AINLEE

Born: 24.06.1999 : Died: 07.01.2002

CHAPTER 8 REVIEW

Newham Area Child Protection Committee

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Contents

Chapter 8

Integrated Review

Subject: **AINLEE LABONTE**

Born: 24.06.1999

Died: 07.01.2002

Family:

Leanne Labonte	Mother 07.12.81
Dennis Henry	Father 11.11.59
Child A	Half Brother 07.07.97
Child B	Brother 19.05.00

Profile of Helen Kenward

1. I am Helen Ruth Kenward, an Independent Consultant/Trainer in Child Protection.

2. I have worked with abused children and families for twenty-nine years. I specialise in interviewing children and young people who make complaints of sexual abuse.

3. I have worked in thirty-seven police forces including South Africa, Hong Kong, Canada and Estonia.

4. I worked at the Police Staff College, Bramshill for eight years teaching Strategic Response to Child Abuse for Senior Police Officers.

5. I currently work at the Scottish Police College tutoring on the Child Protection Course.

6. I worked on the Memorandum of Good Practice and ran the National Briefing at Hendon.

7. I teach and assess the competence of Police Officers and Social Workers to interview child witnesses on video.

8. I am currently leading an investigation in London into paedophile behaviour.

Helen Kenward
October 2002

INTRODUCTION

The Chapter Eight Review was commissioned by the London Borough of Newham following the death of Ainlee Labonte.

The Review was written following the submission of reports from all of the agencies who had had contact with Ainlee and her parents, Leanne Labonte and Dennis Henry and her brothers.

Individual agencies compiled chronologies, which were subsequently integrated in order that an analysis of the decision making process could be effected.

The preparation for the Report included:

- Reading the files on individual members of Ainlee's family
- Reading the family files
- Interviewing members of the social services' department who had been involved in the management of the service provided to Ainlee and her family
- Interviewing key members of the health service responsible for the management of the service to Ainlee and her family
- Reading documents appertaining to the criminal proceedings
- Completing a critical analysis of the integrated chronology.

The process of completing the Review was made more complex by the manner in which the single agency reports became available. Draft reports and amendments caused a domino delay effect.

The recovery of documents not previously disclosed made a re-assessment of the Report necessary and significant sections had to be rewritten a number of times.

In the interest of presenting as complete a picture as possible there was a continual dialogue with the Chair of the Area Child Protection Committeein order to reassess the time frame for completion.

Throughout the task of writing the Report the focus has been on the life of Ainlee, the impact of her family in preventing the professionals from safeguarding her, and the response of the professionals working together.

There has been an overwhelming sense of sadness at the life that must have been Ainlee's as revealed through the post mortem and the criminal investigation. There are other victims in this family; both of her brothers have lived through an experience which they may not understand but which leaves them without a sister and with absent parents.

AIMS AND OBJECTIVES

The aims of the Review are

- an independent analysis of the inter-agency response to the Labonte family
- an independent analysis of single agency responses to the Labonte family in the light of each agency's assessment of their response.

The objectives of the Review are

- to understand the circumstances of Ainlee Labonte's life and her death
- to critically analyse the quality of the inter-agency service provided.

CRITICAL ANALYSIS

In assessing the performance of the inter-agency network during Ainlee's life, it is necessary to consider the wealth of information available to them and the impact that knowledge had in the decision-making process.

The significant events were

1. Leanne was the subject of a Child Protection Order as a fourteen year old and ran away to avoid foster care.

2. Leanne was placed on the Register – Category Physical Abuse. This was the beginning of Leanne's non co-operation with the agencies. Leanne was known to be violent and came from a family where domestic violence was part of her childhood.

3. Leanne became pregnant at fourteen and had her first child. Despite her age and the age of the father – over twenty-four – no proceedings were taken against the father.

4. Leanne had a skin problem, which was to cause her referral to a dermatologist and ongoing low self-esteem.

5. Leanne became homeless after the child's birth and there followed a significant sequence of events. Social services helped Leanne find temporary accommodation whilst negotiating on her behalf with housing.

Leanne could not claim benefits, had a baby to care for, was only fifteen and moved from one bed and breakfast to another. Leanne was unco-operative, aggressive and refused to accept any rules. Leanne formed a relationship with Dennis Henry, a man who lied about his age and was, in fact, more than twice Leanne's age.

Dennis had no job and himself lived in a homeless persons' hostel. Dennis was known to break the rules, be aggressive and encourage Leanne in her anti-authority responses.

Leanne's response to the agencies, which at that time included social services and housing with some involvement with the police, was ambivalent. Leanne manipulated the situation, gaining support to be given permanent accommodation whilst at the same time being unco-operative and demanding. The chronologies indicate that the level of communication

between the agencies did not include an assessment of Leanne's maturity. During this period Leanne was lost to the health care professionals; she was not registered with a G.P. and the baby was not seen by a health visitor. Leanne had a record for shoplifting.

Summary

- Leanne at fifteen was homeless with a small baby and no income
- Leanne was manipulative, aggressive and ambivalent in her responses to the caring agencies, Leanne formed a relationship with a man who was thrice her age, aggressive and violent.
- Leanne had an abortion, the baby was a girl she called Ainlee.
- Leanne became pregnant a third time and considered a further abortion.

Significant events leading to Ainlee's birth

1. Leanne's first child was taken into care as a result of being left alone for a considerable period. Leanne has consistently minimised this event.
2. Leanne's responses to social services became a process of minimal co-operation with just enough for her to be able to manipulate situations.
3. Leanne was given a permanent tenancy for her and her son.
4. Leanne was offered a place at the Amber Project to rehabilitate her son and an assessment of her parenting skills.
5. Leanne introduced Dennis Henry to the equation and he became part of the residential assessment.
6. The assessment of Leanne's relationship with her son and her focus on him as a parent was lost in the power struggle between Leanne and the agencies. Dennis actively encouraged the non co-operation of Leanne.
7. Leanne refused access to her son and made the task of observation of her interactions with him almost impossible.

8. Leanne and Dennis were caught shoplifting whilst out with her son.

9. Leanne continued to make promises to see health visitors and doctors whilst failing to do so.

10. Leanne did not keep her ante-natal appointments.

11. Leanne was aggressive towards the unborn child.

12. Leanne made allegations against her son's foster mother re. her care and abuse of the child . This was investigated separately and unfounded. He was observed to be unhappy in the presence of his mother whilst being medically examined.

13. He was observed to become compliant through the process of assessment at the Amber Project.

14. Dennis refused access to a social worker.

15. Dennis arranged to undertake the care of the child during Leanne's delivery and refusing to allow the residential staff to assist.

Summary

- At seventeen Leanne is pregnant with her second [or third] child
- Leanne has been unco-operative and anti authority
- Leanne agreed to a residential placement which she then began to manipulate and failed to co-operate in the assessment process
- Dennis Henry is a powerful figure in her life and refused access to Leanne's son to social workers and health visitors

The Birth of Ainlee Labonte

1. Leanne was still resident at the Amber Project when she gave birth to Ainlee.
2. Leanne refused access to Ainlee to residential staff and limited access to midwives.
3. Leanne returned to the Amber Project for one week and at this stage staff did not know the baby's name, nor that she was a girl.
4. Leanne moved to her flat and failed to comply with the Amber Project and the post-residential assessment.
5. Amber Project closed the case as it had become unworkable and a report was submitted.
6. Leanne effectively isolated herself with Dennis Henry and two babies in a second storey flat.
7. Leanne refused to co-operate with health staff and the children's development checks were always late and after many failed appointments.
8. Leanne was described as very stubborn and would not listen to advice on the care of her children.
9. A Child Protection Conference was convened.

Summary

- Dennis Henry took a major role with Leanne's son during the birth of Ainlee.
- Residential staff excluded from contact with Ainlee.
- Social work staff led to believe the baby was a boy.
- Residential assessment terminated because of lack of co-operation.
- Leanne returned to her flat with two babies and Dennis.
- Leanne failed to co-operate with health care staff, stole medical records and refused immunisation of the children.
- Information from Probation and the Police revealed the criminal record of Dennis Henry.

Issues leading to the Birth of Leanne's second son

1. Leanne Labonte failed to work with health care staff who tried to monitor the development of Ainlee.

2. Leanne and Dennis Henry became involved in a serious dispute with neighbours shortly after moving into the tenancy.

3. Leanne and Dennis had a violent relationship, which frequently involved calling in the police. Leanne would ask for help and then reject it.

4. Ainlee was presented at A & E with different episodes of breathing difficulty, rash, rigid limbs and shaking. Ainlee was admitted to hospital but discharged by Leanne.

5. Ainlee's weight loss was a cause for concern.

6. Ainlee was reviewed by a neurologist.

7. Leanne and Dennis were aggressive to all professional staff and in turn each agency limited the contact. Health visitors and housing staff would not visit her home because of intimidation. Leanne and Dennis were barred from the Housing Office and staff at clinics and hospitals would only see them when supervised.

8. Leanne's health was a problem with a new pregnancy and a serious health risk. Leanne failed to co-operate in her own health care.

9. Leanne used her knowledge of the system to move her family between different G.P.s, hospitals and health visitors; effectively preventing an overall picture of the health and development needs of the children.

10. Ainlee was taken to hospital for her poor weight gain. It was noted that she was not registered with a G.P. and the family had declined access to health visitors. The parents were observed as extremely anxious.

11. The records for social worker and health visitor show a discussion took place between the two with regard to Leanne's care of the children. It had been observed that Leanne's ability to care for her children was not in doubt nor was her ability to relate to the children.

12. Leanne continued to fail to attend appointments for routine medical care of the children.

13. The Review Conference Report as recorded by the health visitor observed that the Amber Project Assessment was for the purpose of assessing and assisting both Dennis and Leanne's ability to meet her son's emotional and developmental care.

14. The Child Protection Conference decisions were deferred to allow the social worker to do a home assessment.

15. Leanne assaulted a health visitor at the clinic.

16. Dennis Henry was alleged to have assaulted a member of the wider family.

17. Leanne and Dennis were abusive and threatening at the clinic, health care staff were uncomfortable being alone with them.

18. Leanne and Dennis confronted individual professionals about their contributions to case conferences.

19. Leanne's son's name was removed from the Register.

20. Ainlee was not discussed at the conference, which focused on the original terms of reference for her brother.

21. Neighbour complains to the Housing Office about violence and aggression of Leanne and Dennis; this was not reported to social services.

22. Ainlee treated as a 'failure to thrive' baby.

23. Leanne having problems with her pregnancy.

24. Leanne and Dennis complaining that there was a breach of confidentiality and snatching the notes from the consultant.

25. At thirty-one weeks old, Ainlee was seen at the clinic by a dietician and paediatrician; her weight was dropping but nothing abnormal discovered. Ainlee was observed as active, healthy, good speech heard and reported to eat and sleep well.

26. Leanne frequently admitting and discharging herself from hospital.

27. Nurse Specialist notified social services of her concerns – Ainlee's failure to attend eight-month check and failure to thrive. There are records in both departments of this concern.

28. Ainlee is finally seen by the Community Physician – nothing abnormal, except weight loss.

29. Ainlee's failure to thrive notes stolen by parents.

30. A strategy meeting was informed that health visitors were not providing a home visiting service for reasons of personal safety.

Summary

- Ainlee was failing to thrive.
- Leanne and Dennis were aggressive, threatening and violent towards health care staff and housing officers.
- Health visitors would no longer make home visits.

- Housing officials would not make home visits nor would they allow Leanne and Dennis to visit the Housing Office.
- There was an on-going dispute with neighbours.
- There were numerous incidents of domestic violence with the police being called.
- Leanne was experiencing a difficult pregnancy and ambivalent about accepting medical care.
- Health visitors and social workers had different perceptions of the care of the children.
- Hospital records were stolen and those appertaining to Ainlee's failure to thrive were not returned.

Birth of younger son

1. The Nurse Specialist was concerned for staff safety and child protection issues.
2. Leanne changed hospitals.
3. Ainlee was re-referred from the Community Clinic for failure to thrive.
4. Leanne was confronted by a social worker for failing to keep health appointments.
5. Ainlee was seen by a different paediatrician and some weight gain was observed. The decision was made to continue to monitor Ainlee through the outpatient's clinic in view of the responses from both parents. An appointment was made, which was not kept. A further appointment was made for four months – seemingly an error since a failure to thrive baby would be monitored more closely.
6. Leanne and Dennis attempted to see the Nurse Specialist by falsely claiming they had been sent by a social worker.
7. Leanne stole hospital notes, intimidated staff, discharged herself and the baby and failed to confirm to expectations whilst in hospital.
8. Child protection concerns were expressed by health care staff to social services.

9. Parents refusing all but basic investigations re. failure to thrive.

10. Concerns for Leanne's safety as a member of her family is released from prison. A social worker made a home visit. Leanne made it clear that she did not want social work assistance.

11. Younger son was born 19 May 2000. Leanne needing to be stabilised before discharge. Leanne discharges herself.

12. Social services close the case, advising Housing and the family by letter that referrals will be dealt with by duty.

13. The family have assured the social work manager that they will keep appointments and seek medical care for the children.

