Wolverhampton Safeguarding Children Board

Executive Summary

Child J

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EXECUTIVE SUMMARY

Serious Case Review: Child J

1 Introduction

1.1 In Late December 2008 an emergency 999 call was received by West Midlands Ambulance Service reporting that a 3 year old child was having a fit, not breathing properly and slipping into unconsciousness, having, so it was reported, fallen in the bath. The address given was a flat in Wolverhampton, the address of PQ, then aged 18, where at that time she was living with her boyfriend, LD, then aged 23.

1.2 The child, Child J had stopped breathing, and had bruising to the head, face and legs.

1.3 Child J died at a specialist Paediatric Intensive Care Unit 2 days after the initial incident.

1.4 The nature of Child J's injuries suggested that the child had been the subject of non-accidental injury.

1.5 PQ and LD were not Child J's parents. Child J's mother was EF, then aged 20, and father was GM, then aged 23. GM no longer lived with EF. It was not at that time clear why Child J had been in the care of PQ and LD.

1.6 EF, PQ and LD were all known to the statutory agencies. PQ had been subject to care proceedings taken by Wolverhampton City Council (WCC), and at the time of these events was in receipt of Leaving Care support, including the provision of accommodation under the intensive supported service, a service provided by a third party under contractual arrangements with WCC.

2 Terms of Reference of the Review

2.1 Child J's death is regarded as a case from which lessons can be learned, and as such meets the criteria in Chapter 8 paragraph 8.5 of the HM Government document Working Together to Safeguard Children ("Working Together"). This Review was commissioned to be carried out by the Wolverhampton Safeguarding Children Board ("WSCB") Serious Case Review Panel.

2.2 The formal Terms of Reference of the Review were to consider:

- A factual chronology of the action that has been taken in each agency
- Whether assessments and interventions completed were of sufficient quality, rigour and to standards required
- Whether the WSCB child protection procedures have been followed

- Whether the case suggests that there is an urgent need to review those procedures
- Whether any other action is needed now within any agency
- Whether the analysis of the information and the consequent response by all agencies was appropriate

3 The Review Process

3.1 It was important to establish firstly why and how it was that EF had left Child J to be looked after by PQ and LD. Was there anything that could or should have been done by any agency that could have changed that?

3.2 It was important secondly to establish whether there was anything that could or should have been done by any agency that would have diminished or eradicated the risk to Child J once placed with PQ and LD.

3.3 This process required an examination of Child J's own history, an examination of the history and circumstances of the family, and particularly of Child J's mother, EF, and an examination of the history and circumstances of PQ and LD in whose care Child J had been in the days leading up to the child's death.

3.4 Each agency that had had direct involvement with PQ, LD or EF was asked to undertake an Individual Management Review, to look fully and critically at its involvement in the case, both within the agency itself and in its interrelationship with other agencies, and to produce a detailed chronology.

3.5 The panel initially were unable to instigate direct involvement with the parents in this review, due to the ongoing Police investigation. Once the investigation was completed two meetings were arranged in collaboration with the Family Support Officer and Public Protection Unit for the Police. The initial meeting to explain what a Serious Case Review was and what it entailed, the second, more recent meeting, to go through the findings of the review with the parents. It was agreed that the parents can request a further meeting at a later stage if they wish.

3.6. However, the parents did feel that they would wish to convey information about their child. Child J was in their view a typical three year old who enjoyed TV programmes and playing with friends. Child J is described as a sweet, content, polite, bubbly, intelligent little child, loving and caring and protective of Child J's younger sibling, loved by everyone, but especially the parents. Child J is so missed for Child J's laugh and cheeky smile and for the things Child J said which made them laugh. Child J will always be in their thoughts.

4 Summary of the Facts of the Case

4.1.1 Facts relating to EF

4.1.1 Child J was born in 2005 when EF was 17 years old. Father, GM, was 19. EF had previously been known to the statutory agencies.

4.1.2 EF attended for Child J's developmental appointments and for immunisations and generally was making good progress developmentally.

4.1.3 During 2007 there were a number of changes in Community Health Visiting services assigned to the family, and in August 2007, shortly after the birth of Child J's sibling, the case was assigned to the "corporate caseload". Initial contacts with EF made during 2007 in relation to nursery attendance for Child J, were not pursued. Contact with EF by a leading support agency (Connexions) to assist with progression to education, training or employment was too long delayed.

4.1.4 There is no evidence of effective communication or liaison between the different agencies involved with EF or Child J at this time.

