CHILDREN'S CHAMPIONS BOARD

MINUTES of a meeting of the Children's Champions Board held in the Seminar Lecture Theatre, Sessions House, County Hall, Maidstone on Tuesday, 21 July 2009.

PRESENT: Mrs A D Allen (Chairman), Mrs P Cole, Mr G Cooke, Mr L B Ridings, Mr M J Vye and Mrs J Whittle

ALSO PRESENT: Ms S J Carey, Mr N Collor, Mr H Craske, Mr T Gates, Mrs S V Hohler, Mr P J Homewood, Mr R A Marsh, Mr W Richardson, Mr J D Simmonds, Mr K Smith and Mr A Willicombe

IN ATTENDANCE: Mr P Gilroy (Chief Executive), Mr P Thomason (Independent Child Protection Consultant), Ms R Turner (Managing Director Children, Families and Education), Mr B Anderson (Director Children's Social Services), Mrs K Weiss (Head of Policy & Performance), Ms D Marriott (Acting Safeguarding Policy & Performance Manager) and Miss T Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

3. Election of Vice-Chairman
(Item A2)

Mr A D Allen proposed and Mr L B Ridings seconded that Mr M J Vye be elected Vice-Chairman of the Board.

Agreed without a vote

4. Minutes of the Board Meeting held on 12 February 2009, and an extract from the Minutes of the Board Meeting held on 20 May 2009
(Item A4)

RESOLVED that the Minutes of 12 February 2009 be noted, having already been agreed and signed at the Board's March meeting, and the 20 May 2009 extract be noted as an update on progress since the February meeting.

5. Dates of Board Meetings for 2009 and 2010
(Item A5)

RESOLVED that dates reserved for the Board's meetings for the remainder of 2009 and 2010 be noted.

6. Protecting Children in Kent
(Item B1)

(1) Mr Gilroy introduced the report by reminding Members that the present national review had arisen from the Joint Area Review following the death of Baby Peter in Haringey in 2007. He emphasised that the review team was independent of the CFE Directorate. The review was being conduced in three phases and included

Serious Case Reviews (SCRs) and a review of the Integrated Children's System (ICS). SCRs had looked at more cases involving under 5s than any other age group as this was the main area of concern following the death of Baby Peter. Phase One had been reported to the Children's Champions Board in February 2009 and today's report included the further work which had arisen from Phase One. Phase Two, on partnership working, would be reported to the Board and CFE POCs in September 2009 and Phase Three aimed to be completed in September 2009 and would be reported to full Council later in the Autumn.

(2) Mr Thomason presented a series of slides setting out the findings of the self-assessment questionnaire and the case audit of Kent's Children Social Services (CSS), and compared these to what had been found by Haringey's Joint Area Review. *A copy of the slides is appended to these Minutes.*

(3) Mr Gilroy added that, since the February meeting of the Board, the Government had allocated £1.5 million to Kent and this had been used to employ 33 more Social Workers as well as 11 new Social Work Support Officers to cover the recording work, thus freeing up social workers to concentrate on front line work. He added that Kent needed to be sure it had done its best to address the issues, and be seen to have done its best. He said he was very pleased with the quality of the review undertaken and congratulated the review team.

(4) Ms Turner thanked the review team and all those who had taken part, as the review outcomes would be very helpful for everyone involved in Child Protection and Safeguarding. The review offered a good chance to take stock and it was a credit to social workers, management and support staff that the services had shown up so well, given the difficult and sensitive nature of the issues they had to deal with on a daily basis. The findings of the review had reinforced that good services needed both good social workers and good business support staff. The Directorate had a good peer review system run by the teams of Kay Weiss and Bill Anderson. Ms Turner welcomed the training and staff development moves that had come out of the review. Following Haringey's Joint Area Review, there were now "no notice" inspections, performance figures were prepared monthly and vacancies monitored regularly. Members also had a role to play by serving on Adoption Panels and the Children's Champions Board, as Members' judgement and input was important. The Board's role in raising the profile of Members' Corporate Parenting responsibilities was also an immense help.

(5) Mr Anderson added that the Review had been reassuring for Members, as a culture of ongoing challenge insured that the Directorate never became complacent. He emphasised the vital role of Mrs Weiss's team in this ongoing challenge and monitoring of services and thanked the review team.