Summary

- Leanne had a difficult pregnancy.
- Ainlee was failing to thrive.
- Leanne consistently failed to keep appointments, changed doctors, changed hospitals, changed names.
- Tracking became very difficult since Leanne and Dennis would not respond to letters and housing and health care officers were not visiting.
- Ainlee began to gain weight and was referred back to the community clinic for monitoring.
- There was an administrative error with regard to appointments.
- Ainlee's notes were stolen and not recovered.
- Leanne and Dennis became more threatening and confrontational.
- Social services closed the case.

Issues leading to Ainlee's death

1. Nurse Specialist expressed her concerns that social services had closed the case.

2. Health visitors continued to try to engage with the family by letter.

3. Neighbour reports her concerns to housing and social services. The telephone number and name given by the neighbour do not appear to relate to anyone working at social services at that time (checked after the trial).

4. Difficulties with the neighbours increase with phone calls to the police and complaints to housing.

5. Leanne makes a complaint of racial harassment and threats to her baby to the police.

6. Leanne is advised by letter to register with a G.P. for Ainlee.

7. Dennis is removed from the G.P.'s list for abusive behaviour.

8. Leanne submits medical forms for all three children to the housing department, claiming ailments due to the state of the flat and requesting a move.

9. Ainlee did not attend for her eighteen-month development check. Ainlee did not attend her hospital appointment.

10. Leanne was informed of Housing's decision to seek legal advice re. threats and abuse to staff, destroyed records, damaged Freephone and dumped building materials.

11. Housing receive a letter from Leanne's solicitor alleging disrepair, noise nuisance and racial harassment.

12. Housing reply to Leanne's solicitor with information re. (10).

13. Their elder son has a problem with his hand; Leanne fails to take him for his follow up appointments.

14. Leanne offered treatment for skin condition.

15. Health visitor informs social services of failure to keep appointments and refusal to have children immunised; health visitor not having access to the children.

16. Social worker visited the family and saw all three children asleep.

17. Leanne visited social work office; the children were seen and noted to be clean and appropriately dressed. They interacted well with the parents.

18. Social worker made a home visit in August 2001 to assess the family needs. Ainlee and her older brother were in the bedroom. Social worker saw Ainlee in her high chair facing the wall 'because kept throwing food around'. The recommendations were to check G.P. contact, support nursery and housing applications.

19. A police referral was made to social services about a domestic dispute. Dennis was arrested for breach of the peace. The children were seen, 'all appeared happy and well cared for and unaffected by the incident.' Drug paraphernalia was observed.

20. Family deemed not to meet the criteria for nursery placement.

21. In November 2001 social services records show a discussion with a health visitor indicating that she had not heard of Ainlee – contact with the G.P. to obtain the records was recommended.

22. Leanne failed to take Ainlee for a developmental check in October, no other appointment was made and the health visitor would not visit the family, as they were dangerous. Duty officer requested urgent visits. Health visitor expressed the view that it was a social work task. A joint visit was suggested.

23. Health records show Leanne had assaulted a patient at the surgery who subsequently required hospital treatment.

24. On 27th November Leanne requested a home visit from social worker.

25. Leanne was informed by telephone on 20th December 2002 that the appointment would be the 4th January 2002.

26. There were three references to police contact between 24th December 2001 and 1st January 2002; the last call being abandoned as no response and the first two for domestic violence.

27. There are no health records after 27th November 2001 until Ainlee's death on 7th January 2002.

28. Police documentation showed two visits by a doctor to the house, which involved the need for police protection.

Summary

- Social services closed the case, holding it on duty.
- Health visitors continued to try to engage with the family by letter.
- Relationships, both inside the family and out, became more threatening, abusive and violent.
- Leanne failed to keep appointments and seek appropriate health care.
- Children were registered with different doctors.
- Ainlee got lost in the system.
- The children were seen but not examined.
- Ainlee was observed being punished in an inappropriate way for her age
- Leanne tried to use the agencies to get a housing transfer.
- Leanne assaulted a stranger at the surgery.
- No contact with the family by health or social services for six weeks.
- Police did not refer the domestic violence issues.

The period between Ainlee's birth and the birth of her younger brother was one of extreme manipulation of the agencies by Leanne and Dennis.

One by one the agencies withdrew for personal safety issues. Health visitors would not visit the home and made attempts to ensure the children were brought to the clinic. Staff at the clinics were concerned for their safety and there were incidents of assault, theft of notes, intimidation and abuse. Housing officers would not make home visits, nor allow the couple to visit the office after experiencing the violence of Dennis and Leanne. Maintenance was unable to be carried out on the property.

The communication between the agencies was not constructive; the different perceptions and failure to convey the implications of not accessing the family were not assessed. No one appears to have taken a step back and evaluated the situation.

There was concern for the welfare of the children and attempts to make sure they received health care, but the impact on them of the violence of their parents was not evaluated. The children were living in an environment that adults were not prepared to visit.

As Leanne's pregnancy progressed the family became more threatening and aggressive. Ainlee was presented as a failure to thrive baby and there were different perceptions as to the significance of the weight gain. The Paediatric Registrar was able to relate to the family and referred Leanne for consultation with the Paediatrician and a subsequent clinic referral for monitoring by the Community Physician. A further appointment was made and when this was not attended, an appointment was given for a four-month's date. It was felt [in interview] that this was an error.

The effect for Ainlee was that a positive weight gain was seen as an indicator of a resolution of her difficulties. Leanne's reluctance to accept social work intervention, her son's removal from the Child Protection Register and the assurances from Leanne that she would keep appointments and seek health care, all lead to the decision to close the social work case and monitor from the Duty System.

There is no evidence on file of a thorough Risk Assessment, nor of housing officials contributing to the knowledge base of this family. The extent of police involvement was not evident in social work files. There was a failure to bring together all the information known about a clearly dangerous family.

The autumn of 2001 saw Leanne contacting all the agencies in an attempt to engage support with her application for re-housing. Leanne does not keep her constant promise of seeking health care for her children.

The fear with which the family are regarded leads to almost paralysis in terms of action. The theory being that there are social work visits and the children are 'seen but not engaged'. Leanne successfully manipulates the situation to keep the focus on housing

Social service documents do not reflect the anxiety of those from health. The police do not refer the level of attendance at the house nor the domestic violence that is being expressed.

The agencies were compartmentalised in their knowledge and responses. The Nurse Specialist attempted to express her concern at child protection issues but the weight of her argument was not appreciated.

There was no clear Risk Assessment at any stage with all the agency information available.

Agency Responses

At fifteen social services were attempting to support Leanne and negotiate with housing. Health visitors were attempting to carry out the responsibilities towards her baby and were being thwarted by Leanne's application. Despite there being a case conference to de-register Leanne, there is no Risk Assessment completed on either her or her baby.

Social services undertook a residential assessment of Leanne's parenting. They allowed this process to be clouded by Dennis Henry. There was no Risk Assessment on a man who was clearly older than Leanne, anti-authority, violent and verbally aggressive. The police checks were not completed until the end of the residential period. Probation supplied information of Dennis Henry and Leanne's offending behaviour at the end of the assessment. The police were involved with Leanne and Dennis shoplifting whilst out with the baby . Leanne refused access to health visitors and residential staff.

The assessment was incomplete because of the failure of Leanne and Dennis to co-operate. The boundaries were not enforced nor were the couple confronted with their behaviour. The staff were unable to relate to the baby and the focus of his vulnerability was lost in the agencies attempts to work with the couple.

Social services allowed Dennis Henry as a man recent in Leanne's life to assume a parental role with her child and allowed him to be part of the assessment process without undertaking a Risk Assessment.

Health carers had the ability to access Dennis Henry's medical records and had they done so their contribution to a Risk Assessment would have provided valuable additional information.

Communication between health care staff and health and social services was poor. A midwife phoned social services to tell them of the birth of a boy, a strange mistake and one which took time to correct since Leanne would not give the baby's name.

The couple were allowed to return to Leanne's flat with two young children and no assessment made of the vulnerability of the children.

The age of Leanne, the refusal to accept advice, to receive visitors or to access medical services were all causes for alarm. The elder child was on the Child Protection Register,

Ainlee's safety was not risk-assessed pre-birth as had been part of previous recommendations.

It seemed that this couple became so powerful through their manipulation, aggression and refusal to co-operate that the focus on the needs of the children became lost.

Good Practice Issues

The Chapter Eight Review of the life of Ainlee Labonte, who died at the age of two, has revealed issues for each agency and for the inter-agency network.

The Report details the documentary search and the interviews undertaken in order to establish the practice issues chronologically and in the context of the agency responses. Cognisance has to be given to the fact that judgements were made by individuals who submitted reports on behalf of the respective agencies. The Report relies on the documents submitted by the individual agencies; the analysis is derived from them and the records of interviews undertaken as part of the process.

The role and responsibilities of Leanne Labonte and Dennis Henry have been examined by the criminal investigation and subsequent court hearing.

Leanne and Dennis are held accountable for the death of Ainlee and are beginning custodial sentences.

The two boys are left with a legacy of the experience of living in a dangerous family and losing a sister and both parents.

The Report was commissioned to review

- Involvement with the family, including a chronology
- All information available and actions taken
- Co-operation and communication with other agencies
- Compliance with current child protection procedures.

It is my view as author of the Report that there are serious gaps in the conceptual understanding of working with dangerous families.

The Child Protection Guidelines clearly give a message of the need to share information and make joint decisions. If the information available is not evaluated in the light of current knowledge and research, the decisions can become flawed. The longer the process the more dangerous the outcome can become until someone says 'Stop' and assesses the knowledge base, or as in this case, the child dies.

There are clear points at which the knowledge available, were it to be gathered together and seen in the light of dangerous families, would have or should have changed the outcome.

The first assessment should have been a Risk Assessment and Vulnerability Check of Leanne and her baby when she was made homeless.

The factors that were known were:

- Age – very young pregnancy
- Physically and sexually abused within her family and extended networks
- Isolated
- Health problems
- No financial support and too young for benefits
- Relationship with a man over twenty-four years older, which resulted in two pregnancies.

This would put Leanne into a category of Vulnerable and At Risk.

The second assessment should have been a thorough assessment of Dennis. Factors known:

- More than twice Leanne's age
- Unemployed
- Homeless
- Drug habit
- Criminal record.

Dennis Henry was allowed to become resident at the Amber Project before being police checked and having known Leanne for less than three months.

Dennis Henry was allowed to assume a parental role with a child with whom he had little contact, the baby having been in foster care, and who was resident at the Project in order to assess rehabilitation to his mother in the light of her parenting skills.

The Amber Project did not complete the assessment; the family returned home and Leanne was not confronted nor boundaries set with regard to her responsibilities towards her baby.

The housing department held valuable information with regard to Leanne and Dennis's responses in the community. Their violence and aggression was serious and visits were stopped both at the tenancy and the housing office.

There was communication between health visitors and social workers and anxiety about the health and development needs of the children. The fear for personal safety was seen in the light of protecting health staff and therefore home visits were stopped. The dilemma became one of ensuring the children were monitored amidst the deliberate actions of Leanne and Dennis who were totally against any involvement with the agencies other than for their own needs. Leanne was quite happy to approach doctors, health visitors and social workers for assistance with re-housing, but even when engaged at this level would refuse to co-operate with questions about the children.

Health care workers knew that Leanne was opposed to immunisation and resisted any long-term relationship.

Leanne and Dennis worked on the principle of divide and rule, registering with different G.P.'s and hospitals, tampering with notes and records to prevent a true picture from emerging.

The police experience of Leanne Labonte and Dennis Henry was of dealing with 'a violent, aggressive, obstructive, devious and dishonest couple'.

The essential practice issue becomes one of sharing the information in a manner, which helps all the agencies come to a view about the safety of the children, both physically and emotionally.

In school the elder child was acting out in the same way that his parents were behaving. The incidents at school, are recorded as, 'verbal, racist remarks; physical assault on staff; loud erratic responses; violence towards children and adults who challenged him and biting staff.' His parents were said to be in denial.

Each of the agencies had important information about the family, each agency experienced the aggression and threat and some of the professionals experienced violence. The neighbours experienced the violence and intimidation and heard the violence within the home.

The essential good practice issue has to be that if the parents create the responses in professionals, which cause them to retreat, then what must the experience be for the children? The only direct work with the eldest child was in school and that was not referred as a child protection issue. Medical care was refused for the children other than on Leanne's terms. The children were presented at A & E where the parents were described as over anxious. This was incongruent for a couple who were so resistant to health visitors. The behaviour at surgery and clinics took the emphasis away from the children, and there are many instances where the children were present and observed their parents' behaviour.

The Pathology Report describes injuries, most of which would have been hidden by clothing. There are comments in reports that the children are clean, well clothed and fed. There are also observations that the boys are present with Dennis and Leanne, and Ainlee is not. A basic question should have been, 'Where is Ainlee?' The professionals knew that the family had no support mechanisms, Leanne's mother did not look after her grandchildren, there was a war of attrition with neighbours, the children were refused nursery placements as not meeting the criteria, so the inevitable answer has to be that she was alone. Ainlee was alone for most of her life.

In summary, the Children Protection Guidelines focus on the need to work together, share information and trust one another for the sake of the child. The key good practice guide in working with families is the assessment of information at each of the life changing events in the family. The stress of living in a family with three babies, finance difficulties, drugs, ill-health, isolation and domestic violence leads to the question that has to be asked 'How much can a child take?'