4.1.5 An Emergency Duty Social Worker and Police were involved with EF mid year 2008 when the younger sibling was found to be in the charge of unsuitable carers. The initial assessment concluded that no further action was required, although full information had not been obtained.

4.2 Facts Relating to PQ

4.2.1 Children's Services had involvement with PQ from age 1 onwards, due to chaotic home circumstances and neglect. The family were subject to Child Protection processes and legal action or consideration of legal action on a number of occasions from 2001 onwards.

4.2.2 In 2005 PQ became involved with the Wolverhampton Youth Offending Team.

4.2.3 Throughout this time the Education Services had been pursuing PQ's mother in relation to failure to ensure that her children attended school. PQ did not engage with education to any significant extent from primary level until attaining school leaving age in 2007.

4.2.4 In the autumn of 2005 a family member reported that PQ's 6 year old sibling had been hit by both PQ and another sibling, causing a minor injury. This incident was tardily dealt with by the police. The original allegations of assault became "lost". The absence of any record meant that the fact that there had been an allegation made that PQ had assaulted a child was not something known or available to agencies having future dealings with PQ.

4.2.5 In the same month in 2005 applications were made for interim care orders in respect of the family including PQ.

4.2.6 In latter months of 2007 PQ moved to live with her boyfriend LD at his flat. At this point PQ was nearly 17 and the care order application was to be withdrawn a few days later, but PQ continued to be entitled to Leaving care Services. There is no record of any checks having been carried out in relation to LD, which should have been done.

4.3 Facts Relating to LD

4.3.1 LD is known to have had an unsettled upbringing. Concerns as to drug and alcohol use have been a feature of the involvement of all agencies with him.

4.3.2 In January 2005 LD was admitted to a unit for mental health support. LD was discharged late that month with out-patient follow-up and referred to Specialist Services.

4.3.3 In October 2005 LD was assessed for a Pre-Sentence Report and assessed as constituting a medium level risk of serious harm to children left in LD's care if unable to cope with the pressures of life. This assessment was not properly recorded by the Probation Service involved on introduction of a new database in 2007 and so did not appear on LD's profile after that date.

4.4 Facts Relating to Both PQ and LD

4.4.1 In November 2007 the application for a care order on PQ was withdrawn. PQ was assessed as suitable for the Intensive Specialised Supported Living Service, a service provided by a third party ("the Contractor" Shaftesbury) under contractual arrangements with WCC, whereby a flat/bedsit was provided and the young person assisted towards independence with intensive visiting and practical support.

4.4.2 In June 2008 PQ moved in to the flat. This initial period was one of frequent engagement with PQ by various agencies. Following this PQ's engagement declined.

4.4.3 The Probation Service was aware of LD's relationship with PQ at least from July 2008, when LD registered this address as living with PQ at the flat. LD was in fact living with PQ at the flat throughout the period from June to December 2008. LD was frequently seen by the Contractor's staff, including at the flat. The Contractor was aware of the history of the couple's relationship, and was made aware of concerns felt by another leading support agency regarding LD's presence and influence on PQ. Nevertheless, the Contractor was not actively aware that LD was living there.

4.4.4 PQ's co-operation with the Contractor and other agencies was patchy, and visiting by the Contractor was sporadic.

4.4.5 The Contractor was made aware that a leading support agency considered LD to be a negative influence and that LD's presence was hindering PQ's progression. The Contractor corporately did not share that view.

4.4.6 In October 2008 Wolverhampton City PCT Adult Mental Health wrote to LD's GP to inform of failure to attend 2 out-patient appointments and so was being discharged back into GP care.

4.5 Facts Relating to PQ, LD and Child J

4.5.1 Child J was believed to be living at the flat with PQ and LD from early December 2008. EF had been finding it difficult to cope with 2 young children, and so PQ and LD had agreed to look after Child J, in exchange for payment.

4.5.2 In early December 2008 LD attended at the Probation Office for an interview. LD accompanied by a child who LD said was a cousin's 3 year old child. The child was in fact Child J. The Officer took no action. The fact that LD had been assessed in the context of a Pre-Sentence Report in criminal proceedings as posing a medium level risk to children in LD's care should have resulted in a "flag" having been entered on the record, but this had not been done.

4.5.3 Several of the Contractor's staff saw PQ and/or LD in company with Child J during the course of December 2008, at the flat, at the Contractor's offices and elsewhere. The different sightings of Child J were not collated, and no other agency was notified. The Contractor was not actively aware Child J was living at the flat or who the child was, other than that the child was described as PQ's "cousin's" child.

