Safeguarding: Information sharing for child protection

A review by the Children and Young People Select Committee

December 2009

Contents

1. Chair's introduction

Making sure children are safe is one of the most important responsibilities of public, private and voluntary bodies and of all of us as individuals. From time to time things go seriously wrong and a particular case attracts national attention, as happened with the Victoria Climbie and Baby Peter cases. For a while public debate rages, often giving rise to more heat than light.

When things go seriously wrong the law requires council's to undertake an investigation called a Serious Case Review. There have been a number of these at Lewisham recently. The Council's Select Committee felt it was important to investigate how safeguarding is conducted in Lewisham and to see if there were any lessons we could learn to add to all the detailed recommendations made in the reviews themselves and in the Laming review.

The Committee interviewed witnesses, including front line workers and senior managers, from a range of agencies working across the borough. We considered the implications of this evidence and have produced recommendations. We hope these will be implemented and help to improve procedures and operations.

I should like to take this opportunity to thank all the witnesses from the Council and all other partner agencies for presenting their evidence to us. I should also like to record my thanks to my colleagues on the Select Committee for their contribution to the review and their genuine interest in the subject and to Salena Whatford for all her hard work in supporting the Committee.

It has been clear to us throughout this year's review that all those we have met are completely committed to ensuring the best possible safeguarding standards for Lewisham's children and young people.

Councillor Julia Fletcher

Chair Children and Young People Select Committee

2. Executive summary

The Children and Young People's Select Committee carried out a review of safeguarding: information sharing for child protection, in 2009-2010. The Committee wanted to carry out a detailed review into this vital statutory responsibility to assure itself, and the public, that safeguarding responsibilities were being robustly implemented in Lewisham, and perhaps also identify possible improvements to safeguarding practices in Lewisham

Four evidence gathering sessions were held between June and October 2009. The evidence sessions involved:

- questioning officers of the Council and partner agencies
- consideration of quantitative performance evidence and the executive summaries of recent Serious Case reviews
- considering formal reports from senior officers.

The Committee found a real commitment to robustly meeting safeguarding responsibilities across all levels of staff the Council and all partners agencies. Chief officers from all partner agencies demonstrated a clear organisational commitment to meeting their safeguarding responsibilities, however all accepted that embedding a culture of awareness and information sharing through to every single member of staff at every level of every organisation in Lewisham was a challenge that they had to continue to prioritise.

Staff from all organisations confirmed that progress was being made in improving communication and joining up services and practices to develop a truly multi-agency approach, although all agreed that there was still room for improvement in the way in which agencies communicated and worked together.

It was evident to the Committee that there is a genuine desire at all levels across all agencies to continue to improve practices and communicate more effectively to safeguard children in Lewisham and that work is being done to implement previous Serious Case Review recommendations. Upon consideration of the evidence gathered, the Committee identified a number of strategic and practical recommendations to support continued improvements in communication and safeguarding practices in Lewisham. These are detailed in section six of this report.

3. Objectives of the review

After the tragic death of Baby Peter in Haringey, all local authorities needed to redouble their efforts to ensure that their safeguarding arrangements were fit for purpose.

The members of the Children and Young Peoples Select Committee wanted to ensure that their in depth review in 2009–10 focused on safeguarding, so that they could assure themselves and the public that safeguarding responsibilities were being robustly implemented in Lewisham, and perhaps also identify possible improvements to safeguarding practices in Lewisham.

As it is such a vast area of work that covers a number of agencies, the Committee wanted to focus on a challenging area of safeguarding practice that it felt it would be the best placed local body to investigate in depth and report on.

At the initial review planning discussion the Committee agreed that the focus of the review would be information sharing for child protection. The specific objectives of the review were to:

- understand the structures in place to safeguard children in Lewisham
- understand the relationships and processes in place to facilitate information sharing for safeguarding purposes across all relevant agencies in Lewisham
- understand the implications of failures of communication
- review the effectiveness of the structures in place to safeguard children
- review the effectiveness of the relationships and processes in place to facilitate information sharing for safeguarding purposes across all relevant agencies in Lewisham
- review the effectiveness of the partnerships in learning from mistakes, to improve communication and practice
- identify any areas for improvement to enable the Committee to make recommendations.

The Committee agreed that to meet the objectives of the review fully, it needed to be broken down into three key areas of enquiry:

- Partnership Working – Structure/Strategic
- Communication – Process/Operational
- Research/Case Studies.

4. Methodology

How the review would be executed was discussed and agreed by the Committee in April 2009. The objectives of the review and key areas of enquiry were formally agreed and the methodology, specific evidence sessions and witnesses to be invited were also agreed.