(6) The offices present then responded to a number of questions and comments raised by Members, as follows:-

(a) Members welcomed the invitation to all County Councillors to attend this special meeting to hear the outcomes of the review. This reinforced the importance of Safeguarding and Child Protection issues for all elected Members. Members' attendance and participation in meetings to talk about Child Protection sent the message to the Social Work team that Members valued their work;

(b) Lord Laming had expressed the view that having a stated threshold at which a child would start to receive services was a useful tool, although not a statutory requirement. As resources were always finite, having a threshold helped with resource allocation;

(c) Preventative work was also very important and would receive targeted resources. Mr Anderson's team was to lead on KCC's Preventative Strategy;

(d) Mr Gilroy suggested that the full County Council could have an annual report on Safeguarding/Child Protection issues and dedicate a morning's debate to the subject;

(e) The review team had chosen not to apply Ofsted's standard definitions or its language to their review, but the rating of "satisfactory" meant that no cases reviewed had actually failed, and some were very good. Overall, children in Kent are very safely protected;

(f) Research had shown that alcohol misuse was a very significant risk factor relating to Child Protection issues, and handling it was a challenge for the public sector. CSS managers would need to ensure that social workers liaised with professionals involved in treating a family member for alcohol misuse, but this added another challenge to the safeguarding work;

(g) The most accurate screening method currently available could identify approximately 85% of those parents who were most at risk of abusing their children, but if a department were to aim to resource services for all of these families, the caseload would quadruple immediately. Thresholds were applied to ensure that services were target appropriately at the most high risk families. Under Every Child Matters, more services had been invested in supporting families. Over the last 10 years, the percentage of CSS budget spend used for preventative services had risen from 5% to 33%;

(h) Lord Laming had estimated that 1.3 million children were living with an alcoholic parent, and it was just not possible to resource services for all of these children. The KCC's Alcohol Misuse Select Committee report had emphasised the need for prevention work and to change public policy and attitudes to alcohol misuse;

(i) The age at which a child could be consulted personally about his or her Child Protection Plan varied depending on the child's confidence and ability to express themselves. Social work contact over a period of time would suggest the most appropriate method for any particular child, and the child's responses would always be contributed to the setting of their Child Protection Plan. With adolescent and older children, the approach could be more direct. Social workers working with children and young people needed to use their skills and experience to judge the most appropriate way to engage a young person. An experienced practitioner would also take account of non-verbal communication and coded behaviours/language which, in some families, were very extensive. It was simply not possible to build up these skills and relationships using temporary social work staffing;

(j) New parents no longer receive health visitor and midwife home visits as they would have done 30 years ago, when the home visiting period lasted much longer into a child's early years. Both health visitor and home midwifery services had been cut back, but now domestic midwifery services were starting to return. A review of health visitors and midwifery commissioning was shortly to be undertaken;

(k) Mr Gilroy expressed the review that post-graduate social worker training had become too academic in recent years and had lost its practical element, eg., how to take a good history. Liaison with Vice-Chancellors of Universities had shown that the thinking about post- graduate training was now changing;

(l) The evidence of recent years had shown that a high profile case like Baby Peter and the media attention and outcry surrounding it raises public anxiety, insecurity and panic and the number of Child Protection referrals rises, increasing the workload and making the system less effective. Boosting public confidence in the system would reduce the number of referrals and make the workload easier to manage;

(m) Being able to show results and changes promised in return for the expenditure of public money is a challenge for the public sector. For example, the SureStart scheme promised to make a difference which had not yet materialiseg;

(n) One Member pointed out that nervous young parents could be frightened to take their child to hospital with a genuine injury, innocently acquired, for fear of being reported and investigated as having abused or neglected their child;

(o) Kent had a history of having a large number of children in care placed by other local authorities, many concentrated in areas such as Thanet and Swale. This was partly due to a shortage of foster parents in London and partly due to the fact that placing a child in Kent benefitted London Authorities financially. In the past, also a large number of children and adults with learning difficulties had been placed in Kent by other local authorities, and these children/young adults had then become Kent's responsibility. Some of these had been placed as a result of the closure of large old hospitals and institutions. A debate was needed of the public policy which had allowed a large number of vulnerable children and adults to be moved into deprived areas of Kent;

(p) The majority of children who enter council care do so due to neglect. It is not good for children to be in council care, so CSS needed to support them in the community if at all possible, although it is not easy to identify and support children living in chaotic family set ups. This would require good partnership working to deliver a multi-agency package;

(q) The huge amount of paperwork and bureaucracy associated with adoption hearings could divert social workers' attention away from other cases. Whilst it was important to be thorough in the preparation of adoption cases, so parents could see the process being thorough and the panel could make a well-informed decision, it was possible to remove some bureaucracy without having a negative effect on the process. The adoption system and care

proceedings both needed to be transparent, well documented and inspire public confidence.

(7) The Chairman thanked the review team once again for their thorough preparation and clear presentation of the findings, and Directorate officers who had supported and taken part in the review and attended the meeting to help answer Members' questions.

