progress against each of the SCR action plans

7.3 The report to the minister, addresses each of the concerns raised in the evaluation letter and sets out how the safeguarding board and each partner agency has responded to Ofsted's findings. In relation to case A 2008, Ofsted has already confirmed that the revised action plan is regarded as good and therefore members can be confident that the nature of Ofsted's concerns were understood and remedial action taken.

7.4 In relation to the 'first case', yet to be published, an update on the implementation of the action plan was presented to Ofsted in their annual performance assessment site visit in October. The inspector expressed satisfaction with the report and subsequently, 'staying safe' was graded as 'adequate', endorsing this position. Members can therefore be confident that appropriate action has also been taken in this case.

8. Conclusion

8.1 Peterborough Safeguarding Children Board fully respects the need to ensure that when a child dies or is seriously harmed as a result of abuse or neglect that serious case reviews are conducted with independence and rigour. Whilst the board maintains that this has always been its practice, there have nevertheless been lessons learned as a result of Ofsted applying new criteria retrospectively to these two serious case reviews.

8.2 The review has confirmed that appropriate lessons were learned within each SCR and that actions are being progressed within each relevant partner agency accordingly. We believe that Ofsted and DCSF will be satisfied with the action taken.

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