4.5.4 A member of the Contractor's staff saw PQ, LD and a child who it is presumed was Child J, at the flat on the morning in late December 2008. The child was under a pile of bedclothes on the bed. PQ distracted the worker's attention by drawing attention to a puppy that LD had apparently given PQ as a birthday gift.

4.5.5 The worker took PQ to an appointment and dropped PQ back home at early afternoon but did not at that point enter the flat and had not had any discussion with PQ as to the child.

4.5.6 On that same evening a 999 call to the ambulance service was made from a neighbour's telephone. Information was given that a child at the flat had fallen in the bath and had had a seizure. The child, Child J, was found lying unresponsive on a bed in the living room. Child J was noted to have bruising to the head, face and lower legs. Despite receiving treatment at a Paediatric Intensive Care Unit Child J died.

4.6 Facts Relating to the Contract between WCC and the Contractor

4.6.1 The Contractor's involvement with PQ arose under a contract between the Contractor and WCC. The provisions of this contract prescribe the required level

of visiting and contact the Contractor was to have with PQ and the required level of qualification and training of relevant members of staff.

4.6.2 WCC has a statutory duty towards young people who have been in its care and a more general statutory duty to promote and safeguard the welfare of children in its area. WCC is entitled to arrange for actions in relation to children leaving care to be carried out by another person.

4.6.3 The contract is unclear and contradictory in key areas, in particular that of visiting frequency. Contractual provisions as to training to be provided to the Contractor's staff are unclear and confusing.

4.6.4 While the lack of clarity in the contract might have made it difficult for the Contractor to know exactly what it was intended to provide under the contract, the Contractor's visiting at no point approached the frequency required on any reading of the contract.

4.6.5 WCC had a duty to monitor performance by the Contractor to ensure that WCC's statutory duties were being fulfilled, and also had contractual monitoring responsibilities. WCC's monitoring failed to pick up the deficiencies in the Contractor's performance, both in respect of visiting frequency and in respect of training.

5 Conclusions

5.1 EF, PQ and LD were all well known to the various agencies involved with child protection. Yet Child J was not protected, and suffered non-accidental injury as a result of which Child J died.

5.2 There are some commendable positives in this case. The Youth Offending Team worked hard in difficult circumstances to complete Referral Order work with PQ, achieving some success. A leading support agency, in working with PQ in 2008 "went the extra mile" in trying to ensure that PQ benefited from opportunities available. The Fire Service acted promptly and appropriately in reporting child protection concerns in June 2008, and the Ambulance Service and medical staff involved in trying to save Child J after sustaining injuries in late December 2008 cannot be faulted. But there are negatives too.

5.3 There are clear failings in the manner in which the Contractor provided Leaving Care services to PQ. But to extract the most benefit for the future from this case we must look more broadly at the question of causation. Child J was with PQ and LD. But why was Child J with them, in that situation of risk, at all?

5.4 EF placed Child J with PQ and LD because EF could not cope with the demands of 2 small children. EF was by mid 2008 a single parent and was struggling. EF had no formal educational qualifications, but was trying to remedy that, wanting to access educational and training opportunities. To be able to cope, EF needed some reliable child care arrangements to be made.

5.5 EF had had contact with a Nursery, and with a leading support agency, and ongoing involvement with the Health Visiting service. Child care assistance was EF's most pressing need at this time, yet nothing the agencies were doing was helping with this. The health service provided was at a limited, routine, level only. These agencies were all aware that EF had child care needs, and although a leading support agency undertook an assessment to identify barriers to progression in education and employment or training, none of the involved agencies carried out a parental capacity assessment so those needs were not fully recognised or appreciated.

5.6 In June 2008 EF was seen by a social worker and a police officer after the younger sibling had been left in the care of unsuitable adults. The social worker's initial assessment concluded that no further action was required. This assessment was inadequate. Supervision and management should also have identified that something more was needed before the case could be closed.

5.7 During the course of 2008 it appears that each agency involved was focused on the immediate task in hand and had failed to consider the wider picture. It may be that staff are overburdened, and so the time and space required to think through the difficult cases is simply not there. It is in these difficult cases that the importance of effective and high quality supervision is most apparent. Through inadequacies in dealing with the immediately presenting circumstances, and inadequacies in liaison between agencies, the safety net of the obligation on agencies to carry out their duties having proper regard to the need to take into consideration the welfare of children was not effective.