Four evidence gathering sessions were planned and were subsequently held in June, July, September and October 2009. The Committee agreed its recommendations in November 2009. The evidence sessions involved the:

- questioning of officers of the Council and partner agencies
- consideration of quantitative performance evidence and the executive summaries of recent Serious Case reviews
- considering formal reports from senior officers.

Specifically, the following evidence was considered at each session:

Evidence session one: Communication – Process/Operational

At the first evidence session the Committee wanted to investigate how relevant officers from the Council communicate with each other and other agencies in practice, how this is effective and how this could be improved. The Committee also wanted to discover whether practice was in line with published guidance and senior officer strategic information, and identify ways in which practicing social workers and social work managers felt that practices could be improved to improve safeguarding.

The following officers gave evidence to the Committee:

- Referral and Assessment Team Manager
- Family Support and Intervention Team Manager
- Quality Assurance Team Manager
- Child Protection Team Manager
- Family Support and Intervention Social Worker
- Referral and Assessment Social Worker.

Evidence session two: Communication – Process/Operational

At the second evidence session, the Committee considered how staff across all partner agencies communicate with each other in practice, how this is effective and how this could be improved. The Committee

also wanted to identify whether practice is in line with the strategic and organisational information to be provided by chief officers at the third evidence sessions, and find out how front line staff across all agencies felt that processes and practices for communication across organisations could be improved.

- head teacher of a Lewisham primary school
- deputy head teacher of a Lewisham secondary school
- Detective Constable with the Metropolitan Police Child Abuse Team
- two Lewisham health visitors.

Evidence session three: Partnership Working – Structure/ strategic

At the third evidence session, the Committee took evidence from the members of the Lewisham Safeguarding Childrens Board, it's independent chair and other senior officers of the Council. This Board is ultimately responsible for Safeguarding Children and Young People in Lewisham, and is comprised of the chief officers of all key partner agencies.

Board members outlined their role, and that of their organisation, in leading safeguarding in Lewisham, the structures and process they have put in place to ensure interagency working between their organisations and where they felt practice was good and where there was room for improvement both within and between their respective organisations.

The following officers gave evidence to the Committee:

- Executive Director for Children and Young People
- Director of Children's Social Care
- Independent Chair, Lewisham Safeguarding Children's Board
- Interim Director of Governance, Lewisham Primary Care Trust (PCT)
- Chief Executive, University Hospital Lewisham
- Chief Superintendant and Superintendant of Lewisham, Metropolitan Police
- Service Director, South London and Maudsley (SLaM)
- Head of Adult Assessment and Care Management, London Borough of Lewisham (LBL)
- Head of Crime Reduction, London Borough of Lewisham (LBL)
- Executive Director of Customer Services.

Evidence session four: Research/Case studies/Performance

At their final evidence session, the Committee considered in more detail a wide range of performance data, including executive summaries of Serious Case Reviews in Lewisham to "close the loop" and evaluate if the arrangements currently in place are working in practice and if lessons have been learned and improvements implemented. The Director of Children's Social Care provided a summary report with all the performance data provided, and answered further questions from the Committee.

Additional evidence considered

In addition to formal questioning at Committee meetings and consideration of published performance data, a series of follow up questions to senior officers from across a range of organisations in Lewisham were sent out, after further consideration of the evidence taken, and written responses to these questions were received and further considered by the Committee.

The Chair of the Committee also interviewed the Parents' Advocate, Mr Gary Robinson of Barnardos, and the lead doctor and nurse for Safeguarding in Lewisham Dr Adeyemi and nurse Sylvia Williams

Wider background information was also considered, including current procedural guidance for social workers. A full list of all evidence considered is listed at appendix 1.

5. Findings

Background

The safety of children, keeping children and young people safe from harm, abuse and criminal activity, is a priority outcome for Lewisham, as outlined in the borough's Sustainable Community Strategy. The protection of children: better safeguarding and joined-up services for children at risk, is one of the Council's corporate priorities.

On 17 November 2008, Lord Laming was commissioned by the Secretary of State for Children, Schools and Families to provide an urgent report on the progress being made across the country to implement effective arrangements for safeguarding children, in response to the case of 'Baby P'. Lord Laming was tasked with:

- evaluating the good practice that has been developed since the publication of the report of the Independent Statutory Inquiry following the death of Victoria Climbie
- identifying the barriers that are now preventing good practice becoming standard practice
- recommending actions to be taken to make systematic improvements in safeguarding children across the country.