It is my view that the focus became the adults and they successfully prevented the attention being directed towards the children. There were, however, individuals trying to respond to the needs of the children, a duty social worker who completed an exemplary piece of work then handed on, what was, however, not followed up, a Nurse Specialist who attempted to keep the case open to social services and a paediatrician who attempted to obtain a G.P. for Ainlee.

There are other examples but because the knowledge was not integrated and complete, no clear Child Care Plan evolved.

RECOMMENDATIONS

The recommendations fall into five categories

1. Direct work with families
2. Supervision and Management responsibilities
3. Record keeping
4. Inter-agency responses
5. Personal and corporate responsibilities.

It is my recommendation that priority be given to training in the area of direct work with dangerous families

- that the concept be re-defined within the inter-agency network
- that cognisance be given to the importance of information held within all the agencies.

It is my recommendation that supervision of staff in all the agencies be assessed in the context of management responsibility

- that where any agency decides that they are no longer able to visit a family or have a family visit their offices, that decision and all supporting evidence should be submitted to the Child Protection Committee for Senior Management to evaluate.

It is my recommendation that each agency re-assess the process of record keeping and tracking the information relevant to the protection and welfare of children.

It is my recommendation that there be a monitoring process of Case Conferences and their decisions and that where there is dissent from one of the partners, the minutes be passed to the Child Protection Committee for ratification of the decisions.

It is my recommendation that the focus of work with families should be evaluated in the light of Child Protection and that all staff undertaking direct contact with families should have basic Child Protection Training

- that within this context all staff should know where their personal responsibilities lies and the action they should take.
- that the supervision of Child Protection cases needs to be in the context of Risk Assessment and that supervision records be kept as part of the case files.
- that de-registration of a child be ratified at Senior Management level with evidence that all agencies are in agreement.
- that where there is dissent or absence of any party from the decision, that the evidence counteracting that view be submitted.
- that the work with dangerous families be considered a task requiring skills and knowledge of research and current thinking.
- that where an unskilled worker is involved with social services, that worker requires the highest level of supervision and scrutiny.

FAMILY HISTORY

Leanne Labonte was born 07-12-81. In 1996 aged fifteen, Leanne was subject to Emergency Protection Orders from 24-05-96 to 29-05-96 and was placed with her 'Nan'.

At this time Leanne was described as coming from a very violent background. Leanne was placed on the Register following a violent incident and the subsequent removal of her name was the subject of dissent at the case conference.

Leanne gave birth to her elder son on 07-07-97; the father of the baby was aged about 27 years. Leanne was fifteen and still living at home.

At this point Leanne was below the age of consent and the father was over twenty-four, which meant he could not use as a defence that he thought her able to consent. There was no prosecution.

Shortly before her sixteenth birthday Leanne rowed with her mother and left home. Her son was left with his father whose mother agreed to care for him.

The period following saw Leanne in a succession of placements with contact with Social Services for support.

Leanne was involved in shoplifting and disputes with her mother. Significantly there is a reference on file that states: '16 year old mother whose needs are much greater than the needs of her baby who is well cared for.'

Leanne alleged that she had been sexually abused by a member of the family since she was nine years old. Leanne's behaviour reflected the disturbed adolescent responses common to many victims of sexual abuse.

Leanne began a relationship with Dennis Henry during the summer of 1998 whilst still only sixteen. By her seventeenth birthday Leanne was twelve weeks pregnant with her second child.

Leanne was offered a property, which she refused because of its proximity to her son's father Leanne was again involved in shoplifting this time with Dennis.

In October 1998 there is written assessment in the form of a letter, of Leanne's experience of being parented.

In December 1998 the elder son was left alone for three hours; he was seventeen months old. Police Protection was invoked and he was placed with foster carers.

It is significant that at this point there is a note on file reporting that Dennis Henry, who was not the child's father, had served time in prison – reason unknown.

A risk assessment would have been appropriate with regard to Dennis Henry on two accounts. The child was vulnerable and had been exposed to danger by being left alone by his mother Leanne and her partner Dennis Henry. Leanne was a vulnerable teenager, pregnant and with a child of sixteen months, both before she was seventeen.

The summary on file outlines the vulnerability of the family including the facts of six bed & breakfast placements. Leanne, it was stated, was not receiving income support and had been arrested for stealing. Leanne was extremely isolated and therefore an easy target for a predatory male.

In pure survival terms a parent with no income will be tempted to steal. There is a duty of care on the local authority to ensure the welfare of the baby and to work in partnership with his parent. Leanne was very resistant to social work intervention in any way other than practical help. The poverty trap is all too easy for a rejected teenager.

The focus of the social work became the practical needs of Leanne and her contact with her son. On 5th January 1998 it is noted that Leanne did not want her partner Dennis to be present at the case conference. It is further recorded that on 7th January 1998 that Dennis is to have contact with the baby at the foster carer's home, Tuesdays, Thursdays and Saturdays. There is no indication of a risk assessment.

The baby is not Dennis' child and had only known him for a short period of time. It is extraordinary that he be given contact at all, let alone three times per week.

Leanne and the baby were referred to the Amber Project, the focus to be on his needs and Leanne's parenting capacity.

He was placed on the Child Protection Register under the category of neglect with a Child Care Plan of assessment at Amber and to be accommodated until the assessment commenced. It was further recommended that there be a Pre-birth Child Protection Case Conference for Leanne's second child.

Leanne made a complaint against her son's foster carers alleging physical abuse. The management review concluded that the complaints were unfounded and that the injuries sustained by the child may have happened whilst in his mother's care. He was not moved from the carers and ultimately Leanne withdrew the complaint.

It is significant that Leanne was unhappy that her child was doing well in the foster home who, if anything, were viewed by the social workers as over-protective. There was speculation that Leanne wanted him moved because she was jealous. It has to be remembered that Leanne was still very young and her behaviour typical of that of a troubled adolescent.

It is recorded that in February 1999 there was a debate within social services as to who would take responsibility for the family. A management decision was made that it should be within the Family Support team.

It is at this point that the focus of the work with the family shifted. The efforts became directed towards parenting skills and rehabilitation; this is in the light of an assessment of risk dated 20th January 1999, which observed:

'Leanne sets the boundaries for working with social services.'

The report is sensible in that the incongruencies were recognised and 'the changes essential to protect (Child A) at this stage were largely untested.'

A further factor in the decision-making process is that of the inclusion of Dennis Henry in the Amber assessment. In interview the manager was asked to comment on his inclusion and responded with "– at the referral stage, the project may have been instructed to allow Dennis to reside at the project". Both the Child Protection Team and the Amber Project were managed by one person.

The residential assessment commenced on the 6th April 1999. There were critical events at the project, which in my view reflects the control maintained by Leanne and Dennis.

- The baby was reported missing from care. He was returned six and a half hours later; Leanne and Dennis having been arrested for shoplifting
- Leanne was sent a warning letter following failure to return to the project within the designated time

- Leanne refused to allow the health visitor to see the baby , claiming he was not dressed
- Dennis refused to admit the social worker alleging that social services did nothing for them and they did not need to co-operate.

This lack of co-operation within the first three weeks of the assessment needed to be confronted.

Leanne had agreed to her son being accommodated under Section 20 of the Children Act 1989 and thus avoided care proceedings. The service agreement signed by Leanne on commencement of the assessment does not allow her or Dennis to control the process. The risk factors began to increase as the family sought to isolate themselves from those whose task it was to assess their parenting capacity and the level of risk to the child.

By June and towards the end of the assessment process there appeared to be an increased level of co-operation. The physical care of the child was good and the parents had the ability to stimulate him but there were references to him being restrained in a chair or buggy for excessive period of time. He was twenty-three months old and would be expected to be very active at that age. Interactions with him were observed as 'too much aggressive play, inappropriate language and too ambitious unsafe play'.

On the 12th July there is a letter to Leanne reminding her of the legal issue for her son subject to Section 20 1989 Act as staff had been unable to gain access – of ten visits in twelve days only one was successful.

In summary, Leanne and Dennis were unco-operative and controlling. Despite contracts and attempts to engage them they were resistant to social workers, health visitors and staff.

AINLEE

born 24-06-99 died 07-01-02, aged two years and seven months

Ainlee was born at Newham General Hospital. Ainlee's name was not disclosed until September.

Ainlee and Leanne were discharged from hospital to the Amber Project. Leanne took control and refused to allow the staff at Amber to have access to the baby, Leanne's justification being that the assessment was on her son and not the baby.

It is significant that the birth announcement, by phone and by a midwife, was that Leanne had a second boy. Four days later the case records note that 'the health visitor saw the baby this morning and he (sic) is fine'. The family were due to return home four days after Ainlee's birth and this was accepted on the basis of there being no further concerns.

It is difficult to imagine there being no concern for a four day old baby born in a situation of conflict with her parents who were resistant to help and support and being very isolated in the community. When taken in the context of a teenage mother of two children the elder being two years and one month; added to the fact that Ainlee was taken to the hospital by the parents for breathing difficulties and the project thought that she was a boy, Ainlee could be seen as very vulnerable.

Ainlee returned to the family home, her parents having agreed to a post residential assessment. Nine visits were made to the family and on eight there was no contact. On one visit the family were met by the workers as they were on their way in/out despite it being an arranged visit.

The Amber Project closed the case as unworkable.

The Amber Project report focused on the difficulties of the parents identifying that both Leanne and Dennis 'displayed difficulty in maintaining effective relationships with the professionals involved in supporting her son .'

It was noted that 'the project gained no insight into the care of the baby' nor were they able to see her since the parents went to great lengths to ensure the project staff did not see her face. Leanne and Dennis claimed the staff had the 'evil eye'.

The Amber Project report expressed 'curiosity about whether Leanne and Dennis would seek professional assistance if the family or children were in a position of need'. Both Leanne and Dennis 'displayed an inability to place the needs of their children above and beyond their feelings as reflected'.

The recommendations were on the boy – registration and monitoring. Ainlee's needs were not the focus.

There was a Child Protection Conference on 19th July 1999; **Ainlee was not placed on the Register.** Information on record was factually incorrect and this led to a positive view of Leanne's parenting of Ainlee.

There was a Child Protection Case Conference Review in October 1999. Ainlee was four months old. The file indicates that during this period Ainlee was seen at the clinic and her weight was down 2 centiles; she was referred to the Consultant Paediatrician. By this time Ainlee had had two visits to A & E Royal London Hospital, reported as having fits. On the second visit she was admitted for observation and discharged – staff reported parents to be 'anxious' and inappropriate at times. There was also a report of an incident at the clinic involving an injury to the health visitor. The decisions were deferred to allow the new social worker to visit and complete the risk assessment.

The social work recommendations to the conference were that Ainlee's brother should remain on the Register, having only 'caught sight of the children'.

It is incongruent that the issues of concern were Ainlee's weight loss, her referrals to the hospital, the assault of the health visitors and an inability for the workers to gain access to the children; yet the elder child was the focus and continued registration the recommendation.

The minutes on file indicate that the meeting was informed that the Amber Project recommended registration although no representative was present.

It is inconceivable that a conference be convened without the presence of a member of the team who had been charged with assessing the ability of the parents to care for the subject of the review and who had residential experience of the family.

The outcome of the conference held in November 1999 was that despite the documentary evidence of recommendations to stay on the Register Ainlee's brother be de-registered. It is

recorded that there was 'unanimous agreement that (Child A's) name be removed from the CP Register'.

Ainlee was not discussed at the conference. There was a discussion that the family would be transferred to the Family Support team.

The minutes of the meeting held on 17th November 1999 were dated 21st January 2000. it is unacceptable that it take nine weeks before a record is distributed to the agencies.

Between the November conference and a Services meeting called in April 2000 there are concerns passed to social services from the health department.

They raise issues and concerns for both children which are related to the behaviour of the adults:

- Leanne stole the hospital notes.
- Leanne presented herself at Maternity but discharged herself at midnight.
- The hospital social worker was concerned about the welfare of both children whilst in the care of Dennis when Leanne was in hospital, citing Dennis can be violent towards them. However there was no specific evidence other than observations of his abrupt behaviour towards the children when visiting Leanne.
- Leanne took her file from the hospital.
- Leanne discharged herself from the hospital with a possible serious health risk. She took the medical notes with her.

These have to be seen in the context of the concern of the Amber Project and the social worker as to the ability of the adults to focus on the needs of the children before themselves.

It was during this period that Ainlee failed her eight-month development check.

A decision was made that should Leanne fail to present Ainlee at the clinic a Child Protection Conference would be called.

Health Visitor Y wrote to social services expressing her concern re. Ainlee .

- Notes referring to Ainlee's failure to thrive were taken by Leanne.

- Ainlee reported to have failed her two month and eight month development checks and to be 'falling off the centiles'.
- Ainlee taken to A & E several times including worries about breathing and convulsing. There were concerns in September 1999 about a possible viral infection – Dr N felt the parents were inappropriately anxious.
- Leanne was pregnant for the third time aged eighteen years and four months.

In May 2000 a discussion re. Ainlee's failure to thrive is recorded. Ainlee was seen at two hospitals. The action plan included liaising with doctors, discussion of a nursery referral for her elder brother and child care support for Leanne whilst Leanne was delivering her third child. Leanne is observed to be withdrawn and uncommunicative.

