WALTHAM FOREST SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD B

EXECUTIVE SUMMARY

19.01.12

1 BACKGROUND & REVIEW PROCESS

BACKGROUND

1.1.1 Child B was the third child of a White British couple whose first language is English. The family, which is wholly dependent on Benefits, is nominally Christian but does not belong to any particular denomination.

1.1.2 The family has lived in a one bedroom flat in Waltham Forest since 2007 and both parents' respective families of origin are also long time residents of the borough. Child B's mother had lived in another borough for a brief period in 2006/07.

1.1.3 At the age of eleven, mother (now aged twenty three) had been assessed as a 'child in need' and was accommodated by the local authority on more than occasion. Throughout mother's adolescence, there had been professional concerns about her mental health. Child B's father (now aged twenty seven) was known only to universal services and more recently as a result of domestic violence allegations by the mother of child B, to the Police.

1.1.4 The couples' first child (eldest sister of child B) was born in 2007 and is referred to in this report as 'sister 1'. A second daughter (sister 2) was born in 2009. As a result of concerns about neglect of both daughters and about mother's mental health, there had been several episodes of involvement by Children's Social Care.

1.1.5 According to her parents, child B aged eight weeks old was awake and fed at 1am and found unresponsive in her cot next morning at 10.30am. The baby was taken to a local hospital and was pronounced dead. The death was unexpected and there were no underlying health issues known to local professionals. The parents' initial account of the two days before child B died was disputed by the medical staff who had examined her within the previous week.

1.1.6 The initial cause of death ascribed by the pathologist was 'dehydration due to gastroenteritis' and included observations that '…at 8 weeks of age, baby measures 57cm in length (50th centile) and weighed 3,810gms (2nd centile) indicating she was underweight for her height. The presence of dirt beneath finger nails and in skin creases as well as the nappy rash might be taken as evidence of sub-optimal care'.

1.1.7 The Metropolitan Police Service commissioned a paediatric expert to review the case and offer an opinion about the care provided by the parents and whether neglect was a contributory factor to the death. On legal advice, the results of the above medical review could not be shared with the panel prior to the completion of the serious case review, though a briefing provided to the overview author suggested its conclusions were unlikely to impact upon the recommendations in the serious case review.

The panel therefore took the decision that the completion of the serious case review should not be delayed.

REVIEW PROCESS

1.1.8 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of *Working Together to Safeguard Children* HM Government 2010. A Serious Case Review should be initiated when a child has died and abuse or neglect is known or suspected to be a factor in that death. Its purpose is to:

- 'Establish what lessons can be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and
- As a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children'

1.1.9 The then chairperson of the Local Safeguarding Children Board (Mark Benbow) determined the case satisfied the criteria of *Working Together 2010* and that a serious case review would be completed. Ofsted was notified of that decision and the following agencies were identified as likely to have information and opinions of relevance to the serious case review:

- London Ambulance Service (emergency response)
- Outer North East London NHS Community Services (health visiting)
- NHS Waltham Forest (GP services)
- Waltham Forest Children's Social Care (care and protection)
- North Middlesex University Hospital (midwifery and A&E)
- Whipps Cross University Hospital Trust (midwifery and medical services)
- North East London Foundation NHS Trust (children and adolescent and adult mental health services)
- Ascham Homes (providing housing for the family)
- Metropolitan Police Service (investigation of reported crimes)
- A Children's Centre and three local schools (early years services)
- Haringey (where, briefly, police, midwifery, ante natal care, health visiting, GP, children's social care, adult mental health and substance misuse services were provided)
- Waltham Forest Environmental Health (pest control, animal warden and noise services)

- Royal Society for the Prevention of Cruelty to Animals (allegations of mistreatment of dog/s owned by child B’s family)

1.1.10 Members of the panel set up to consider the case were as follows:

- Steve Liddicott (Independent Chairperson)
- Principal Lawyer London Borough of Waltham Forest
- Detective Superintendent Metropolitan Police Service
- Metropolitan Police Service individual management review author
- Detective Chief Inspector and Detective Superintendent Metropolitan Police Service Waltham Forest Command Unit
- Interim Divisional Director London Borough of Waltham Forest Children & Families Services
- Group Manager London Borough of Waltham Forest Child Protection, Planning and Partnership
- Group Manager London Borough of Waltham Forest Extended Services
- Designated Doctor for Child Protection Outer North East London Community Services
- Interim Designated Nurse NHS Waltham Forest
- Individual management review author North East London Foundation Trust

1.1.11 Panel members had no prior involvement with child B or her family; the panel was chaired by a suitably experienced independent person and the overview report was drafted by an experienced author Fergus Smith (www.caeuk.org) who has no connection with agencies or professionals involved in this case.