Lord Laming noted that: "despite considerable progress in interagency working, often driven by Local Safeguarding Children Boards and multi-agency teams who strive to help children and young people, there remain significant problems in the day-to-day reality of working across organisational boundaries and cultures, sharing information to protect children and a lack of feedback when professionals raise concerns about a child. Joint working between children's social workers, youth workers, schools, early years, police and health too often depends on the commitment of individual staff and sometimes this happens despite, rather than because of, the organisational arrangements. This must be addressed by senior management in every service."

Lord Laming has made a number of recommendations under 7 'strands':

1. Leadership and accountability
2. Support for children
3. Interagency working
4. Children's workforce
5. Improvement and challenge
6. Organisation and finance
7. Legal

The Committee recognised the importance of Lord Laming's report and identified three of the seven strands in Lord Laming's review, as being the areas that they wanted to focus on understanding and reviewing locally as the key areas of their enquiry:

Lord Laming's review framework	**Committee Key areas of enquiry**
Leadership and accountability	Structure/Strategic – Partnership Working
Interagency working	Communication – Process/Operational
Organisation	Communication – Process/Operational including Research/Case studies

Their findings are set out below using Lord Laming's framework.

Leadership and accountability

Within Lewisham the strategic oversight of the whole children's partnership agenda is secured through the Children and Young People's Partnership Board which is chaired by the lead member for Children and Young People.

It publishes the three year Children and Young People's Plan which is reviewed annually and declares the strategic priorities in relation to all the partnerships' children's services.

The local Safeguarding Children Board has the statutory oversight of children's safeguarding, with the Executive Director for Children and Young People having statutory responsibility for the Council's role (as per the legislation in the constitution page 341). Its Independent Chair is a permanent member of the partnership board.

To fulfil their commitment to safeguard and promote the welfare of children, all organisations are required to:

- set clear priorities for safeguarding and promoting the welfare of children which are explicitly stated in strategic policy documents
- ensure there is a clear commitment by senior management to the importance of safeguarding and promoting children's welfare, e.g. in job descriptions and individual performance targets
- have in place clear lines of accountability within the agency for work on safeguarding and promoting the welfare of children

- have appropriate whistle blowing procedures and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed
- maintain accurate records of decision making and actions.

Safeguarding has been identified as a top priority for Lewisham, it is part of the Sustainable Communities Strategy and is incorporated in all other plans and strategies. The Committee heard there had been an increase of team managers in child protection services from 12 to 15 to cope with the increased service demand since the Baby P case. This and the commitment to continued recruitment, in the face of difficult financial times and financial cuts across the Council assured the Committee of the Council's commitment to its safeguarding responsibilities.

The Committee was advised by senior officers of all partner agencies that since the Baby P case and the recent Serious Case Reviews in Lewisham, a lot of work had been done to review practice at all agencies in Lewisham, and the strategic partnership had agreed a programme, "Safe and Sound", to review and agree how it can improve practice and information sharing. Part of that work has been to focus on strengthening the Lewisham Children's Safeguarding Board (LCSB). The new structure of the LCSB will have a top strategic steering group of chief officers to steer the work of the larger group of staff in all agencies.

Senior officers across the partnership feel strongly that they have the collective responsibility to make sure their organisations and staff are sharing information as a core part of their every day business. The Executive Director for Children and Young People has the statutory responsibility for Safeguarding within the Council, as per the Lewisham Constitution, and the role of the Independent Chair is to make sure that the communication is happening across the organisations and that everyone is working together, and to hold the senior officers to account across the partnership if that is not happening.

The recently appointed Independent Chair of the Safeguarding Board assured the Committee that she had been impressed at the commitment of all agencies in Lewisham to safeguarding. She further advised that those that attended the board came with the authority from their organisation to make decisions, which shows commitment from the organisations. She further advised that she was impressed that the board was well attended.

The Committee was advised that the senior boards of all partner agencies regularly take reports on safeguarding and that in the PCT

the Chief Executive personally signs off all management reviews in terms of safeguarding practice. University Hospital Lewisham had invested in a named doctor and nurse responsible for safeguarding, in addition to the PCT named doctor and nurse responsible for safeguarding. SLaM advised the Committee that it also had regular formal board reports on safeguarding procedures and practices and there are designated leads at board level for safeguarding that report directly to the Chief Executive. SLaM holds safeguarding training every month and there is a nominated doctor and nurse for safeguarding in every borough within the Trust.