The third child was born on the 19th May 2000 at Royal London Hospital.

It is at this point that social services closed the case. The health visitor's concerns that the pattern was being repeated with Leanne visiting the clinic but refusing to talk with the health visitor and refusing permission for the baby to be examined. The community midwife reports him as thriving.

From September 1999 - February 2000 the social worker was S. In interview she stated that when the case was closed to her she failed to remove her name from the computer records and mail continued to be sent to her with reference to the Labonte family.

April 2000 – emails on the elder boy's file marked 'Importance HIGH' indicate that the Doctor reports **AINLEE LABONTE FAILED TO THRIVE** and will be writing to request a planning meeting.

Letters to social worker S from the health visitor Y, indicate confusion about the registration status of Ainlee . The report on his file suggests that Ainlee was not discussed at the conference which focused on the de-registration of her elder brother .

These letters whilst addressed to S would have been dealt with by the duty system.

In August 2001 there were two visits to the family, the first unscheduled, all the children were seen; they were clean and appropriately dressed and interacted with their parents during a fifteen minute visit. The second was made to assess the support services the family

needed. In practice terms this visit raises issues of professional knowledge, understanding of abusive families and integration of that knowledge with observations.

The two older children were in another room throughout the visit whilst the social worker discussed issues of support networks, respite from the child, the baby books being checked and the fabric of the building. The social worker asked to see the children – the boy was playing and Ainlee was strapped in a chair facing the wall, 'because she kept flicking food around'. Ainlee was two years old.

The visit was to assess the children's needs; there is no evidence that any direct work was attempted or permitted. There was no evaluation of the time the children were alone. There was no expressed surprise that a child of two was being punished in this manner. There was no eye contact with Ainlee to assess her demeanour or condition. The control and power exerted by Leanne and Dennis was reinforced by the lack of direct action on behalf of Ainlee.

The police were called to the house following a domestic disturbance. Leanne alleged that she had been assaulted by Dennis and feared for the safety of the children. Dennis agreed to leave but returned and subsequently was arrested to prevent a breach of the peace. The police stated that the children appeared happy and cared for and undisturbed by the incident. There was concern that there were empty syringes and drug paraphernalia left around. Leanne alleged it was a ploy to help get a housing move.

The family did not meet the criteria for a nursery placement and were recommended to register for nursery school.

In September the two boys are seen with Leanne at the office; Ainlee is allegedly with her father.

Contact with the family during September, October and November focuses on practical issues, failed appointments and promises made by Leanne re. contact with health officials. Leanne's truthfulness does not appear to have been challenged despite the evidence of her history.

Between the 1st and 8th November a duty social worker shows more rigour in her approach to determine whether the children had been seen by a health visitor. Despite Leanne's assertions that they had, it was proved that whilst she had seen a health visitor Ainlee and her younger brother had not.

At this point having completed an excellent piece of work by being persistent in checking for the truth, the social worker established a high level of concern and risk for Ainlee .

On the 23rd November a telephone call to the health visitor established that Ainlee had not been taken for a developmental check in October and no other appointment was made. The health visitor would not do a home visit as the family was considered dangerous.

The social worker urged a joint visit.

On the 20th December Leanne phoned for an appointment and was given the 4th January.

Given the urgency expressed by the Duty Social Worker on the 12th December the question has to be asked whether the second duty social worker read the notes. How could it be deemed appropriate to leave a vulnerable child who had not been seen since August over the Christmas period of fifteen days?

On the social work file the last recorded details of her being seen were in August by the police. The officers were investigating a domestic dispute complaint, they saw all three children; the officers reported that 'the children appeared to be well cared for and happy'.

A police visit was recorded on 24th December 2001 as a result of a complaint by Leanne's mother to another Police Service. No action was taken on behalf of the children.

Ainlee died on 7th January 2002.

CONCLUSION

It is with great sadness that I conclude this Report.

Ainlee was successfully isolated from all those people who could have protected her; the systems available were manipulated by Leanne Labonte and Dennis Henry; individuals were intimidated and rejected.

The malevolence that grew out of Leanne and Dennis's experiences cannot be excised and Ainlee's brothers continue to be victims through the loss of their family.

Helen Kenward

October 2002

Please note the rest of this document consists of an analysis of each of the individual agency reports. This analysis has not been included in this summary, but the issues are incorporated into the action plan of the Area Child Protection Committee. Some of these matters had already been dealt with as agencies have taken positive actions without waiting for the outcome of this report.

CHAPTER 8 REVIEW

Report of

Newham Area Child Protection Committee

Introduction

Circumstances Leading to the Review

On 7th January 2002 Ainlee was taken by ambulance to Newham General Hospital following a call to the emergency services from her father Dennis. She was found to be dead on arrival and a post mortem revealed over sixty injuries including cigarette burns to her body, and a body weight well below that expected for a child of her age. The cause of death was subsequently established as chronic abuse and neglect. At the time of her death the family was an 'open' case to the Social Services Department who had known them for a number of years, and they were also well known to several other agencies.

The Director of Social Services, who is also the Chair of the Area Child Protection Committeewas notified on the evening of 7th January and the Department of Health was informed early on 8th January together with local agencies. All agencies were in agreement that a Chapter 8 Review in accordance with "Working Together" should be undertaken.

Terms of Reference

A meeting of senior representatives of the agencies involved, who are also members of the Area Child Protection Committee, and Police Officers investigating the death, was convened on 25th January 2002.

The group comprised :-
Director of Social Services and Chair of Area Child Protection Committee
Head of Service Planning and Review, Social Services
Principal Officer, Children's Planning and Reviews, Social Services
Service Manager, Children In Need, Social Services
Housing Department Representative
Senior Education Welfare Officer
Child Protection Nurse Specialist, Primary Care Trust
Police Major Investigation Team, 2 Representatives

The following terms of reference were agreed:

1. All agencies involved (Newham Healthcare, the Newham Primary Care NHS Trust, the Social Services, Education and Housing Departments of the London Borough of Newham, the Metropolitan Police, Probation, Parks Constabulary, General Practitioners, Royal London Hospitals and Tower Hamlets Primary Care NHS Trust) should secure the relevant files and appoint an appropriate senior officer or independent person to undertake an individual agency review of

    - involvement with the family, including a chronology
    - all information available and actions taken
    - co-operation and communication with other agencies
    - compliance with current child protection procedures

    The review should include interviews with staff involved where appropriate.

    These reviews should identify any gaps in information or areas requiring further investigation, an evaluation of whether appropriate services were provided, recommendations regarding current practice and where appropriate, proposals for change in the individual agencies.

2. An independent chair will be appointed in consultation with the SSI. Reports should be sent to the chair of the Area Child Protection Committee, who will pass them to the independent chair, by the end of March 2002. The chair will compile a draft report for discussion by the agencies involved, which includes

    - a detailed social history and details of previous agency involvement
    - details of the events leading to the death of the child
    - a full composite chronology
    - a geneogram
    - identification of the issues emerging
    - a list of recommendations of individual agencies.

    Specific issues already identified in this matter should be given close attention:

    a) A review of the decisions made and work undertaken leading to the de-registration of Ainlee's brother in 1999 and the non-registration of Ainlee at birth or thereafter.

b) What was the quality and effectiveness of communication between the agencies and within individual agencies, and Social Services' response to concerns being raised between 1999 and 2001.

c) How the referral to Social Services in July 2001 was dealt with, and what were the implications of this.

d) What wider practice issues arise from the consideration of this case, e.g.

- structural issues
- working with dangerous families/evasive families
- loss of historical information through non-recording or lack of use

This list is not exhaustive and not intended to restrict agencies in addressing any matters of concern which they identify.

3. The chair of the review group should then convene a meeting to discuss the findings and the issues, identify and obtain any additional information required and agree the Area Child Protection Committee recommendations by mid May. A draft action plan should be produced.

4. The report, recommendations and action plan should be presented for discussion to the full Area Child Protection Committee, preferably the meeting on 12th June 2002, before the report, including as appendices the individual reports of all agencies, is sent to the Department of Health. A plan to disseminate the findings should be agreed by the Area Child Protection Committee.

   This work should be completed by the end of June 2002.

The meeting agreed that agency reports should not be undertaken by any member of staff who had had involvement with the family and the Director of Social Services indicated that the review of Social Services' involvement would be undertaken by the independent consultant.

Conduct of the Review

In consultation with the Social Services Inspectorate, an independent consultant, Helen Kenward was appointed by the Chair of the Area Child Protection Committeeto undertake the review of Social Services' involvement and the overview on behalf of the Area Child Protection Committee.

The following agencies contributed to the review:-

Newham Social Services Department - All relevant files were secured and made available. Four members of staff, including managers, were interviewed and background information on the departmental context was provided by the Director. The report was written by the consultant and recommendations prepared by the Director and Assistant Director, Children and Families.

Newham Housing Department - Files were secured and a search instituted for one local tenancy file, which has not been found. Three members of the housing staff were interviewed and following the trial a neighbour of the family was also seen in the context of evidence she had given the manager of ALERT (the company contracted by the Council to investigate racial harassment) was also interviewed. A report was prepared by an officer of the Housing Department.

Newham Education Department - The department had very limited contact with the family since the eldest child had only just reached the age of school admission, but a report on this involvement was prepared by an Education Welfare Officer.

Probation Service - The Probation Service had no relevant information but following evidence at the trial that referrals had been made to them, a review was undertaken by the Assistant Chief Probation Officer, which identified that there were no records of any referrals concerning the children.

Metropolitan Police - A report on police involvement was received from the Officer in Charge of the criminal investigation. However, further information on police involvement subsequently became available and a new report, compiled by another officer from the Police Major Investigation Team, was submitted in July 2002. This report examined CAD, CRIS, CRIMINT and SO3 reports, Form 78's and 27 statements of officers involved. The Police have subsequently investigated further and an internal report has resulted in wide ranging action plan which is included in the action plan for this review.

Health Agencies - The health report was compiled on behalf of the Newham PCT by a nurse seconded to do the work from NE London NHS Direct. She was assisted in some interviews by the Designated Doctor for Child Protection for the Trust. The investigation included the review of 21 sets of records from G.P.s, Newham Healthcare Trust, Newham Primary Care Trust, Tower Hamlets Primary Care Trust and the Royal London Hospital NHS Trust involving a variety of professionals (midwives, health visitors, G.P.s and paediatricians). A total of 28 people were interviewed, and three of those and the authors of the report also spoke with the independent consultant.

Complete health records were not available as some papers had been stolen by the family and some information was not recorded on G.P. files.

There were difficulties in co-ordinating this work, which was not possible within the original time-scales set, and resulted in 3 draft reports before the final report was provided in September 2002 .

Pathologists Report - The full report was provided.

All of the above material has been appended to the overview report submitted to the Department of Health.

Material from the Criminal Trial - The consultant was given the opportunity to read evidence collated by the Police in connection with the trial of Leanne and Dennis, following their convictions.

It was not possible to achieve the time-scales set out in the original terms of reference because of the complexity of the work involved in collating the individual agency reports, and the consequent effect upon the compilation of the overview report. Time-scales were re-negotiated between the Chair of the Area Child Protection Committeeand the consultant to ensure that all emerging information was reviewed and incorporated into the overview.

The trial of Leanne and Dennis for manslaughter began on 4th September 2002 and concluded with verdicts of guilty in respect of both of them on 20th September. During the course of the trial some additional information was given by various witnesses, and this too was investigated and included in the final report.

A meeting of representatives of the Area Child Protection Committee was convened on 23rd October to consider the draft of the consultant's report. Following that meeting a small number of factual corrections were made to the report and an action plan was developed in response to the recommendations. In addition to these documents, this report, all the individual reports of agencies including notes of interviews, the pathology report and a chronology of approximately 216 pages have been submitted to the Department of Health.

The consultant's report from which personal information has been removed, a summary of this report and the full action plan are being published.

Ownership by the Area Child Protection Committee

It can be seen from the above that most of the information used in the preparation of this report has been derived from the internal reports of the agencies concerned, their records and interviews with their staff. This has been a difficult and painful experience for staff involved and for the managers of the relevant services. However, the Area Child Protection Committeeas a whole, and the individual agencies, accept the outcome of this very detailed piece of work and acknowledge the shortcomings evidenced in child protection work in the borough. The agencies concerned have themselves developed the recommendations and the action plan and are fully committed both to the implementation of the plan and to the strengthening of multi agency work through the Area Child Protection Committee. Senior managers are also considering the future strategy and shape of children's services within the borough to ensure that every possible opportunity is taken to address the level of need and the quality of services required in Newham.

Meeting The Requirements of Chapter 8 'Working Together'

Chapter 8 of 'Working Together' sets out the purpose of case reviews to

> ‘establish whether there are lessons to be learnt from the case about the way in which local professionals and agencies work together to safeguard children.
>
> identify clearly what these lessons are, how they will be acted upon and what is expected to change as a result, and as a consequence
>
> to improve inter-agency working and better safeguard children.
>
> case reviews are not enquiries into how a child died or who is culpable...’ (p. 87)

The Chapter goes on to set out the criteria, scope, timing and conduct of the review.