5.8 The Police should have recorded child protection concerns in relation to PQ in September 2005.

5.9 The Probation Service should have recorded the assessed child protection risk posed by LD and information should have been passed to Children's Services. This was not just a failure to record a matter of possible concern, but a failure to record a specific, formally assessed and quantified risk that LD posed to children.

5.10 If the records had been in place there is a chance that action would have been taken to remove Child J from PQ's flat, but that is not certain.

5.11 The agencies primarily involved with PQ in the second half of 2008 were the Contractor and a leading support agency.

5.12 The leading support agency's work with PQ was diligent and persevering, and concerns particularly with respect to LD's influence were identified and properly communicated to the Contractor.

5.13 The Contractor tendered for and was awarded a contract to work with some of the most needy young people in Wolverhampton. The fact that the service users were needy, and no doubt often difficult and uncooperative, would have come as no surprise. Yet the Contractor sought to carry out this difficult task with staff of

limited experience and qualifications, and having themselves provided those staff with minimal training.

5.14 Having contracted to provide a certain minimum level of contact, the Contractor did not provide that level of service. There are deficiencies in the contract drafting which will have caused uncertainty as to exactly what level of service the Contractor should have been providing, but the level actually provided fell below all of the possible options.

5.15 The Contractor was visiting PQ, substantially less frequently than it should have been, with staff substantially less trained in relation to child protection and safeguarding than they should have been. The Contractor claims not to have known that either LD or Child J were living with PQ, or even staying overnight, and in any event the Contractor did not consider that LD's presence was a problem, despite concerns expressed by a leading support agency. If the Contractor had been visiting more frequently it would in all likelihood have been more apparent not only that LD was living there, but also that LD was a negative influence, and it would probably have been apparent that Child J was living there too.

5.16 The last Contractor visit, carried out on that day in December 2008, is significant. The member of staff involved had no specific social work qualification, limited qualifications and experience generally, and had received insufficient training from the Contractor. Supervision received appears to have been of poor quality. One is driven to the conclusion that the Contractor was giving this worker more responsibility than it was reasonable for someone in those circumstances to bear. Having seen a child at the flat the worker took no action.

5.17 WCC also bears a responsibility. The contract under which the Contractor operated is not sufficiently detailed or precise to govern the complex arrangements with which it deals. It is badly drafted and in key areas self-contradictory. WCC's monitoring of the Contractor's contractual performance was not effective. The Contractor had been providing a performance substantially below the contractual specification, both in terms of visiting frequency, and in respect of training. WCC's monitoring had not identified these failings.

5.18 This case has also highlighted some other issues of general importance.

5.19 Adult Mental Health Services, and other adult focused services, need to ensure that they carry out their functions with children's interests in mind. Perhaps understandably, where children's interests are taken into account in the provision of adult focused services, the focus will be on the need to carry out such services bearing in mind the interests and welfare of particular, identified children – as for example the known children of an adult with drink, drug or mental health problems. What is not so clearly addressed is how the interests of children not specifically identified or identifiable to the adult service agency are to be protected. This case is a good example. LD was discharged from mental health

care in October 2008 as a person who, in principle, was likely to pose a risk to children. But, as there were no particular children in view, there was no notification of LD's discharge to any other agency. This meant that when, very soon after, LD came to be a carer for Child J, that risk was not known.

5.20 This is a difficult area, where disclosure decisions must strike a careful balance between the rights and interests of the adult, and the public interest in ensuring that children in general are kept safe from harm. What is needed is a more active awareness that unidentified children as well as identified children need to be considered by agencies as within the scope of the Children Act 2004 duties. Where there are no identified children the balance of necessity and proportionality in making a disclosure decision may fall in a different place, but the question must still be asked.

5.21 Important issues arise also in relation to Education, particularly from PQ's case. Failure to ensure that a child engages effectively with education is as much "neglect" as a failure to keep that child clean and well fed. Any tendency to treat school attendance and educational failure generally as an issue separate and distinct from other social care issues must be avoided. In PQ's case this is what happened. PQ's woeful school attendance was treated as largely an issue of enforcement involving the mother. It was not addressed within the overall context of neglect within the family.

5.22 Finally, this case highlights the fact that often the agencies have to rely on members of the public as their "eyes and ears". Neighbours, family and friends are often in a better position to see or become aware of possible child protection issues. The potential value of the general public in the child protection task needs to be better exploited. Some thought and attention needs to be devoted to development of strategies to unlock that potential.