The Metropolitan Police advised that the core business of the Police was to keep people safe. Senior Police officers advised the Committee that the Police force wasn't naïve or complacent and that they continue to work hard with managers at all levels to try and ensure that information was shared appropriately within the force, and that all senior officers saw it as their key responsibility to make sure that the strategic importance of safeguarding and relevant key information was filtered down to all staff. The Superintendant of Police in Lewisham further advised that they felt that there was sometimes a "disconnect" between police officers and CSC social workers. She further advised that there was an escalation process agreed across the partnership to deal with any disagreements, and it was important that staff believed and trusted in that process.

The Head of Crime Reduction advised the Committee that there were a number of panels that acted as gateways for information sharing across agencies: the Youth Inclusion Panel, the Family Support Panel, the multi-agency referral and assessment model is used for victims of domestic violence and there is a youth Multi Agency Risk Assessment Conference (MARAC) which is the first in the country.

The Committee was advised that the PCT takes a leadership role in terms of safeguarding across the health sector. The PCT has 2 designated safeguarding doctor and nurse posts, who offer practical support and supervision for all named safeguarding leads across the health economy. These highly experienced professionals act as an expert resource for practitioners to use above and beyond formal procedures.

The PCT reported that the most challenging area of safeguarding for it to manage was currently independent practitioners. Although there had been a safeguarding GP lead that had been in place for many years and was known to all practices across the borough, there were still concerns about GP engagement in safeguarding processes. The lead GP for safeguarding encourages all practices to engage in "reflective practice"

in relation to their safeguarding processes and information sharing and smaller practices are supported and encouraged to "buddy" each other to provide challenge and support in relation to safeguarding.

The PCT advised that it was currently involved with the Strategic Health Authority and PCT's across London in working towards a London wide protocol for information sharing, and all staff are encouraged to use encrypted exchanges (nhs.net), which is a safe way to share information across the NHS.

The Committee was informed by all those that gave evidence that there were lots of systems in place to aid information sharing and all agencies were keen to share information, but at the front line level staff can't always know how to interpret the information they have and whether they should share it. A lot of relevant information on its own has no apparent significance at all, but when put together with other information from other front line services (GP's, schools etc) the relevance is seen and problems highlighted. Front line staff are faced on a daily basis with a vast range of information which they have to prioritise in relation to sharing.

The Independent Chair of the LCSB advised the Committee that in her view there would always be a problem with information sharing, both within Lewisham and replicated across the country, as people only see what they see with their own eyes, and that all organisations and people involved in safeguarding needed to focus their efforts on helping people broaden their view and see the possible importance of their information if it was linked with other information, rather than view their own piece of information as inconsequential.

Part of the role of the strategic partnership is to raise awareness with front line practitioners about what those little pieces of information could be, for example a large number of school age children with plans in place had poor school attendance, so now all children with persistent absence must have a Common Assessment Framework (CAF) form completed. The Committee were advised that in the view of the LCSB the priority for improving safeguarding practices was embedding the culture of information sharing, making sure the bits of information picked up were appropriately noted and passed on and shared with relevant colleagues in a timely fashion.

The Metropolitan Police advised the Committee that all contact with children and young people they had is recorded on the computer (through the "Merlin" process) at the pre-assessment desk, and then that information feeds into risk monitoring. This procedure is repeated on a daily basis and feeds into daily management meetings.

The public protection desk was felt to be the key area of Police practice in safeguarding, as it was the place where all police checks and Merlin reports are funnelled into and then shared from. A good system for Police Merlin forms to come over to CSC was felt by senior officers to be an important procedure.

Co-location of services to support information sharing and the development of relationships between both organisations and staff was put forward to the Committee as a model of service delivery that was beneficial to safeguarding

Training

Training of all staff is a key task that all organisations with a responsibility for safeguarding need to prioritise. The Committee heard that safeguarding training was mandatory across all agencies represented on the LCSB. The strategic partnership and LCSB all recognised the opportunity for networking and sharing and improving practice that joint training provided, and provided examples of where this happened and voiced a commitment to ensuring this continued.

The chief officers of the LCSB assured the Committee of their commitment to supporting communication between staff and to provide the opportunities to staff to meet and reflect on practice. The Director of Children's Social Care advised the Committee that in his view communication between staff of a variety of agencies was essential and that all organisations needed to work continually to build and strengthen those relationships in the face of shifting staff groups and legislative and organisational changes.

It was noted that a lot of communication between professionals and across organisational boundaries happened at case conferences and core group meetings, but there were other opportunities for professionals to share practice and communicate with each other also. Larger scale opportunities for networking and sharing best practice, such as the LCSB conference, were seen as key to strengthening relationships and practices.