The above commentary establishes:-

- That the criteria for a review were met and that a panel was set up.
- The scope of the review was set out in the terms of reference and in the minutes of the first meeting of the panel.
- Time-scales were set in accordance with guidance but could not be met because of the complexity of the case. It was of prime importance that all aspects of the situation should be properly investigated, and time-scales were reviewed in order to achieve this outcome.
- The conduct of the review was undertaken in line with the guidance and additional advice on the value of an independent overview.
- The format of the overview report was not in accordance with the guidance, which does accept that 'precise format will depend upon the features of the case' (p.91). This additional report is written to ensure all aspects of the guidance have been covered.
- Dissemination plans are still under discussion but will include publication of most of the overview report and detailed discussion with professional staff and senior managers. All relevant papers have been sent to the Department of Health.

The process of the review and the outcome do therefore meet the requirements of the guidance with the exception of time-scales and the format of the overview report.

THE FACTS

Chronology (Not published)

Overview Of Relevant Information

The full report includes a 7 page summary of the family background and details of Ainlee's life. In the interests of the confidentiality of this information, this section has been removed from this summary report. However, the overview report by the independent consultant does include a summary of the main relevant events in the lives of Leanne and Ainlee.

Analysis Of Issues

The overview report contains, in the section entitled 'Critical Analysis', a detailed discussion of the issues arising from the way in which agencies worked together and their understanding of child protection procedures and practice. It is not intended to repeat that analysis here, but only to identify and summarise the main issues to ensure that the link to the recommendations is clearly established. The information available is complex and detailed and will repay close study by all those involved. Not every issue is highlighted in the section below.

1. Assessment and Planning

The seeds of the tragic events leading to Ainlee's death can be seen in the management of work in 1999, around the time of her elder brother's birth and his inclusion on the Child Protection Register. Any assessment of Leanne's situation at that time leads to a conclusion that he was at risk on information available then. A comprehensive assessment was not undertaken then or at any other time. As a result of this, it was not reasonable to shift the focus of work with him and Leanne away from his protection towards an assumption that rehabilitation and 'family support' were the plan. No assessment at all was undertaken of Dennis, nor was there any work to understand the reasons for his involvement with Leanne and her son. Assumptions made by workers were not challenged or clarified and they were not given the necessary supervision and support to enable them to challenge the parents.

While recommendations were made at conferences, social workers did not develop a clear plan for the child's protection and changes of worker and team, including periods without an allocated worker, led to the loss of focus on his needs, which enabled Leanne and Dennis to disrupt any possibility of work with them.

Many of the recommendations to the Social Services Department seek to address these issues by re-emphasising accepted good practice and reinforcing the action plan to which the Department is working following an inspection in December 2001. For Health Services, similar issues arise with a lack of co-ordination of information across agencies, and no opportunity to co-ordinate and review the planning. Supervision is also an issue, as is the recording of relevant information by G.P.s (eg, reasons for removal from list).

2. Child Protection Issues

Procedures and accepted good practice have not always been followed in the course of working with Ainlee and her family. The need for a Pre-Birth Conference was identified, but a conference was not convened. It appears that a conference on Ainlee was held after her birth, which took the decision not to register her, and subsequently she was not considered in conferences in relation to her brother. The conference which de-registered him did so without a report on the residential assessment and with the knowledge that due to the family's lack of co-operation, no assessment had been completed. Files do not contain summaries or chronologies. The sharing of information between agencies is considered as a separate issue, but did not conform to the requirements of procedures. Health services focused on the need for the children to receive health care and the protection of staff during the period from July 2000, rather than a holistic view of their needs. Information from all agencies is not collated and in some cases health professionals were unsure of their responsibilities in this area. Again, this leads to a situation in which the focus is no longer on the child. Newham is fully involved in the plans to implement the pan-London Child Protection Procedures early in 2003 and will take that opportunity to reinforce the importance of the procedures for front line workers and managers and the significance of practice in this area.

3. Communication

Perhaps one of the most distressing findings of this review has been the amount and depth of information available to agencies and the failure to share it. Although there were on occasions tensions between agencies or individuals, there is nothing to indicate any deliberate withholding of relevant information. However, individual agencies, particularly the large number of different Health professionals, did not collate and evaluate the information they had and then to share it with other agencies in a way which communicated the depth of concern. There is also a failure by Social Services to understand and respond to the level of concern expressed by Health colleagues. It is particularly remarkable that for almost a year (14th July 2000 to 26th June 2001) Health agencies, the Police and Housing all had serious concerns, but none of this information passed to Social Services. There are issues about how to raise concerns when initial referrals are not accepted. For many of the staff involved, it is in this area above all that the concern remains that they could or should have done more to voice their anxieties for Ainlee.

In a wider context, there are issues for the Area Child Protection Committeeand its responsibility to raise the profile of child protection in an area of very high social need. The Police have recognised the need for all staff, not just the Child Protection Unit, to be aware of children and child protection issues in their contact with families in the borough and to ensure supervision and effective reporting of issues. There are recommendations in relation to the way in which Housing Officers dealt both with the family and with neighbours to ensure that in future information relating to children is not overlooked. However, the AREA CHILD PROTECTION COMMITTEEhas more work to do in ensuring the general public know where to turn when they have concerns and also begin to accept a responsibility for this.

4. Working With Dangerous Families

This was a violent and intimidating family, who treated all agencies with suspicion and mistrust and did all that they could to prevent their involvement. They deliberately caused confusion, destroyed records and moved frequently between health agencies. It was extremely difficult to work with them and it is to the credit of many of the staff involved that they attempted to meet the needs of the children in the circumstances. However, there was a lack of understanding and a lack of skills in working with dangerous families and a failure to recognise what was happening. Most of the records do not acknowledge that the family was frightening and there is no evidence that the effect they had was addressed in supervision. Health agencies protected staff by arranging contact at the clinic and the Housing Department took action to ensure staff safety. The consultant's report identifies clearly the need to focus on children in these situations and consider the effect upon them of life in this context.

The challenge of achieving successful protection for children living with dangerous families demands skilled and experienced workers in all agencies. The Area Child Protection Committeecan consider appropriate multi-agency training and each agency will need to develop good supervision and support for staff. However, difficulties in recruiting and retaining good staff and the limits of resources available to all agencies have a direct impact on this issue.

5. Other Issues

In the detail of this review, numerous other smaller but no less important issues became apparent, many of which relate to individual agencies, rather than to all. These are picked up through some of the recommendations of individual agencies, but inevitably there will be those which are not spelt out separately. Perhaps the overriding issue is the need for a culture which focuses on the outcomes for individual children and helps agencies to challenge repeatedly the way in which they work, in order to ensure that systems and practices contribute to these outcomes. The Area Child Protection Committee will consider carefully the findings of the Joint Inspectors' Report, and in due course the report of the Laming Enquiry into the death of Victoria Climbie and seek to develop the trust and co-operation needed between agencies to ensure high standards of practice. At the same time their senior managers will be considering the future of children's services in Newham, to ensure that structural arrangements assist, rather than hinder, the development of good quality services.

Relevance of Recent Research

During 2002 there have been two publications of considerable relevance to this Chapter 8 review. Both of these were published well after Ainlee's death.

The first, 'Learning from Past Experience' was published by the Department of Health in June 2002 and presents a review of services and reviews undertaken by Ruth Sinclair of the National Children's Bureau and Roger Bullock of the Dartington Social Research Unit. The issues explored were:-

- The conduct of the case review process.
- The production of overview reports and implementation of action plans.
- Patterns or common themes in terms of children's circumstances and needs, histories and inter agency work.

All of these issues are relevant to this review.

While it is difficult to generalise concerning children who suffer fatal abuse or serious injury some features appear frequently and these include:-

- Poor standards of care.
- Emotional neglect.
- Domestic violence.
- Mental health problems.

However, over concentration on these features (some of which are present in this case) may ignore other relevant factors such as:-

- Social isolation,
- Young age of the child,
- Cultural factors,
- Lack of developmental checks,
- Poor use of early years services,

many of which are also present in this case.

The analysis of Ainlee's history identifies many risk factors in her situation, which were not appreciated because of the lack of a thorough assessment at any stage. The report lists several of the factors, which were of significance in a large number of the 40 cases reviewed and in particular identifies the need for good inter-agency communication when several agencies are involved and families are mobile. This issue is further addressed by the identification of the need for common understanding between agencies of the threshold for assessments of need, or risk of significant harm, and the appropriate response to such assessments. Greater clarity in decision making will assist this. Sadly these matters are particularly evident in Ainlee's situation.

Chapter 6 of the research considers the process of the review and echoes some of the issues apparent in Ainlee's review. Practice shortcomings identified are apparent in this case and we would agree strongly that recommendations from the review are relevant to the whole Area Child Protection Committee area rather than to a specific agency, and that the process of implementation cannot be by instant 'tick box' outcomes, but is about a long term improvement in practice across all agencies. In none of the cases reviewed did the fault lie clearly with a single agency and this finding is true of the work with Ainlee.

The multi-agency discussions and training which follow from the conclusion of the Chapter 8 reviews concerning Ainlee will include an examination of the clear relevance of the findings of this report to the work with her and her family.

The second recent publication is 'Safeguarding Children', the joint Chief Inspectors' Report on Arrangements to Safeguard Children published in October 2002. This report identifies that:-

- In many areas the priority given to safeguarding children has not been reflected firmly, coherently or consistently enough in service planning and resource allocation nationally or locally across all agencies.
- While there were good working relationships between almost all local agencies many services were under pressure and experiencing major difficulties in recruiting and retaining key skilled and experienced staff and this was having a major impact upon safeguarding arrangements.
- Many staff from all agencies were confused about their responsibilities and duties to share information about child welfare.

- In most areas there were serious concerns about the thresholds Social Services were applying in their children's services.
- Some specific services did not appear to be well integrated into the local safeguarding arrangements.

Many of these general issues are recognisable in Newham and in the last 2 years have achieved a significant profile. Working relationships between agencies have improved and at the most senior level a group chaired by the Chief Executive of the Council has begun to consider the future strategic direction of children's services. Other initiatives are addressing referral and tracking mechanisms for children, recruitment and retention of staff and the involvement of all relevant agencies. In the last year the threshold criteria for children's services have been rewritten.

The leadership of the Area Child Protection Committeeis also addressed by the report with findings that:-

- Few Area Child Protection Committees were equipped and able to exercise their responsibilities to promote and exercise safeguards for children.
- Strong leadership of the Area Child Protection Committeemust be combined with the commitment of all local agencies to support its work.
- Effective joint funding arrangements are essential.
- Area Child Protection Committees do not command the authority to require local agencies to account for their safeguarding arrangements because they are not statutory bodies.
- Some areas do not have recent business plans specifying objectives and providing evidence of local activities and standards for their work.

Newham's Area Child Protection Committeewas re-launched in December 2001 and does now attract the support of senior representatives of all relevant agencies. However, joint funding arrangements are not yet effective and this limits its ability to fulfil an appropriate business plan. The Joint Inspectors' Report will be discussed at the next meeting of the Area Child Protection Committeein order to progress some of their recommendations as appropriate for the borough.

Conclusion

A detailed consideration of the circumstances surrounding Ainlee's death focuses attention on a distressing life experience of neglect, poverty, ill-treatment and violence. Agencies and individuals were not able successfully to protect her and her brothers from parents who, for whatever reason, were unable to offer her the care and support she needed. The only possible positive outcome from Ainlee's death must be the renewed commitment of all the agencies involved to work together to improve the protection of children in Newham for the future.

Kathryn Hudson
Chair Of Newham Area Child Protection Committee

RECOMMENDATIONS

of the

Newham Area Child Protection Committee

Recommendations

In addition to the recommendations set out below the Area Child Protection Committee will review the findings of the recent joint inspectors' report on child protection 'Safeguarding Children' and ensure that appropriate recommendations to strengthen the Area Child Protection Committee and joint working are built into the business plan for 2003/04.

1. OVERVIEW REPORT

1.1 It is recommended that priority be given to training in the area of direct work with dangerous families :-

1.1.1. The concept be re-defined within the inter-agency network.

1.1.2. Cognisance be given to the importance of information held within all the agencies.

1.2 It is recommended that supervision of staff in all the agencies be assessed in the context of management responsibility.

That where any agency decides that they are no longer able to visit a family or have a family visit their offices, that decision and all supporting evidence should be submitted to the Child Protection Committee for Senior Management to evaluate.

1.3 It is recommended that each agency re-assess the process of record keeping and tracking the information relevant to the protection and welfare of children.

1.4 It is recommended that there be a monitoring process of Case Conferences and their decisions and that where there is dissent from one of the partners, the minutes be passed to the Child Protection Committee for ratification of the decisions.

1.5 It is recommended that the focus of work with families should be evaluated in the light of child protection and that all staff undertaking direct contact with families should have basic child protection training.

1.5.1 Within this context all staff should know where their personal responsibility lies and the action they should take.

1.5.2 that the supervision of child protection cases needs to be in the context of risk assessment and that supervision records be kept as part of the case files.

1.5.3 that de-registration of a child be ratified at senior management level with evidence that all agencies are in agreement.

1.5.4 that where there is dissent or absence of any party from the decision, that any evidence counteracting that view be submitted.

1.5.5 that the work with dangerous families be considered a task requiring skills and knowledge of research and current thinking.

1.5.6 that where an unskilled worker is involved with social services that worker requires the highest level of supervision and scrutiny.