6 Recommendations

6.1 There are a large number of recommendations contained within the IMRs produced by the individual agencies. It is to be assumed that where agencies have in this way themselves identified necessary action then they will take that action which will be monitored. The recommendations below identify key areas for action within the various agencies. Some of these do repeat, and often amplify, recommendations proposed by the agencies themselves. Some of them are additional. Some agencies have made recommendations in their IMRs but do not appear as addressees of any of the recommendations set out below. Individual agencies need to approach implementation of the recommendations of this report on the basis that both the recommendations set out below that are applicable to them, if any, and the specific recommendations proposed in their individual IMRs should be taken into account. The Wolverhampton Safeguarding Children Board will be responsible for monitoring progress on completion of all the recommendations of which a substantial number have already been completed.

6.2 Wolverhampton Safeguarding Children Board

6.2.1 Guidance and information be made available to all agencies providing services that apply primarily to adolescents or older children to emphasise and reinforce the need to assess and address as a training issue the level of understanding of their safeguarding role as including children of all ages.

6.2.2 Guidance and information be made available to all agencies to emphasise and reinforce the need for the position of each child or young person in a situation under consideration, irrespective of age, to be considered separately, and for there to be individual and robust assessments leading to the making of a clear plan in respect of each child.

6.2.3 Guidance be issued to all agencies to emphasise their responsibility to ensure the full and accurate recording and transmission of inter-agency notifications relating to children.

6.2.4 Guidance be issued to all agencies engaged in service provision to children and adults to emphasise the need to ensure the existence of effective policies relating to disengagement or non-engagement of service users in service provision and to ensure 'did not attend' and 'discharge from service' arrangements, and case closure policies, accommodate the on-going safety and welfare needs of children and young people.

6.2.5 WSCB to review the need for, and the priority to be given to, work to encourage public engagement in child protection, so as to encourage and facilitate members of the public in notifying appropriate agencies where ill-treatment or abuse of children is suspected, or where other relevant issues, such as unauthorised or unregistered childminding or fostering arrangements, arise.

6.3 Wolverhampton City Council, Children and Young People's Service, Quality and Improvement, Safeguarding Children Service

6.3.1 Taking into account the guidance in "Working Together" as to Child Protection Conferences, and in particular the responsibilities of the conference Chair, to review current arrangements and issue guidance to conference Chairs to reinforce the need to record where there is dissent at a conference, and for there to be a decision made, and recorded, as to what follow-up action may be required consequent upon that dissent.

6.4 Wolverhampton City Council, Children and Young People's Service, Children and Families Directorate, Children in Need and Child Protection Service

6.4.1 To review child assessment procedures and amend as necessary to ensure that:

6.4.2 Appropriate checks on available internal and inter-agency files and databases for relevant family information have been made, and other relevant agencies consulted, before an initial assessment is completed.

6.4.3 A child affected by or the subject of an initial assessment is physically seen before an assessment is completed.

6.4.4 All persons identified as able or available to provide support to the child or family concerned relevant to the conclusion of the assessment have themselves been adequately checked before the assessment is completed.

6.4.5 No initial assessment is completed without there having been consideration given to the situation and significance to the child concerned and his or her circumstances of both of that child's parents.

6.4.6 Members of staff responsible for making initial assessments are aware that where it has not been possible for any reason to obtain all relevant information or make all relevant checks within the timescale required for the completion of the assessment, the conclusion of the assessment should include reference to that fact.

6.4.7 The conclusion of an assessment must include clear recommendations for progression.

6.4.8 No assessment can conclude that no further action (NFA) is required unless all such outstanding checks have been made or information obtained. In cases where such conditional initial assessments are made the responsibility for a decision of NFA should rest with the supervisor or manager who should also have a duty to seek to obtain the missing information.

6.4.9 Guidance to be issued to remind all social work practitioners that proper checks must be carried out when a looked after child is subject to a change of circumstances, such as moving to live with another adult (even where that adult is a boyfriend/girlfriend rather than a carer), and that the duty applies whatever the age of the looked after child and however close is the date when the child is expected to cease to be a looked after child.

6.4.10 Review existing Policies and re-issue as necessary to ensure clear reference to the need for notification to other services or agencies that may be engaged in on-going care provision to children and their carers at the point of case closure by Children's Services, whether involvement of Children's Services has been brief or of longstanding.