The Independent Chair of the LCSB advised the Committee that it was in part the role of the LCSB to ensure that those opportunities for staff networking were provided, and that lots of training in Lewisham is now multi agency. The LCSB conference this year will look at neglect, as that is an issue from the recent Serious Case Review and the event will be attended by staff from all statutory organisations and some voluntary sector organisations too, and that event will provide opportunity for staff to reflect and discuss this important area together.

Serious Case Reviews in Lewisham

There have recently been Serious Case Reviews in Lewisham, published within the period the review was underway, that include over 100 recommendations for improvement. The Committee asked for assurances from all organisations that lessons from previous failures were being learnt and that they were implementing the recommendations for improvement. The Committee was advised that the LCSB was responsible for making sure that all recommendations were implemented and monitored and that chief officers were held to account. The independent Chair of the LCSB assured the Committee that all organisations were actively working to ensure the quality of their safeguarding procedures and practices.

Senior officers from all statutory organisations working in Lewisham feel assured that they have the relevant procedures and personnel in place to enable their organisation to fulfil its safeguarding duties effectively. All senior officers demonstrated to the Committee a clear organisational commitment to meeting those duties, however all accepted that embedding a culture of awareness and information sharing for safeguarding purposes was a difficult task to filter through every single officer at every level of every organisation, and this was their primary goal and something that they were taking practical steps to achieve, in partnership with each other, led at the strategic level by the LCSB.

Interagency working and organisation

All agencies whose staff come into contact with children in their daily activities, and/or who provide services to adults who are parents, must have systems and arrangements in place to ensure that:

- staff are recruited safely, including obtaining enhanced Criminal Record Bureau (CRB) checks for all permanent and agency staff, students and volunteers
- staff receive child protection training which is appropriate to their function within the agency
- staff receive regular supervision, sufficient to support staff to recognise children in need of support and/or safeguarding, and which is appropriate to their responsibilities within the organisation
- their agency has internal safeguarding children policies and procedures, which are known and easily accessible to all staff.

All agencies must ensure arrangements for effective multi-agency working to promote children's welfare and safeguard them from harm, including information sharing, collaborative assessment, care planning. All agencies whose staff come into contact with children in their daily activities, and/or who provide services to adults who are parents, must ensure their staff are familiar with the *London Child Protection Procedures*. The agencies and the staff themselves must ensure that they:

- understand risk factors and recognise children in need of support and/or safeguarding
- recognise the needs of parents who may need extra help in bringing up their children, and know where to refer for help
- recognise the risks of abuse to an unborn child
- understand the risks posed by and needs of children who harm others
- access the agency's nominated child protection adviser from whom child protection advice can be sought.

Local authorities (LA) are required to ensure that children in their area are protected from significant harm. LA children's social care services have the following responsibilities:

- to be the principal point of contact for children about whom there are safeguarding concerns
- to be available to be contacted directly by children, parents or family members seeking help, concerned friends and neighbours, or by professionals and others
- to assess, plan and provide support to children in need, including those suffering or likely to suffer significant harm
- to make enquiries under s47 of the *Children Act 1989* wherever there is reason to suspect that a child in the LA area is at risk of significant harm
- to convene and chair child protection conferences
- to maintain a list (accessible to relevant agencies) of children resident in the area, including those who have been placed by another local authority or agency, who are considered to be at continuing risk of significant harm and for whom there is a child protection plan
- to provide a key worker for every child who has a child protection plan

- to ensure the agencies who are party to the protection plan co-ordinate their activities to protect the child
- to undertake a core assessment in relation to each child with a child protection plan, ensuring other agencies contribute as necessary to the assessment and that assessments take account of key issues (e.g. domestic violence or neglect)
- to convene regular reviews of the child's progress through both core group and child protection conference review meetings
- to instigate legal proceedings in accordance with these *London Child Protection Procedures* and other relevant procedures.

The Committee took a lot of evidence regarding the processes involved in safeguarding across the various agencies in Lewisham, and particularly focussed on the referral system to CSC and how cases were managed across the partnership from that point onwards.

The Committee learned that the "core group" usually includes whoever is involved in the childs life, including health services and the voluntary sector and their task is to meet and have a case conference, at which they devise and agree a plan of action, then implement that plan and meet every 6 weeks to share information about how the child is doing from their various perspectives, and then make a decision whether the progress is satisfactory or whether more action is needed.

School staff advised the Committee that in the last year or two communication between schools and CSC has been much improved as clear information has now been given to all schools about the structure of teams in childrens social care and school safeguarding leads have built up the knowledge and relationships with staff so are confident about who to talk to and they feel confident in working with the CSC staff to work through different views or expectations.