2. HEALTH AGENCIES' REPORTS

MIDWIVES

Newham

2.1 Midwives' awareness of child protection needs to be addressed.

2.2 Midwifery practice around record keeping, report writing, liaison and referrals to be addressed.

2.3 Child protection supervision systems to be introduced for midwives.

2.4 Role of Named Midwife for Child Protection and/or child protection supervision to be reviewed and a policy re supervision introduced.

Newham and Tower Hamlets

2.5 Midwifery units to review policies and procedures to ensure "Changing Childbirth" and child protection practices are compatible. Information should be passed on and/or requested when a mother with a high risk pregnancy and/or child protection concerns chooses to change midwifery unit.

2.6 Communication between Midwives and Health Visitors to be improved and formalised.

HEALTH VISITING

Newham

2.7 Newham Primary Care Trust should continue to implement the audit report recommendations relating to records to improve all trust records.

2.8 When child protection and/or child in need families are transferred between Health Visitors in Newham they should inform the Practice Facilitator and arrange an early supervision appointment for complex cases.

2.9 Tower Hamlets to reaffirm expectations of Health Visitors practice around statutory New Birth Visits and the transfer process, monitor and audit this.

CHILD HEALTH DEPARTMENTS

Newham and Tower Hamlets

2.10 RICHS to be developed to capture data, which can be retrieved including child protection data. Failing this a paper audit trail to be established recording type of records requested/received/ sent out, with dates and professionals identified.

GENERAL PRACTITIONERS

Newham

2.11 G.P. awareness of Child Protection issues and their responsibilities to be improved through training, monitoring and audit of practice.

2.12 G.P. documentation and record keeping needs to improve, and audit introduced.

2.13 Patient registration with G.P.s and transferring to G.P. records needs to be addressed.

GENERAL PRACTITIONERS AND PAEDIATRICIANS

2.14 The Designated/ Named Doctors for child protection to oversee monitoring and audit of practice and doctors involvement in Child Protection cases. Child Protection Supervision, advice and support systems to be developed for Paediatricians and General Practitioners.

2.15 The training needs of paediatricians and G.P.s should be assessed and suitable training provided.

DESIGNATED PROFESSIONALS

Tower Hamlets

2.16 The current plans to appoint a Named and Designated Nurse for Child Protection be progressed as a priority.

2.17 Once in post consideration be given to reviewing any current policies in place re Chapter 8 Enquiries to ensure appropriate management of such cases.

ACCIDENT AND EMERGENCY

Newham General Hospital and The Royal London Hospital

2.18 A&E departments to liase immediately with Midwife and Health Visitor for all babies under 28 days old who attend A&E.

HEALTH AUTHORITY

2.19 Policy and Procedure for conducting Chapter 8 inquiry across Primary Care Trusts to be introduced.

AREA CHILD PROTECTION COMMITTEE

2.20 Policy for review of cases when there are major differences of opinion between agencies of the risk to children to be introduced. Introduce a multi-agency forum where such a case can be reviewed. Links to 1.4 above.

3. HOUSING

3.1 All Housing caseworkers to be reminded of the importance of maintaining adequate file records and ensuring file records are passed on securely to the appropriate caseworker when a tenant transfers.

3.2 All Housing caseworkers to be contacted and reminded of the importance of ensuring any child protection issues including allegations of neglect or abuse are reported to Social Services within 24 hours.

3.3 All managers to ensure that staff they are responsible for have access to a copy of the Child Abuse Policy and Referral Forms.

3.4 All Housing caseworkers who have not attended a training course to complete the training within the current year. Housing to maintain an ongoing audit of new officers requiring the training and to liase with Social Services on future training needs.

3.5 All Alert Officers to attend a 'Signs & Symptoms of Child Abuse Training Course' within the current year. Housing Department to liaise with Alert to ensure any new staff are included in any future training.

3.6 Allocations Policy to be updated, requiring Allocations Staff to refer all allegations of domestic violence to the appropriate Community Housing Officer.

3.7 All Allocations Staff to be advised of the requirement.

3.8 Social Services and Housing to consider what information, if any, should be provided to Community Housing Staff and Residential Social Landlords managing a tenancy where child protection issues are currently being investigated or have been investigated in the past.

4. POLICE

4.1 Ensure that appropriate training is given to all officers concerning

- Immediate measures to protect children.
- Specific investigation into the welfare of children when responding to CAD calls.

4.2 Procedures should be developed and guidance and training given to police officers to ensure that child protection information is recorded and passed to other specialist units and outside agencies on every relevant occasion.

(1) Appropriate action is taken to comply with Special Police Notice 15/00.

(2) Ensure effective supervision of ALL initial investigations.

(3) To provide training to front line staff (police / SROs) re minimum standards for crime investigation and supervision.

(4) To implement effective crime management policies for the ethical screening of crime.

(5a) To develop and implement minimum secondary investigative standards.

(5b) To maintain secondary investigative standards.

(6) All secondary investigations must be quality assured before completion.

(7) CMU to be robust in the administration of their Core Functions e.g. ensuring CRIS flags, Features, VSS refusals etc are correctly documented (and quality assurance of the same).

(8) Development and Implementation of Borough Diversity strategy.

(9a) Documented risk assessments to be conducted for all hate crime investigations.

(9b) In medium and high risk cases a Risk Management Plan must be completed.

(10) Establish more effective/supportive partnership between Newham Police CSU and CPU teams.

(11) Policy instruction - form 78 to be submitted in ALL domestic violence cases, where children form part of the family.

(12) CSU 'single point of contact' to be nominated for DV repeat victims

(13) Considered/informed training to be delivered to borough staff re Child Protection issues.

(14) Considered/informed training to be delivered to borough staff relating to hate crime investigation.

(15) Development and promulgation of 'Good Investigative Practice' document for CSU Investigators.

(16) Develop a repeat victimisation strategy (Gold, Silver, Bronze response).

(17) Provide with multi-agency partners a diverse range of non-police reporting site options.

(18) Appointment of a Station Inspector.

(19) Daily review of CAD performance.

(20) Restructuring all units, which police vulnerability under one strategic command.

(21) Review of CID Supervisory duties e.g. Det Sgts deployed 2200 - 0600hrs daily.

5. SOCIAL SERVICES

5.1 Ensure that a child focus is maintained in all direct work with families.

5.2 Improve the quality of work in child protection.

5.3 Where parents are intimidating, a professionals' meetings should be held without parents present to ensure a proper exchange of information and development of a strategy on the part of all agencies to manage the situation.

5.4 Ensure that residential assessments are effective and used to ensure that children are protected.

5.5 Ensure that the management structure can respond effectively to issues of concern in order to protect a child.

5.6 Where any re-organisation takes place in future that planning must include the retention of the memory of cases and the associated concerns and history within the organisation.

5.7 Review the operation of the Duty System.

5.8 Improve the management of unallocated work.

5.9 Improve the quality of supervision of workers.

5.10 Ensure that the important information and "memory" of each child's history is retained and carried forward.

5.11 Improve joint working with health visitors.

5.12 Ensure that remedial action is taken in the case where a worker is incompetent.

ACTION PLAN

of

Newham Area Child Protection Committee

Newham Area Child Protection Committee

Action Plan in response to the Chapter 8 Review on Ainlee Labonte/Walker

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
In addition to the recommendations set out below the Area Child Protection Committee will review the findings of the recent joint inspectors' report on child protection 'Safeguarding Children' and ensure that appropriate recommendations to strengthen the Area Child Protection Committee and joint working are built into the business plan for 2003/04.	Chair Of Area Child Protection Committee	To be discussed at the Area Child Protection Committee meeting Dec. 2002.	Agenda for meeting on 4.12.02.	Business Plan April 2003 then ongoing
1. OVERVIEW REPORT **1.1** It is recommended that priority be given to training in the area of direct work with dangerous families:-	Chair Of Prevention Working Group	Work will be undertaken to look at research and practice in this area in the next 3 months. Discussion of the concept to Area Child Protection Committee meeting and then for consultation with all agencies.		March 2003 April 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
1.2 The concept be re-defined within the inter-agency network.		New definition in place and training for front line staff in progress.		June 2003
1.3 Cognisance be given to the importance of information held within all the agencies.	Chair Of Area Child Protection Committee Business Group All Agencies	Review current ways of sharing information in the light of the report. Consider additional ways of ensuring information is fully shared and bring proposals to the Area Child Protection Committee. Implement proposals as agreed by Area Child Protection Committee.		March 2003 March 2003 March 2003 onwards
1.4 It is recommended that supervision of staff in all the agencies be assessed in the context of management responsibility.	Chair Of Area Child Protection Committee Chair Of Area Child Protection Committee Chair Of Area Child Protection Committee	Copies of the report and action plan to be sent to all Chief Executives and Directors of relevant agencies with a covering letter addressing this issue. Meetings to be convened to discuss the implications of the report and encourage appropriate action. Outcome to be fed back to Area Child Protection Committee and further action considered.		December 2002 January 2003 March 2003
1.5 That where any agency decides that they are no longer able to visit a family or have a family visit their offices, that decision and all supporting evidence should be submitted to the Child Protection Committee for Senior Management to evaluate.	All Agencies Chair Of Review Sub-Committee	Relevant families to be identified in supervision or other management meetings and referred to the Practice, Monitoring and Review Sub-Committee. Reports from this sub-committee to highlight the issues to the full Area Child Protection Committee on a quarterly basis.		Immediate From March 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
1.6 It is recommended that each agency re-assess the process of record keeping and tracking the information relevant to the protection and welfare of children.	All Agencies Chair Of Business Sub-Committee AD Children and Families	Report from each agency together with an action plan to be brought to the Business Sub-Committee. Summary and progress report to full Area Child Protection Committee meeting. Issues to be highlighted and addressed in the pilot project for referral and tracking children.		April 2003 June 2003 Ongoing
1.7 It is recommended that there be a monitoring process of Case Conferences and their decisions and that where there is dissent from one of the partners, the minutes be passed to the Child Protection Committee for ratification of the decisions.	Head Of Children's Planning & Reviewing Centre Chair Of Review Committee	Process to be set up to refer these situations to the Review Sub-Committee. Process to be agreed by full Area Child Protection Committee meeting. Quarterly reports on all cases to full Area Child Protection Committee.		March 2003 From June 2003
1.8 It is recommended that the focus of work with families should be evaluated in the light of Child Protection and that all staff undertaking direct contact with families should have basic Child Protection Training.	Chair Of Area Child Protection Committee	The Area Child Protection Committee will take responsibility through its Business Plan for raising awareness of child protection services in all agencies with direct contact with children and, as resources allow, assist in the provision of basic training.	Particular attention is already being paid to ensuring appropriate procedures are in place in all groups working with vulnerable children.	March 2003 & ongoing
1.9 Within this context all staff	Director of Social Services	To be linked to work with Chief Executives outlined in 1.2.	Work already undertaken in Social Services to be	March 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
should know where their personal responsibility lies and the action they should take.	All Agencies		developed and discussed with other agencies.	
1.10 That the supervision of Child Protection cases needs to be in the context of Risk Assessment and that supervision records be kept as part of the case files.	All Agencies	To be linked to 5.7 in Social Services.		Immediate
1.11 That de-registration of a child be ratified at Senior Management level with evidence that all agencies are in agreement.	Head Of Children's Planning & Reviewing Centre Chairs Of Reviews	Outcome to all conferences to be discussed with Chairs of conferences in regular supervision. Evidence of agreement to be recorded in all minutes.		Immediate Immediate
1.12 That where there is dissent or absence of any party from the decision, that any evidence counteracting that view be submitted.	Head Of Children's Planning & Reviewing Centre	Develop a system to ensure this happens in all cases and that issues of dissent are referred to the Review Sub-Committee.		March 2003
1.13 That the work with dangerous families be considered a task requiring skills and knowledge of research and current thinking.	Chair Of Training Sub-Committee and Area Child Protection Committee Development Worker	Review current knowledge and research and develop appropriate multi-agency training for front line staff and managers.		June 2003
1.14 That where an unskilled worker is involved with social services that	All Agencies	Review the management and deployment of unskilled and newly qualified workers to ensure appropriate supervision and allocation of work.		Immediate

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
worker requires the highest level of supervision and scrutiny.	Chair Of Business Sub-Committee	Discuss appropriate action on a multi agency basis.		March 2003
2. HEALTH AGENCIES REPORTS **MIDWIVES** **Newham** **2.1** Midwives' awareness of child protection needs to be addressed.	Head Of Midwifery	CP training for midwives to be reviewed and monitored		Ongoing
2.2 Midwifery practice around record keeping, report writing, liaison and referrals to be addressed.	Head Of Midwifery	Training for midwives to be initiated. Records to be audited.	All nurses in post prior to June 02 have now undertaken training. Those since June on-going. Last audit June 2002 Achieved	Ongoing
2.3 Child Protection Supervision systems to be introduced for midwives.	Head Of Midwifery	Interim process to be introduced. Policy to be developed		December 2002
2.4 Role of Named Midwife for Child Protection and/or child protection supervision to be reviewed and a policy re supervision introduced.	Head Of Midwifery Head of Midwifery Head of Midwifery	Review named midwife for child protection. Additional resources identified for 0.6 WTE Supervision Policy to be written and consulted.	Recruitment underway	December 2002 March 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
Newham and Tower Hamlets **2.5** Midwifery units to review policies and procedures to ensure "Changing Childbirth" and child protection practices are compatible. Information should be passed on and/or requested when a mother with a high risk pregnancy and/or child protection concerns chooses to change midwifery unit.	Head of Midwifery at NHCT and The Royal London Head of Midwifery	Policies to be reviewed and amended as necessary. All staff to be made aware of changes.		December 2002 January 2003
2.6 Communication between Midwives and Health Visitors to be improved and formalised.	Head Of Midwifery	Combine Newham HV/Midwifery training on use of liaison from Tower Hamlets to address Liaison issues with HVS		December 2002
HEALTH VISITING **Newham** **2.7** Newham Primary Care Trust should continue to implement the Audit report recommendations relating to records to improve all trust records.	Head Of Locality Services	Recommendations to be implemented	Last records audit(August 2002) As a result changes to clinic records	Immediate and ongoing
2.8 When Child Protection and/or Child in Need families are transferred between Health Visitors in Newham they should inform the Practice Facilitator and arrange an early supervision appointment for complex cases.	Designated Nurse Child Protection	Review Child Protection Supervision Policy		November 2002