6.5 Wolverhampton City Council, Children and Young People's Service, Children and Families Directorate, Social Inclusion Services

6.5.1 Review arrangements for supervision and guidance of Education Welfare staff and issue appropriate guidance to ensure that procedures are in place to require

regular strategic review of cases at least once every 6 months in addition to supervision of day to day casework activity, for there to be specific consideration as part of that strategic review of the need to identify appropriate care pathways in conjunction with other agencies, and for the details of that strategic review and its outcome to be recorded.

6.5.2 Conduct an audit of current caseloads to identify cases where any child has been substantially failing to engage with education, whether that be through failure to attend school as required or through failure to engage with other provision, for a period of 6 months and to require an immediate strategic review to be undertaken in such cases.

6.5.3 Review management and supervision arrangements and issue appropriate guidance to ensure that Education Welfare work is appropriately coordinated with the work of other services involved with a child or family.

6.5.4 Implement appropriate training provision to embed the above requirements, to include ensuring provision of training for Education Welfare staff designed to improve the quality of assessment formulation, case planning, intervention and review, such training to include safeguarding responsibilities with respect to children of all ages, and to include content sufficient to ensure that members of staff understand the importance of supervision in the safeguarding context.

6.5.5 Review supervision arrangements within the Education Welfare Service, to include consideration of qualifications and experience required of those people given supervisory responsibility, and provision of appropriate training and guidance for supervisors to include ensuring that all staff involved in supervision of others receive specific training and written guidance as to the purpose of supervision and the exercise of supervisory responsibilities.

6.5.6 To review the role of the Psychology Service in cases relating to pupil absence from school, in particular to review the priority given by the Psychology Service to such referrals, and the identification and development of means by which the Psychology Service can improve support to Education Welfare Officers in such cases.

6.5.7 To review and clarify Education Welfare Service procedures for opening and maintaining files and for record keeping, and to introduce robust supervision procedures to ensure compliance.

6.6 Wolverhampton City Council, Children and Young People's Service, Looked After Children Services in consultation with The Commissioning and Partnership Development and the Youth Service

6.6.1 To undertake a thorough review of arrangements currently in place where Aftercare services, or other child care services, are contracted out to be performed by providers in the private or voluntary sector to include in particular:

- To make arrangements for the review of all contracts currently in place to establish whether current contract documentation is adequate:

  (i) in terms of whether the documentation adequately specifies the subject matter of the contract and the services to be performed by the contractor
  (ii) as to the definition of expectations on the contractor as to ancillary matters such as staff recruitment, training and supervision.
  (iii) as to whether the documentation is appropriately drafted so as to be clear and enforceable in legal terms

- To review all contracts to establish whether the arrangements provide both for formal review and for clear and effective ongoing monitoring of contractual performance, taking into account the need for the monitoring and the management of the service to be kept distinct.

- To undertake an immediate and detailed review of training requirements for persons engaged in Aftercare work and to specify those training requirements with precision and require their implementation. This to include introduction of robust processes to ensure compliance with these requirements.

6.6.2 With respect to the contract dated 1 October 2007 made between Wolverhampton City Council and the Contractor for the provision of Aftercare services:

6.6.3 WCC to conduct an immediate and detailed review of the parties' understanding of the contractual performance required of the Contractor under that contract and to agree necessary clarifications to the contract specification.

6.6.4 WCC urgently to identify where and the extent to which the Contractor's performance falls short of the contractual requirements and where that is the case to take appropriate action to rectify the position.

6.7 Wolverhampton City Council, Children and Young People, Youth Offending Service

6.7.1 To review current training provision to ensure that training emphasises and reinforces an understanding of the service's safeguarding role as including children of all ages.

6.8 West Midlands Police

6.8.1 Policies and procedures be reviewed and where necessary amended, and appropriate guidance be issued to reinforce the requirement that where a person is apprehended for a criminal offence and a child is present or involved, a record should be made of that fact, and a judgement made as to whether or not other agencies should be notified, with the reasons for that decision being recorded.

6.8.2 Policies and procedures be reviewed and where necessary amended, and appropriate guidance be issued to reinforce and emphasise the particular

importance in cases where children are involved of prompt action to obtain and record their evidence, whether such children are involved as alleged victims of crime or as witnesses, or where any other child protection issue is involved. This is particularly the case with younger children whose ability reliably to recall events may be expected not to be as long as that of an adult. To inform this review, an audit of current procedures and systems be undertaken to establish the extent to which there is currently failure to achieve this.

6.8.3 Guidance should be issued to police officers to emphasise the need to record on the crimes database any allegation of an assault on a child or any instance of neglect, or where any other child protection concern arises, whether the alleged perpetrator be an adult or another child, and whether or not the matter is ultimately the subject of criminal process.