Staff and managers from all agencies appeared confident in the escalation procedures if there were disagreements or miscommunications across agencies, and all felt comfortable with escalating concerns to senior managers when appropriate and felt that the Head of Family Support and Intervention would support officers to resolve any disagreements constructively.

The Committee discussed with a number of witnesses procedures and protocols for disagreements between professionals, and were assured that conflicting views were part of what was needed, as the point of a core group was to get all of those different perspectives on a situation together to get a more complete picture and then agree collective action based on those shared different perspectives.

School staff and CSC advised the Committee that sometimes medical examinations have not happened as quickly as they would have liked. The Committee heard examples of where an issue with a child been identified at 10am, but as no one had been available to examine the child, by the end of the day, they have to be allowed home and then the next day the child will give a "set" answer about the cause of the injury. The Committee was reminded that immediate response after disclosure by a child was a key in tackling abuse.

The Committee heard evidence from senior officers, health staff and schools staff that they all felt that the co-location of services and staff at children's centres can help mitigate against a lack of communication in many cases, as when staff from different agencies are based in the same building they can communicate quickly and easily with each other, and also develop a better awareness of each others roles and limitations. The development of Eliot Bank School as a children's centre was seen by staff and senior officers as an exciting way to link schools and wider organisations for safeguarding purposes, amongst the other wider benefits such centres provide for children and their families.

The Executive Director of Children and Young People's Services and the Director of Children's Social Care both demonstrated a clear commitment to continuing to utilise the independent services of the Parents' Advocate, to support families who are part of child protection proceedings. The Chair of the Committee's interview with the current Parents' Advocate, and the recent report of the service gave clear evidence that not only did this role provide valuable support to parents, but also acted as an independent quality control measure of staff practices, primarily in relation to communication.

Staff from all organisations advised the Committee that the core group systems worked very well, but some commented that they found that, as communication was often via phone calls rather than emails, it could be difficult as people kept missing each other on the phone as most staff by the nature of their jobs were not always next to, or able to answer the phone. All staff mentioned that ICT systems could sometimes be time consuming, or hinder both carrying out their role effectively and communications with other agencies if not working correctly. The Executive Director advised the Committee that work was underway to ensure secure email communication channels across all the partnership organisations.

Police officers who gave evidence to the Committee felt they had a good relationship with CSC as they often carried out joint visits with CSC staff and also worked closely with schools. However, as the relevant Police unit currently covered 4 London boroughs, police

officers and staff weren't able to build quite such close working relationships with professional colleagues as people can in schools, local health sevices and the local authority.

Health visitors advised the Committee that they sometimes felt that when midwives, GP's or Social Services referred families to them, they didn't share what the health visitors felt would have been important information, either when referring a case to them specifically or generally when working with particular families and identifying issues.

Staff from all organisations confirmed the views of senior officers; that in the field of safeguarding, progress was being made across all organisations in improving and joining up services and practices. Although all witnesses agreed that there was still room for improvement across individual agencies, and in the way in which agencies communicated and worked together, what was evident to the Committee was the genuine desire of staff at all levels in all agencies to continue to improve practices and communicate with each other more effectively to safeguard children in Lewisham.

6. Recommendations

On consideration of all of the evidence they have taken as part of this review, the Committee have agreed 32 recommendations that they feel should be considered and agreed for adoption/implementation by Mayor and Cabinet and the boards of the relevant partner organisations.

The Committee feel that the evidence they have amassed leads clearly to the following recommendations.

The recommendations of the Committee have been separated into three key areas:

1. Promoting understanding below the strategic level
2. Mechanics of communication
3. Organisation specific recommendations
    - Police
    - Primary Care Trust (PCT)
    - Schools
    - Lewisham Council
    - Lewisham Children's Safeguarding Board

The three areas of recommendation correspond to the three key areas of enquiry that the Committee identified at the outset of the review, and also correspond to Lord Laming's review framework as outlined below:

Recommendations	**Committee Key areas of enquiry**	**Lord Lamings review framework**
Promoting understanding below the strategic level	Structure/Strategic – Partnership Working	Leadership and accountability
Mechanics of Communication	Communication – Process/Operational	Interagency working
Organisation Specific Recommendations	Research/Case studies	Organisation