(8) RESOLVED that:-

(a) The content of the report, and the information given in response to Members' questions, be noted, with thanks;

(b) The recommendations set out in paragraph 20 of the report, namely that Children's Social Services undertake work to review its supervision policy and, where necessary, strengthen it, and the additional investment in staffing take account of the need to make high quality task-focussed and reflective supervision consistently available to frontline staff, be agreed;

(c) A further special meeting of the Children's Champions Board be arranged for Autumn 2009 to report back on further national developments and their possible impacts on local safeguarding arrangements and on the findings of the work to assess the effectiveness of local inter-agency safeguarding arrangements; and

(d) The outcomes of Phase 3 of the review, when complete, be reported to a meeting of the full Council later in Autumn 2009.

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PROTECTING CHILDREN IN KENT

Peter Gilroy – Review Owner
Martyn Ayre – Review Lead
Peter Thomason – Independent Consultant
Joanne Purvis – Review Assistant

Baby Peter

- Died of non-accidental injuries, aged 17 months
- Had been on child protection register from age 9 months
- Injuries recorded during the period he was on CP register
- Social worker visited regularly (last saw Peter 4 days before death)
- Health services in contact (last saw Peter 2 days before death)
- Mother non-compliant and misled agencies regarding presence of partner
- Lack of authoritative approach by agencies
- Poor supervision
- Poor inter-agency communication

[Haringey LSCB Serious Case Review, February 2009]

Findings of Haringey JAR

- Weaknesses in safeguarding and child protection procedures and practice
- Inadequate leadership and management of safeguarding by local authority and partner agencies
- Poor gathering, recording, and sharing of information
- Failure to identify those children and young people at immediate risk of harm
- Poor child protection plans
- Agencies generally working in isolation from one another and without effective co-ordination
- Failure to consult with children
- Limited evidence of reasons when children were not seen alone
- Inadequate serious case review of death of Baby Peter

Tools for reviewing Kent CSS safeguarding

- Questionnaire completed by all Children's Social Services teams
- Extended audit of 50 current child protection cases

Main findings from questionnaire and case audit for Kent CSS

- Children on CSS caseloads are adequately safeguarded
- Evidence of sound professional practice by CSS
- Effectiveness weakened by caseloads in some teams
- Effectiveness weakened by recording requirements of the Integrated Children System (ICS)
- Importance of supervision in maintaining quality of child protection work

Main findings

QUESTIONNAIRE

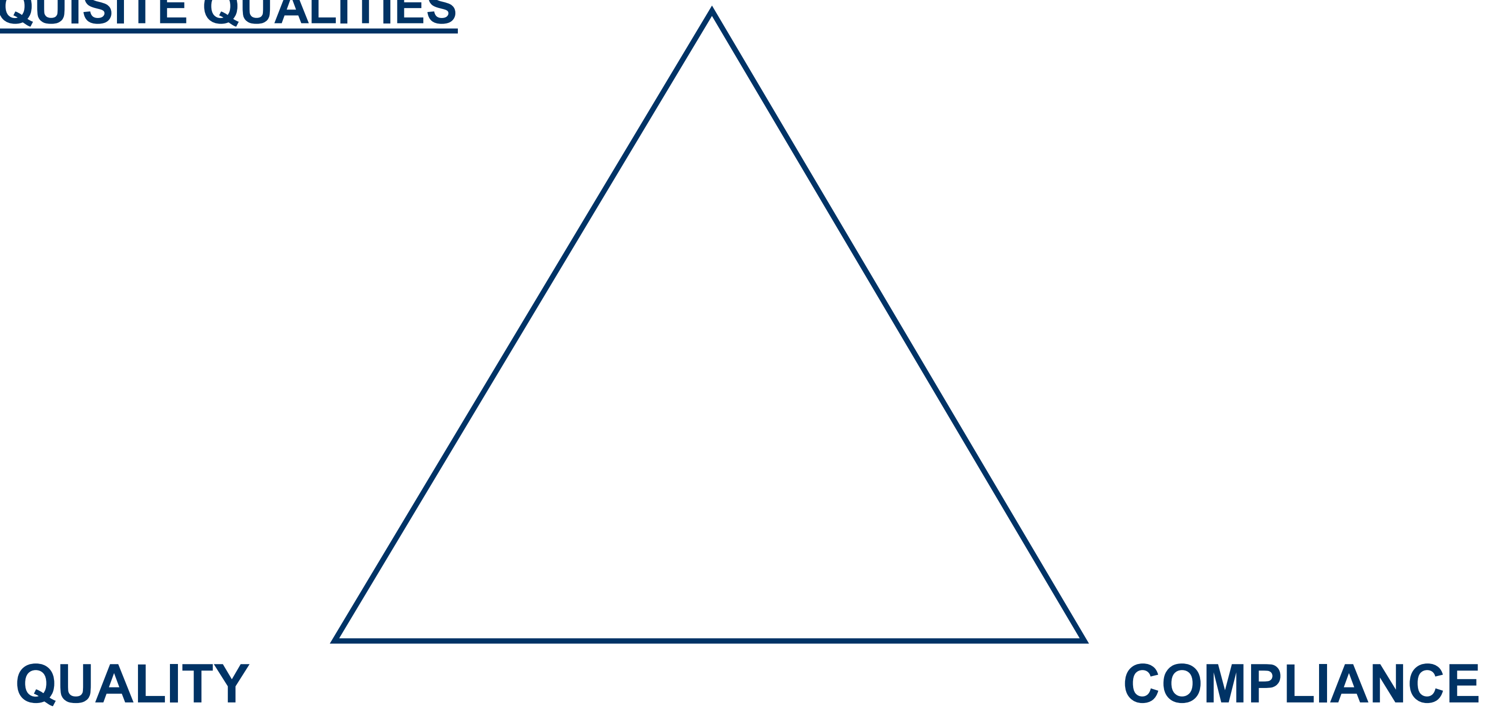
- Kent CSS safeguarding standards are generally safe
- There are some pressures on the safeguarding systems and practice
- Some pressures are county-wide, others are localised
- Localised pressures may change location and focus over time
- Where county-wide and local pressures coincide, there is increased risk that standards may become unsafe