6.8.4 Arrangements be made for the provision of specific training to all front line police officers and community support officers to ensure that they have a sufficient understanding of their safeguarding responsibilities, this training to include the recognition and identification of child protection issues, procedures as to referral of such issues, an appreciation of wider safeguarding responsibilities, and multi-agency responsibilities including inter-agency notification and information sharing.

6.9 National Probation Service West Midlands

6.9.1 To review, and where necessary improve, procedures as to recording of assessments made that a person constitutes a risk or potential risk to children (OASys assessments) to ensure that those procedures are effective to capture and retain all relevant information.

6.9.2 Consider introduction of a procedure for a specific refresh check as to risk to children where a subject changes address or acquires a new partner, particularly where that partner may have children, or where a subject arrives from another area.

6.9.3 To review all cases current in June 2007 at the time when the system of recording OASys assessments was introduced to identify any cases that may not have been properly recorded at the time, and update the record accordingly.

6.9.4 To review procedures and issue appropriate guidance to Probation Officers and Probation Service Officers as to the need to consider, and in appropriate cases investigate, and to identify any risk or potential risk to a child or children, where a probation service user is encountered having charge of a child, and of the need in such circumstances to make a decision as to whether or not any other agency should be notified, and to make a record of that decision and the reasons for it.

6.10 Wolverhampton City NHS PCT Adult Mental Health Services

6.10.1 To review, and if necessary revise, procedures on the discharge of patients from mental health care, and to issue appropriate guidance, to ensure that at the point

of discharge from mental health care an assessment is made and recorded as to whether or not the person concerned is considered to pose a risk to children, whether that be to any particular known child, or to children in general with whom that person might come in to contact.

6.10.2 Such guidance should specifically distinguish between patients who are discharged on completion of a programme of health care and those discharged for less benign reasons, such as repeated failure to attend appointments.

6.10.3 Guidance should deal specifically with the need to consider disclosure of information as to the assessed or perceived risk to children to appropriate agencies, both in cases where a known child is at risk, and in cases where there is no particular child identified. Procedures should require that in all cases where a risk is identified a specific decision should be made as to whether to make full or partial disclosure, or no disclosure, of information, and the reasons for that decision should be recorded.

6.10.4 Guidance should be issued as to the basis on which decisions should be made, and indicate where the person making the decision may obtain advice as to the disclosure decision in cases of difficulty or uncertainty.

6.10.5 To review current training provision to ensure that training emphasises and reinforces an understanding of the service's safeguarding role as including children of all ages.

6.11 Wolverhampton City Primary Care Trust / Royal Wolverhampton NHS Hospitals Trust

6.11.1 The Health Visiting Service to review its policy and introduce guidelines as to actions to be taken in cases of repeated failed contacts or DNAs ("did not attend") or other disengagement of a service user. Such policies on DNAs and disengagement from a case should require active liaison with other services or other agencies rather than simply requiring sending of additional correspondence to the service user.

6.11.2 The Health Visiting Service to develop and implement a policy and issue guidance requiring that where a case is allocated to the Health Visiting "corporate caseload" there is a specified approach taken to case planning and all aspects of service provision ensuring an approach which is both universal and specifically targeted to the particular case, including a requirement that there be provision for consistent managerial overview of such corporate cases.

6.11.3 The Health Visiting Service to develop and implement a policy which accommodates all aspects of service provision as both 'Universal' and 'Targeted' in circumstances relating to 'Vacant Caseload' (including both where a post is vacant and where a member of staff is absent).

6.11.4 The existing Immunisation Policy relating to childhood immunisation to be reviewed and re-issued to ensure expectations of practice include immunisation of children in the absence of a 6-8 week medical examination and in the absence of GP registration. A practice note to be issued to Health Visitors and General Practitioners to ensure that children are not refused immunisations or other necessary care on the basis of non-registration with a GP.