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
2.9 Tower Hamlets to reaffirm expectations of Health Visitors practice around Statutory New Birth Visits and the transfer process, monitor and audit this.	Director of Nursing Tower Hamlets PCT	Use of Inter Centre memos to be reviewed		December 2002
CHILD HEALTH DEPARTMENTS **Newham and Tower Hamlets** **2.10** RICHS to be developed to capture data, which can be retrieved including child protection data. Failing this a paper audit trail to be established recording type of records requested/received/ sent out, with dates and professionals identified.	General Manager Paediatrics Designated Nurse Child Protection	The use of RICHS is currently being reviewed. This will include response to this recommendation Child protection Admin assistant to be trained in RICHS data input		December 2002 December 2002
GENERAL PRACTITIONERS **Newham** **2.11** G.P. awareness of Child Protection issues and their responsibilities to be improved through training, monitoring and audit of practice.	Designated Doctor Child Protection Designated Doctor Child Protection	Appoint Clinical lead for Child Protection in General Practice and support designated professionals with training. Child Protection to be discussed at PLT sessions in November.	Role advertised Programme agreed	December 2002 November 2002
2.12 G.P. documentation and record keeping needs to improve, and audit introduced.	G.P. Clinical Governance Lead Plus Head Of Clinical	Training on record keeping to be offered. Baseline plus ongoing audit		December 2002

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
	Government			
2.13 Patient registration with G.P.s and transferring of G.P. records needs to be addressed.	Director of Primary Care Director of Primary Care	Primary Care Trusts in NE London have commissioned a project to review how best to manage FHS Administration in light of the dissolution of HAs. Newham PCT is reviewing the patient allocation process as it relates to compulsory assignments, required practice activity and the recording of patient data into practice systems	Commenced in September 2002 Guidance being drafted	December 2002
GENERAL PRACTITIONERS AND PAEDIATRICIANS **2.14** The Designated/ Named Doctors for Child Protection to oversee monitoring and audit of practice and doctors involvement in Child Protection cases. Child Protection Supervision, advice and support systems to be developed for Paediatricians and General Practitioners.	Designated Doctor for Child Protection Consultant Paediatrician Designated Doctor for Child Protection	Supervision policy for paediatricians to be written Reviewing of DNA Policy Policy for CP Supervision for G.P.s to be established - pick up in G.P. appraisal		December 2002 November 2002 December 2002
2.15 The training needs of paediatricians and G.P.s should be assessed and suitable training provided.	Designated Doctor for Child Protection	Analysis to be undertaken following November PLT sessions		December 2002

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
DESIGNATED PROFESSIONALS **Tower Hamlets** **2.16** The current plans to appoint a named and designated nurse for child protection be progressed as a priority.	Director Of Nursing Tower Hamlets	Advertise and recruit to vacant posts.	Post was advertised October 2002	January 2003
2.17 Once in post consideration be given to reviewing any current policies in place re Chapter 8 Enquiries to ensure appropriate management of such cases.	Director Of Nursing Tower Hamlets	Review to be undertaken as soon as post holder arrives.		March 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
ACCIDENT AND EMERGENCY **Newham General Hospital and The Royal London Hospital** **2.18** A&E departments to liaise immediately with Midwife and Health Visitor for all babies under 28 days old who attend A&E.	Liaison health visitor at RLHT / A&E Consultant Newham General Hospital / Designated Nurse Child Protection / Director Of Nursing Tower Hamlets	System needs to be identified. Implement system. Review progress.		December 2002 January 2003 June 2003
HEALTH AUTHORITY **2.19** Policy and Procedure for conducting Chapter 8 inquiry across Primary Care Trusts to be introduced.	Director Of Public Health NELSTHA	Review current practice. Review policy and practice in accordance with requirements of 'Working Together'.		Immediate March 2003
Area Child Protection Committee **2.20** Policy for review of cases when there are major differences of opinion between agencies of the risk to children to be introduced. Introduce a multi-agency forum where such a case can be reviewed. Links to 1.4 above.	Designated Professionals	Adopt PAN London procedures. Local PCT health procedures to reflect	Comments on 1st draft submitted	April 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
3. HOUSING **3.1** All Housing Caseworkers to be reminded of the importance of maintaining adequate file records and ensuring file records are passed on securely to the appropriate Caseworker when a Tenant transfers.	Divisional Director, Housing Community Services	Audit to be undertaken of section of file records. All caseworkers to be advised of procedures to follow following assessment.		March 2003
3.2 All Housing Caseworkers to be contacted and reminded of the importance of ensuring any child protection issues including allegations of neglect or abuse are reported to Social Services within 24 hours.	Director Of Housing	All Caseworkers to be contacted and reminded of importance of ensuring referrals reported within time-scale. Process of monitoring referrals to Social Services to ensure referrals are received to be considered.		November 2002 January 2003
3.3 All Managers to ensure that staff they are responsible for have access to a copy of the Child Abuse Policy and Referral Forms.	Director Of Housing	All Managers responsible for caseworkers to ensure staff are aware how to access referral forms and procedures.	Child abuse policy and referral form available to all caseworkers on the housing intranet.	November 2002
3.4 All Housing Caseworkers who have not attended a Training Course to complete the training within the current year. Housing to maintain an ongoing audit of new Officers requiring the training and to liaise with Social Services on future training needs.	Housing Area Child Protection Committee Representative.	Training ongoing. Review of staff who have completed training to be undertaken by November 2002 and assessment made of outstanding training needs. Area Child Protection Committee to be advised of numbers of staff still requiring training and any revised target date to complete current programme.		March 2003 December 2002

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
3.5 All ALERT Officers to attend a Signs & Symptoms of Child Abuse Training Course within the current year. Housing Department to liaise with Alert to ensure any new staff are included in any future training.	Housing Area Child Protection Committee Representative.	2 Alert caseworkers have attended training within current year. 3 new staff now working for Alert to be included in future training programme.		Completed
3.6 Allocations Policy to be updated, requiring Allocations Staff to refer all allegations of domestic violence to the appropriate Community Housing Officer.	Head Of Housing Needs	Allocations policy review currently underway. Procedure to be incorporated in manual.		January 2003
3.7 All Allocations Staff to be advised of the above requirement.	Head Of Housing Needs	Pending completion of Policy, all relevant Allocations staff to be notified of the need to refer incidents or concerns relating to domestic violence to the appropriate Community Housing Adviser.		November 2002
Social Services and Housing to consider what information, if any, should be provided to Community Housing Staff and Residential Social Landlords managing a tenancy where child protection issues are currently being investigated or have been investigated in the past.		To be linked to 1.1.3 in Social Services.		

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
4. POLICE **4.1** Ensure that appropriate training is given to all officers concerning • immediate measures to protect children • specific investigation into the welfare of children when responding to CAD calls		Since recommendations 4.1 and 4.2 were written, a further analysis of police actions has been undertaken and a detailed action plan produced which covers these recommendations and others. The recommendations and actions are listed below.		
4.2 Procedures should be developed and guidance and training given to police officers to ensure that child protection information is recorded and passed to other specialist units and outside agencies on every relevant occasion.		As above.		
(1) Appropriate action is taken to comply with Special Police Notice 15/00.	Community Safety Unit Manager	(1) Improvement in the standard of initial crime investigation; particularly hate crime (including domestic violence) to be measured by :- - Numbers of reports meeting minimum standards. - Numbers of staff trained - Numbers of training sessions conducted		February 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
(2) Ensure effective supervision of ALL initial investigations.	Crime Management Unit Manager	(1) Improvement in the standard of front line supervision and leadership (which impacts on all facets of policing) (2) Improvement in the quality of initial investigation (3) Improvement in the management and development of front line staff (4) Increase in crime judicial disposals. To be measured by:- - Numbers of staff trained - Numbers of training sessions conducted - % of staff numbers of report supervised correctly - Meet current targets set for judicial disposals		Dec 2003
(3) To provide training to front line staff (police / SROs) re minimum standards for crime investigation and supervision	Crime Management Unit Manager	(1) Provide knowledge and guidance about minimum crime investigation standards (2) Improve quality of initial investigations (3) Increase judicial disposals to be measured by:- - Numbers of staff trained - Numbers of training sessions conducted - Meet current judicial disposal rate for all hate crimes		December 2002
(4) To implement effective crime management policies for the ethical screening of crime	Crime Management Unit Manager	(1) To improve the management of all aspects of processing crime e.g. Screening In / Out (2) Demand reduction/suppression e.g. reduce requirement for some secondary investigations (3) Improve quality of secondary investigations (4) Achieve CRIS performance objectives to be measured by - Numbers of staff trained		December 2002

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
		- Numbers of training sessions conducted - % improvement in CRISmanagement performance - % increase/decrease in No Crime rate		
(5a) To develop and implement minimum secondary investigative standards (5b) To maintain secondary investigative standards	Crime Management Unit Manager	(1) Improve the standard of secondary crime investigations by development of minimum standards document (2) Ensure by training that investigations are professional, effective and proportionate to the seriousness of the crime being investigated (3) % Screened In investigations resulting in Judicial Disposal (4) Increase % Judicial Disposals		January 2003
(6) All secondary investigations must be quality assured before completion	Crime Management Unit Manager	(1) Improve the standard of secondary crime investigations by audit of % CRIS reports that are correctly quality assured Policy: NO screened in crimes will be 'Put Away' without a sergeant/inspector quality assuring that report. An entry MUST be made on the CRIS report. (2) Ensure investigations are professional, effective and proportionate to the seriousness of the crime (3) Ensure all appropriate leads have been serviced (4) Increase in Judicial Disposals (5) Reduce complaints against police		Implemented September 2002
(7) Crime Management Unit to be robust in the administration of their Core Functions e.g. ensuring CRIS flags, Features, VSS refusals etc are correctly documented (and quality	Crime Management Unit Manager	(1) To make certain the Borough complies with MPS Policy (2) Achieve recognition for ethical practices (TP Performance Indicators - ethical health checks) Audit through results of published ethnical		December 2002

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
assurance of the same).		health checks.		
(8) Development and Implementation of Borough Diversity strategy	Community Safety Unit Manager	(1) Improve police response to vulnerable victims by development of a strategy (2) Achievement of Performance Policing Plan targets by development of an action plan with SMART objectives (3) Promotion and achievement of the aspirations of the MPS 'Protect & Respect II' strategy by - development of an internal/external communication strategy - Numbers of external/internal groups consulted. - Achievement of Performance Policy Plan targets. - Satisfaction of subjects of police investigations in this sphere (to achieve parity with all other crime). - Development of a Borough Hate Crime and - Domestic Violence 'Positive Action' Policy (1) To achieve satisfaction of subjects of racist incidents and crimes in parity to all crime (2) Attain current Judicial Disposal rate for racist crime (3) Attain current Judicial Disposal rate for homophobic crime (4) Attain current Judicial Disposal rate for domestic violence crimes (5) To improve child protection procedures (6) To improve subjects' care & investigation in		January 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
		cases of rape Policy: Positive Action Policy has been documented and promulgated to all staff.		
	Community Safety Unit Manager	(7) To reduce repeat victimisation in DV incidences Development and implementation of a DV repeat victimisation strategy		December 2002
	Community Safety Unit Manager	(8) Establishment of a fully operation Crisis Intervention Team - Police/Social Services Outcome to be measured by:- - Reduce repeat victimisation by 4% each year (measured against previous years data) - Achievement of PSA Target 11 Business Action Plan objectives	Team fully staffed October 02. N.B. Further development of inclusion of both Probation Officers & Social Workers under consideration.	October 2002
(9a) Documented risk assessments to be conducted for all hate crime investigations (9b) In medium and High Risk cases a Risk Management Plan must be completed	Community Safety Unit Manager	(1)To improve the police response to vulnerable people (2)Reduce repeat victimisation in DV incidences To be measured by:- - 100% of hate crime CRIS reports - 100% of medium/high risk cases to be accompanied by Risk Management Plans - % reduction of DV repeat victimisation cases.		January 2003
(10) Establish more effective/supportive partnership between Newham Police CSU and CPU teams	Community Safety Unit Manager / Child Protection Unit Manager	(1) Development of a professional and effective partnership (2) Utilise and develop skills to enhance service provision to vulnerable people, especially children To be measured by:- - Numbers of joint investigations - Frequency of formalised interactions/meetings - Numbers of joint training initiatives		To be arranged