CASE AUDIT

- Children in review are adequately protected
- Some elements of reviewed cases fell short of best practice
- Mixed recording processes create difficulty in gaining a speedy and comprehensive overview of cases
- Good quality supervision is associated with good child protection

Good child protection organisations

REQUISITE QUALITIES



Haringey JAR - Weaknesses in safeguarding and child protection procedures and practice

KENT CHILDREN'S SOCIAL SERVICES

- **Policies are generally well implemented and followed [Q27]**
- **Quality audits are used to evaluate outcomes and compliance [Q28]**
- **Performance indicators are used to assess quality of practice [Q29]**

Haringey JAR - Inadequate leadership and management of safeguarding by local authority and partner agencies

<u>**KENT CHILDREN'S SOCIAL SERVICES**</u>

Children's Social Services management has been positive in its actions in response to the Secretary of State's request to review safeguarding services and in taking action in response to the findings of this review

Review of other agencies' management and leadership will be undertaken by the Kent Local Safeguarding Children Board

Haringey JAR - Poor gathering, recording, and sharing of information

<u>KENT CHILDREN'S SOCIAL SERVICES</u>

- Information gathering is satisfactory [Q2]
- Account is taken of historical concerns [Q16]
- Child protection reviews involve a range of agencies [Q19]

Haringey JAR - Failure to identify those children and young people at immediate risk of harm

KENT CHILDREN'S SOCIAL SERVICES

- **Thresholds are clearly defined [Q1]**
- **Strategy discussions are held according to *Working Together* requirements [Para 9.1]**
- **Child protection conferences are generally held within timescales and according to *Working Together* requirements [Para 9.1]**
- **Where appropriate, legal processes are used promptly to protect children [Para 8.1]**

Haringey JAR - Poor child protection plans

KENT CHILDREN'S SOCIAL SERVICES

- Care planning and assessment is satisfactory [Q15&17]
- Child protection plans are clear [Q22]
- There is evidence that child protection plans are successful [Q23]
- Children are usually consulted about their child protection plans [Q24]
- Child protection plans are in place and monitored and most show evidence of progress [Para 9.1]
- Core Group meetings are normally held within stipulated timescales and are well-attended and implement child protection plans [Para 9.1]
- Independent chairpersons of child protection conferences maintain focus on child and progress of plans [Para 9.1]

Haringey JAR - Agencies generally working in isolation from one another and without effective co-ordination

To be reviewed with partner agencies on Kent Local Safeguarding Children Board

Haringey JAR - Failure to consult with children

KENT CHILDREN'S SOCIAL SERVICES

- Children are seen and spoken to [Q12]
- Children are visited within agreed timescales [Q21]
- Children are visited regularly and seen and spoken to [Para 9.1]
- Children are usually consulted about their child protection plans [Q24]

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Haringey JAR - Limited evidence of reasons when children were not seen alone

KENT CHILDREN'S SOCIAL SERVICES

- **Managers address reasons when children are not seen alone [Q13]**

Haringey JAR - Inadequate serious case review of death of Baby Peter

Haringey LSCB produced a second serious case review in February 2009

All recent serious case reviews conducted by Kent LSCB have been appraised and accepted by Ofsted

CONCLUSION

"… there can be no guarantee that a single case within Children's Social Services may not be in a state of risk. Standards of child protection work, overall, can only be assured by regular supervision and self-monitoring." [Para 10.2]

"Regular, high-quality, organised supervision is critical." [Lord Laming]

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