6.11.5 Care Pathways for teenage parents (under aged 18 years) relating to both antenatal (to include the Teenage Pregnancy Unit (TPU)) and post birth service (to include Midwifery and Health Visiting Services) provision to be reviewed and guidance issued to take account of the following:

(i) The need to establish integrated services policy and provision which incorporates joint assessment, care planning and collaborative ongoing analysis and monitoring of needs and circumstances

(ii) The need to establish and ensure that information-sharing arrangements between different services and agencies are robust and effective. In particular this to include ante-natal services and TPU to review procedures and issue appropriate guidance on when and whether to obtain information from or notify other agencies when they become aware of a teenage pregnancy, particularly pregnancy of a child under 16 years of age. In particular to consider how use of the "Contact Point" database with the TPU utilising status as a "sensitive service" might assist in maximising the child protection potential while taking proper account of confidentiality issues

(iii) To consider standardised approaches to needs-assessment by implementation of the Common Assessment Framework process beneath the level where Children's Services would become involved

(iv) The need for there to be a policy to require a decision to be made, and recorded, as to any action to be taken, which may include notification of other agencies, where assessment or any assistance deemed necessary or desirable is declined.

6.11.6 There be an urgent review of policy and procedure on transfer of records on case transfer, to cover both Child Health Records and Health Visitor records.

6.12 Connexions

6.12.1 To review and develop policy in relation to work with young mothers or pregnant teenagers as necessary to ensure that it pays specific attention to the particular needs of that client group, and for appropriate guidance to be issued to relevant staff.

6.12.2 Specifically in relation to that client group, but also more widely, to review and clarify policy as to when additional specific assistance beyond "signposting" of relevant resources should be offered to service users.

6.12.3 Review and clarify policy as to case closure, ensuring that such policies prioritise the need to safeguard the on-going safety and welfare of children and young

people. This clarification to pay specific attention to arrangements where case closure results from unplanned disengagement or non-engagement of a service user with services offered or provided.

6.12.4 Review and clarify policy as to cases not formally closed but where contact has lapsed, to include a requirement for a specific management review of any case where there has been no contact for 3 months.

6.12.5 Policies be reviewed and amended as necessary to emphasise and reinforce understanding of the agency's safeguarding role as including children of all ages. Issue appropriate guidance in this regard, and assess whether current training arrangements are effective to cover this perspective.

6.12.6 Where the service is engaged with a service user on a continuing basis (3 months or more) and is working alongside another agency also engaged with that person (as in this case with the Contractor), the interrelationship between the work of the 2 agencies should be the subject of a service level agreement to ensure clarity and mutual understanding of respective roles and responsibilities.

6.13 Early Years Centre

6.13.1 To review procedures to be followed where services offered are not taken up, or where service users cease to take advantage of services offered, to ensure that at the point of non-engagement or disengagement an assessment is made as to any action required to safeguard the on-going safety and welfare of children and young people, to include a specific decision to be made and recorded as to whether or not notification to other agencies is appropriate.

6.14 Contracted Leaving Care Service

6.14.1 Contractor to undertake an immediate audit of all work being undertaken in relation to the provision of specialised supported living services to young people and, taking advice as necessary, and in relation to the contract between Contractor and WCC in consultation specifically with WCC, to establish clear, written, minimum standards with respect to members of staff engaged or involved in such work, those standards to cover:

(i) the required levels of experience and qualification of such staff

(ii) the required training, including in particular safeguarding training, to be received by such staff

(iii) the required levels of supervision of such staff (which may vary according to role, grade etc), including a requirement that the frequency and nature of supervision appropriate for each individual member of staff be agreed and recorded in writing

6.14.2 Contractor to conduct an immediate audit of training arrangements, and implement changes necessary to ensure that every member of staff, as part of their induction process, receives effective and substantial training, and written

guidance, with respect to safeguarding responsibilities, such training to include safeguarding responsibilities with respect to children of all ages, and that such training and written guidance specifically includes content sufficient to ensure that members of staff understand the importance of supervision in the safeguarding context.

6.14.3 Contractor to make provision for members of staff to receive regular and substantial refresher and updating training in respect of safeguarding.

6.14.4 Contractor to conduct an immediate review of supervision arrangements for staff and take prompt action as necessary to ensure not only that appropriate formal systems are in place but that actual supervision of front line staff is robust and effective. This action to include ensuring that all staff involved in supervision of others receive specific training and written guidance as to the purpose of supervision and the exercise of supervisory responsibilities.

6.14.5 Contractor to arrange for an immediate review of its existing contracts to establish whether or not the detail of what it is required to do under those contracts is clear and unambiguous. Where that is not the case immediate action to be taken to clarify those responsibilities.

6.14.6 Where the service is engaged with a service user on a continuing basis (3 months or more) and is working alongside another agency also engaged with that person (as in this case with Connexions), the interrelationship between the work of the 2 agencies should be the subject of a service level agreement to ensure clarity and mutual understanding of respective roles and responsibilities.

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