Promoting understanding below the strategic level

1. The co-location of services should be prioritised and promoted as far as possible
2. Opportunities for joint training across all partnerships should be actively sought out
3. Opportunities for shadowing between different professionals and organisations should be developed to foster a better understanding of organisations' practices and cultures
4. Listening to the direct experiences and views of children and parents who have been through the child protection system should happen regularly, and what is learnt from that dialogue should directly inform practice
5. Clear escalation procedures for urgent safeguarding concerns should be published by each organisation, so practitioners in all organisations are aware of how to escalate an issue that they feel is not being dealt with adequately

Mechanics of communication

6. As and when organisations need to replace and upgrade their IT systems and processes, the possibility of harmonising systems or sharing systems should be looked into (i.e. joint commissioning) to ensure that partnership organisations' systems are at the very least compatible, if not the same system
7. A protocol for sharing confidential information between all partner organisations, including schools, that provides practical guidance for staff should be developed
8. Guidance on how and when to communicate with families and professionals, and the best method to use in each circumstance, should be included in guidance for staff
9. The lead officer, social worker or social work assistant should ensure that clear contact details of all involved parties, and the best method of communication, are noted and agreed at each case conference and recorded as part of the "practical considerations" part of the child protection core groups guidance
10. A high quality, standardised model of recording information should be developed and promoted across all agencies in the partnership
11. Excellent standards of communication, both written and oral, are vital and should be a core competency when recruiting staff
12. Clear and timely communications should be a clear expectation of all staff and action taken if high standards are not met

13. ICT systems should be of benefit to staff, so operational staff should be actively involved in all relevant systems development

Organisation specific recommendations

Metropolitan Police

14. Safer Neighbourhood Teams (SNT), Child Abuse Investigation Teams (CAIT), the Sapphire Teams and Rapid Response Teams should work closely together and regularly, proactively share information on any incidents involving a household that includes children. The SNT should check the intelligence systems daily to keep abreast of and follow up any incidents in their area

15. The police should work with the local authority to explore the possibility of co-located Child Abuse Investigation Teams (CAIT) and Childrens Social Work teams as a priority

PCT and GPs

16. The PCT should explore with the Local Authority ways to facilitate GP and other health professionals' active participation in case conferences, including considering scheduling, location and possible utilisation of technology to facilitate participation (i.e. telephone conferencing)

17. The PCT should investigate providing locum GP coverage to enable GP participation in case conferences

18. The PCT should ensure that when commissioning and tendering for GP services, the explicit expectation of GPs to participate in case conferencing and activities related to safeguarding is included in specification and contract papers

19. The PCT should set up a clear mechanism/process to monitor GP attendance at case conferences and advise GPs that this will be done

20. The important role of health visitors in safeguarding younger children should be recognised and better supported by the PCT when planning safeguarding activities and communications

Schools

21. Schools should forge strong links between local primary and secondary schools to ensure clear communication directly between schools when children in need are transitioning from primary to secondary, or when children from one family attend different schools

22. Absence management should be monitored vigorously at all schools, and there should be a strong link between the safeguarding lead and the lead officer managing absence in a school, to ensure that the two areas are clearly linked in practice

23. Staff, particularly the safeguarding leads, should be clear on the escalation process both within the school and with the local authorities if there are safeguarding concerns

24. Safeguarding training should be provided for all governors, and efforts made to ensure improved take up of training offered

Lewisham Council

25. The Council should continue to prioritise the recruitment and retention of social workers

26. The Council should maintain the high level of management in children's social care that currently allows for a high level of both supervision and support

27. Communication skills should be a core competency of all children's social workers and social work assistants and the testing and then ongoing development of these skills should be effectively managed

28. Once established, the recently announced National College of Social Work should be utilised to ensure best practice amongst all existing staff

29. The roles of the social work assistants and business support officers should be better utilised to ensure that the social workers are able to spend the maximum time on working with families and children, with more administrative tasks supported by the assistants

30. The parents' advocate service should be expanded to ensure there is adequate cover at all times to ensure that all case conferences can be covered by the parents' advocate service, to ensure that all parents have access to this support service, and the external challenge to professionals continues to be robust

Lewisham Childrens Safeguarding Board

31. Continue to monitor and review the effectiveness of the recent structural changes to the board and its activities

32. Consider ensuring the "independence" of the Chair over time – remuneration should be reviewed and the costs split across all members of the partnership and re-recruitment after an agreed time to ensure a fresh independent approach

7. Key legislation relating to safeguarding

The legislative framework of Child Protection Services is contained in the Children Act 1989. In addition the HMG Government document "Working Together to Safeguard Children" provides a guide to interagency working to safeguard and promote the welfare of children. More detailed procedures are contained in the "London Child Protection Procedures" which were commissioned by the London Safeguarding Children Board on behalf of the Association of Directors of Children's Services, the Metropolitan Police Service, NHS London, The London Area of the National Offender Management Services, the NSPCC and London's Voluntary and Community Child Care Services Sector.