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
(11) Policy instruction - form 78 to be submitted in ALL DV cases, where children form part of the family	Reactive Crime Manager	(1) To improve police response to vulnerable children (2) To improve child protection procedures (early identification of child at risk / protection issues) (3) To identify potential victims of child abuse (4) To initiate early intervention in appropriate cases To be measured by:- - Development and dissemination of policy document - this has been initiated through Positive Action Plan, but requires expansion - Numbers of form 78s submitted - 100% compliance with policy. CRIS reports to be rigorously dip-sampled - Numbers of criminal intelligence reports submitted		November 2002
(12) CSU 'single point of contact' to be nominated for DV repeat victims	Community Safety Unit Manager	(1) To improve police response and service delivery to DV repeat victims (2) To develop a positive intervention strategy (positive action) in each repeat DV case (3) To reduce repeat victimisation in DV incidences		Implemented
(13) Considered/informed training to be delivered to Borough staff re Child Protection issues	Reactive Crime Manager / Child Protection Unit Manager	(1) To improve child protection procedures (2) To improve police response to vulnerable victims To be monitored by - Numbers of staff trained - Numbers of training initiatives conducted		To be arranged

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
(14) Considered/informed training to be delivered to Borough staff relating to hate crime investigation	Community Safety Unit Manager	(1) To improve the police response to vulnerable people (2) To achieve Service Performance Policing Plan targets (3) To reduce repeat victimisation To be monitored by:- - Numbers of staff trained - Numbers of training days - Numbers of training initiatives conducted - Meet current hate crime judicial disposal rate - subjects' satisfaction levels - % reduction in repeat victimisation		To be arranged
(15) Development and Promulgation of 'Good Investigative Practice' document for CSU Investigators	Community Safety Unit Manager	(1) To enhance investigators knowledge and therefore enhance the quality of investigations (2) To enhance the quality of service provided to vulnerable people (3) To improve Hate Crime Judicial Disposal rate		To be arranged
(16) Develop a repeat victimisation strategy (Gold, Silver, Bronze response)	Community Safety Unit Manager	(1) To improve response to vulnerable victims (2) To reduce repeat victimisation To be monitored by:- - % reduction in repeat DV crime/incident victims - % reduction in repeat child victims - DV - % reduction in repeat racist crime/incident victims - % reduction in repeat homophobic crime/incident victims		To be arranged
(17) Provide with multi-agency partners a diverse range of non-police	Community Safety Unit Manager	(1) To increase the volume of hate crimes reported		February 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
reporting site options		(2) To enable more effective and reliable crime pattern & intelligence analysis to be conducted (3) To achieve the vision of increasing the trust and confidence in policing amongst minority ethnic communities		
(18) Appointment of a Station Inspector	Performance and Review Manager	(1) To enhance achievement of National Crime Recording Standards (2) To enhance CAD management performance		Implemented
(19) Daily review of CAD performance	Community Safety Unit Manager	(1) Compliance with MPS policies (2) To improve response to vulnerable people (3) Provide more accurate Crime Pattern analysis data (4) To enhance CAD management performance (5) To reduce the numbers of inappropriately referred CAD incidents to TIB		Implemented
(20) Restructuring all units, which police vulnerability under one strategic command.	Reactive Crime Manager	(1) To improve response to vulnerable people (2) To improve child protection procedures (3) Provision of 'joined up' service to vulnerable people (4) Management & Development of specialist skilled staff (5) Achievement of Performance Policing Plan Objectives	Partly implemented....further development of Operating Procedures, Communication Strategy etc required	Implemented
(21) Review of CID Supervisory duties e.g. Det Sgts deployed 2200 - 0600hrs daily	Reactive Crime Manager	(1) To enhance front line leadership of CID resources (2) To enhance the Borough's response to critical incident management (3) To enhance the Borough's initial response to serious crime.		To be arranged

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
5. SOCIAL SERVICES **5.1** Ensure that a child focus is maintained in all direct work with families.	Training Officer / Assistant Director for Children & Families Head Of Children's Planning & Reviewing Centre / Area Child Protection Committee Development Officer	To ensure that all commissioned training has a child focus.	Already included in training plan for 2002/03 to be continued in future Already under consideration as possible multi agency training through the	Ongoing In place by April 2003 & then ongoing
5.2 Improve the quality of work in child protection.	Assistant Director for Children & Families Training Officer	To provide specific training regarding the needs and risks to children living in families who are violent and intimidating Specific training to be included in Training Plan for 2003/04	Core Groups have been improved since the inspection in December 2001	January 2003 March 2003
	Head Of Children's Planning & Reviewing Centre & Team Managers	To ensure that a written agreement with parents is drawn up in all child protection cases as part of the work of the core group and that this is the first point in any child protection plan.	This is already practice and procedure should be followed in all cases	January 2003
	Team Manager	Housing is invited to all child protection conferences as a matter of course when the	This is good practice to be followed in all cases	Immediate

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		child lives in council property, or the Department is directly involved in providing services or accommodation to the family.		
	Team Managers	To ensure that a pre-birth strategy meeting is held in all cases where a looked after young person or a young person on the child protection register becomes pregnant.	This is good practice to be followed in all cases	Immediate
	Head Of Children's Planning & Reviewing Centre & Team Managers	To ensure that where a child is on the CP register police checks are carried out on all new members of a household or new partners immediately.	This is good practice to be followed in all cases	Immediate
	Head Of Children's Planning & Reviewing Centre & Team Managers Head of Children's Planning & Reviewing Centre / Team Managers Head of Children's Planning & Reviewing Centre /	That where an adult joins a family with a child on the register a risk assessment is carried out immediately. To ensure that pre-birth conferences are always held where a parent with children on the register becomes pregnant. To ensure that all children in the household must be considered at each child protection conference whether they are on the register or not.	This is good practice to be followed in all cases This is good practice to be followed in all cases. This is good practice to be followed in all cases. The above 7 recommendations are already part of the procedures and practice of the department. To ensure their	Immediate Immediate Immediate

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
	Assistant Director for Children & Families		implementation:- • Seminars will be arranged to reinforce the learning from this review • Training will be given on the new pan-London procedures to be introduced which will reinforce the practice • Audits of child protection care will be undertaken on a regular basis by the Practice, Monitoring and Review Sub-Committee.	January 2003 January 2003 Ongoing
5.3 Where parents are intimidating, a professionals meetings should be held without parents present to ensure a proper exchange of information and development of a strategy on the part of all agencies to manage the situation.	Head Of Children's Planning & Reviewing Centre Head Of Children's Planning & Reviewing Centre Chair of Practice Monitoring & Review	A list of children living in intimidating households to be drawn up by CP chairs and team managers. Meetings of the Core Group for the above families to be called with professionals only present to consider how the risks to the children and workers will be managed. The Practice, Monitoring and Review Sub-Group to conduct audits of these cases and review the		March 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
	Sub-Group	child protection plans.		
	Team Managers / Service Managers	That a risk assessment must be undertaken for the children living in a household where a family are known to intimidate workers from whatever agency.	Risk assessments for those children to be conducted and presented to the next CP conference	Immediate
	Service Managers	That where families have intimidated workers a multi-agency strategy meeting is called to consider how the situation can be best managed to ensure the protection of the children.		Immediate
	Team Managers / Service Mangers	That where a family refuse access to the children or home that this is to be a determinant of dangerousness and of heightened risks to the children, resulting in any necessary action to protect them.		Immediate
	Head Of Children's Planning & Reviewing Centre & Manager Of Amber Project	That where a residential assessment has been commissioned, senior staff from the unit, whether Amber or any other unit, must be in attendance at any child protection conference held during or immediately after the assessment.		Immediate
5.4 Ensure that residential assessments are effective and used to ensure that children are protected.	Service Manager/ Team Managers	All families being assessed by the Amber Project must be allocated to a key worker in the Children in Need Teams.		Immediate
	Team Managers Children In Neeed Teams /	Written agreements be must be drawn up with the family irrespective of whether the children are the subject of care proceedings. The		Immediate

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
	Amber Project	agreement must be signed by both parents in the case of a two parent family and state the purpose of the assessment, the expectations of the parents, unit and key worker during this period and that it is clear what will happen if the parents fail to co-operate.		
	Team Manager & Service Manager	Police checks must be completed on all adults prior to admission to the Amber Project and where a parent has a history of violence, a risk assessment must be undertaken prior to admission and admission approved by a senior manager.		Immediate
	Team Managers/ Service Managers	That where a family is non-compliant with the assessment, it must be assumed that the assessment has failed.		Immediate
	Team Managers / Service Managers Assistant Director for Children And Families Training Officer	That where a partner joins a family immediately prior to an assessment a risk assessment must be undertaken. Training of Children In Need staff and Amber Project staff will be undertaken.	All of these recommendations are matters of good practice. Relevant procedures will be checked and revised if necessary.	Immediate Immediate
	Director of Social Services	The management of the Amber Project and the Family resource centre to be kept separate from that of child protection.	This has been the situation since January 2001.	Completed

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
5.5 To ensure that the management structure can respond effectively to issues of concern in order to protect a child.	Director of Social Services	To ensure that the Amber Project have an adequate debrief and any counselling necessary around the death of Ainlee.	Debriefing and counselling has been undertaken by a counsellor. Meetings of staff concerned and the Director of Social Services are being set up.	Completed January 2003
	Assistant Director for Children & Families	Lines of communication to be considered by the Children's Management Team overseen by the Assistant Director.		Completed
	Assistant Director for Children & Families	Where there is conflict between the views of the Amber Project and the Children in Need team that the matter is referred to a Senior manager.		December 2002
5.6 Where any re-organisation takes place in future that planning must include the retention of the memory of cases and the associated concerns and history within the organisation.	Team Mangers	In any re-organisation all case files and not just the current files are moved to the new team.		January 2003
	Service Managers	Transfer summarises are compiled for all cases that move teams as a result of re-organisation.		Immediate
	Team Managers	That should any file be mislaid for any reason, any worker who knew the family must complete a history for inclusion on the file.		Immediate
	Duty Managers	Current system to be rigorously followed until new proposals are introduced and fully operational.		Immediate

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
5.7 Review the operation of the Duty System.	Team Managers / Senior Managers	Consider ways of reducing unallocated work to a minimum. Audit currently being undertaken. All unallocated cases or those held on duty must be subject to weekly management oversight.		March 2003
5.8 Improve the management of unallocated work.	Team Managers	Each unallocated case must have a plan of action devised with reasons and signed by the duty manager.		Immediate
5.9 To Iprove the quality of supervision of workers.	Quality Manager / Team Managers	To ensure that regular supervision includes an oversight of the social workers duty work.	New supervision policy was introduced in 2001. Audit of compliance to be undertaken (see below)	Immediate
	Assistant Director for Children & Families	To ensure that every time a case is allocated a worker has sufficient time and space to read the file and any relevant background information.	Workload management is under consideration	March 2003
	Team Managers / Quality Manager	The importance of background information to be emphasised in all social work training and in supervision		Immediate
	Team Managers / Quality Manager	To conduct an audit of supervision to ensure that this is provided regularly to workers and that it is recorded adequately and addresses issues not only of casework but also of professional competence and development.		Ongoing
	Service Managers / Team Managers	A review of recording and an overhaul of the current arrangements for files to be conducted.	(See 5.8).	March 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
5.10 Ensure that the important information and "memory" of each child's history is retained and carried forward.	Team Managers / Social Workers	Each file where a child is on the register or which has been open for longer than three months must have a chronology at the front of the file.	Already expected practice	June 2003
	Team Managers / Social Workers	Each file must have management decisions recorded on the contact sheets and on supervision sheets, also held on the file where discussions are held in supervision.	Already expected practice	Immediate for new cases by June 2003 all open cases
	Team Manager Amber Project/ Team Managers CIN	Files can only be closed by a team manager and that this must be recorded on the file with reasons for the closure.	Already expected practice. Compliance with the above 4 recommendations to be monitored by regular review of files through audit and supervision and to form part of the annual appraisal process.	Ongoing
	Team Managers / Social Workers	Upon closure, all cases that have been open longer than three months must have a closing summary.		Ongoing
	Team Manager Amber Project / Team Managers, Children In Need	Where a residential assessment has been conducted that upon termination, the file at the Project must be sent to be incorporated onto the main file.		Immediate
5.11 Improve joint working with health visitors.	Assistant Director Children & Families / Designated Child Protection Nurses /	Joint work to be undertaken with health visitor managers to establish closer links on a patch basis. Greater consideration to be given to joint training on relevant issues through the Area	This practice has developed recently	June 2003

RECOMMENDATION	Lead Officer	ACTION	PROGRESS & COMMENTS	DATE OF COMPLETION
	Area Child Protection Committee Development Worker	Child Protection Committee and the development of the use of joint assessments and visits.		
5.12 Ensure that remedial action is taken in the case where a worker is incompetent.	Service Managers / Team Managers	That where a worker leaves or is dismissed for incompetence or misconduct that a management planning meeting is conducted to review the work undertaken by that worker and to make any re-assessments necessary to ensure the safety of children.	Implemented	Immediate