The relevant provisions of this Act are,

Section 17, Provision of Services for Children In Need, their families and others. "It shall be the general duty of every Local Authority (in addition to the other duties imposed on them by this part).

(a) To safeguard and promote the welfare of children within their area who are in need and

(b) **So far as is consistent with that duty, to promote the upbringing of such children by their families,** by providing a range and level of services appropriate to those children's needs.

For the purposes of this part a child shall be taken to be in need if –

(a) He is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him by services by local authority under this part;

(b) His health or development is likely to be significantly impaired, or further impaired without the provision for him/her of such services, or

(c) He/She is disabled.

And family in relation to such a child, includes any person who has parental responsibility for the child and any other person with whom he/she has been living.

For the purposes of this part, child is disabled if he/she is blind, deaf or dumb or suffers from mental disorder of any kind, or is substantially or permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed and in this part -

"Development" means physical, intellectual, emotional, social or behavioural development and "Health" means physical or mental health.

Section 47 of the Children Act 1989

Local authority's duty to investigate

Where a local authority –

(a) is informed that a child who lives, or is found, in their area –

(i) is the subject of an emergency protection order, or

(ii) is in Police protection or

(iii) has reasonable cause to suspect that a child who lives, or is found in their area is suffering or is likely to suffer significant harm

The authorities shall make or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

Where a local authority have obtained an Emergency Protection Order with respect to a child, they shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide what action they should take to safeguard or promote the child's welfare.

Section 27 of the Children Act 1989

Co-operation between authorities

(1) Where it appears to a local authority that any authority or other person mentioned in subsection (3) could, by taking any specified action, help in the exercise of any of their functions under this part, they may request the help of that other authority or person, specifying the action in question.

(2) An authority whose help is so requested shall comply with the request if it is compatible with their own statutory or other duties and obligations and does not unduly prejudice the discharge of any of their functions.

(3) The persons are—

(a) any local authority,

(b) any local education authority;

(c) any local housing authority;

(d) any health authority; and

(e) any person authorised by the Secretary of State for the purposes of this section.

(4) Every local authority shall assist any local education authority with the provision of services for any child within the local authority's area who has special educational needs.

The concept of significant harm

The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer significant harm. **There are no absolute criteria on which to rely when judging what constitutes significant harm**.

Consideration of the severity of ill treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Sometimes a single traumatic event may constitute significant harm, e.g. a violent assault, suffocation or poisoning. More often significant harm is a compilation of significant events both acute and long standing, which interrupt, change or damage the child's physical or psychological development.

8. Appendix A

List of Evidence - Safeguarding in depth review.

Council Process in relation to Safeguarding Report to CYP Select Committee 9th June 2009
Minutes of CYP Select Committee meeting on 9th June 2009
Introduction to Partner Officers report to CYP Select Committee 7th July 2009
Minutes of CYP Select Committee meeting on 7th July 2009
Role of Partner Agencies report to CYP Select Committee 3rd September 2009
Minutes of CYP Select Committee meting on 3rd September 2009
Safeguarding Performance Report to CYP Select Committee 13th October 2009
Appendix A (Complaints) Performance report to CYP Select Committee13th October 2009
LCSB Performance Report Aug 09 to CYP Select Committee 13th October 2009
Safeguarding Data CYP Select Sub set report to CYP Select Committee 13th October 2009
Court Order Applications Data report to CYP Select Committee 13th October 2009
Minutes of CYP Select Committee meeting 13th October 2009
Interview with PCT designated Safeguarding Doctor and Nurse
Interview with Parents Advocate
Supplementary Question responses
Contact Point report 07.07.09
NHS Lewisham Safeguarding Committee TOR
UHL Safeguarding Position September 2009
SLaM Safeguarding Monitor Declaration 15.09.09
NHS Lewisham declaration on Safeguarding 21.10.09
Named GP for Safeguarding work plan 2009-2010
Centre for Excellence and Outcomes (C4EO) in CYP services
Safeguarding briefing 1 Oct 09 (Effective Interventions)
C4EO Safeguarding briefing 2 July 09 (Key questions for auditing child protection systems and decision making)
C4EO Safeguarding briefing 3 July 09 (how do people respond to new and challenging information)
National Safeguarding Delivery Unit – Consultation on Safeguarding Targets and Indicators
Pan London Child Protection Procedures
Lewisham Childrens Social Care Procedures Manual
Social Work Assistant Job Description

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