1.1.12 Each agency's individual management review was drafted by a suitably qualified individual with no line management or supervisory responsibility for the case. An independent health overview report was also provided .

1.1.13 Mother, father and the maternal and paternal grandmothers were invited to and contributed directly to the serious case review. Relevant staff were also interviewed and others who were in any way affected by child B's death were provided with opportunities for support.

1.1.14 Initial terms of reference were extended to include mother's receipt of child and adolescent mental health services. The review was completed in the period June – December 2011 and following acceptance by Waltham Forest's Safeguarding Children Board, submitted to Ofsted in January 2012.

1.1.15 It is current government policy to make such reports public and a version identical in most respects to the version submitted to Ofsted was produced and is available on the website of the Waltham Forest's Safeguarding Children Board. On legal advice, it excluded unnecessary medical or personal information and omitted any details that would enable the identification of individual service users, professionals or smaller workplaces. This 'executive summary' of the considerably larger document

highlights the review process, conclusions, lessons learnt and the recommendations for improvements arising from the serious case review.

2 CONCLUSIONS & LESSONS LEARNED

2.1 CONCLUSIONS

2.1.1 The comprehensive analysis within the full report informed the following succinct list of conclusions:

- As a child, mother manifested a very high level of emotional disturbance
- Mother's developmental history was recognised only by some professionals as indicative of probable difficulties in providing adequate parenting and opportunities for mitigating probable risks prior to birth of her first child were missed
- The nature and significance to her parenting capacity of mother's possible mental health difficulties remained insufficiently clear to health and social care services throughout
- Father's developmental history reveals involvement only with universal services, but some behaviours observed by professionals in the period under review indicated significant mental health and substance misuse difficulties in the context of an intrinsically unstable yet enduring relationship with mother and required more exploration
- Overall, there was a collective failure to collate and analyse information about the parents' formative experiences and to use that information to assist in understanding them individually, as a couple and as parents
- Considerable amounts of practical, psychological and medical assistance from local agencies were offered the family throughout the period under review
- The proportion of health related appointments failed by the parents offered a convenient and measurable indicator which was not exploited, of parental inability or unwillingness to organise in the best interests of their child/ren and of 'non compliance' with 'agreed' child protection or child in need plans
- 'Disguised compliance' was evident, examples being parental promises to pursue a mental health re-assessment of mother or to relinquish the dog/s
- There was a lack of rigour in pursuing parental failure to complete agreed tasks and (in spite of those planned or promised) very limited consequences
- There was insufficient challenge by health and social care agencies about the nature and scale of substance misuse by both parents
- There was a consistent tendency to assess incidents and circumstances in isolation and not to contextualise them by reference to known history
- Professional optimism by midwife, health visitor and specified social work practitioners and managers was evident

- The parents (mainly mother) successfully deployed attack as a means of defence and diversion when challenged
- Case supervision within Children's Social Care and the health visiting service supervision was insufficiently reflective
- Domestic violence whether real or more probably fabricated was insufficiently explored with an unhelpful and ill evidenced assumption that mother was the recipient
- Though attentive to presenting symptoms, the service provided by GPs was reactive, at times ill informed and took little account of information contained in the limited child protection conference minutes provided by Children's Social Care
- A very significant source of support, socialisation and monitoring of sister 1's safety and well being was provided by Pre-School 1 and later Primary School 1
- With the exception of early years practitioners, there was insufficient recognition of day to day experiences and likely long term impact of non life threatening neglect of physical and emotional needs
- The lack of understanding of life in the family from the perspective of the children meant that any analysis of the risk of harm to them was insufficiently informed
- Latter Children's Social Care assessments were formulaic and reflected a management-led reluctance to respond to entirely proper referrals from professional and non professional sources
- Though their love and wish to care for their children was often evident, and the children's attachment to their parents appeared secure, the capacity of the parents to provide consistent rather than episodic 'good enough parenting' to their growing family remained insufficient across the period under review
- The level of risks to her elder sisters and to child B (immediate and longer term) were reduced only for as long as there was active and current professional intervention
- Though the results of any legal proceedings would not have been certain, legal advice should have been sought at an earlier stage
- In spite of identified weaknesses in planning, communication and service delivery and a regrettable likelihood of long term 'significant harm' to all three children in consequence of neglect, there are no grounds for concluding that the sudden death of child B could have been predicted nor with any level of confidence that it was preventable by the professionals involved
- Whilst the parents' atypical failure to seek medical attention for what would have been a sudden and obvious onset of diarrhoea and vomiting is believed to be a significant contribution to the death of child B, the precise cause of death and the issue of any criminal liability remain for determination by Coroner and Police respectively

- A number of opportunities for improving the effectiveness and efficiency with which local services operate and collaborate have been identified by this serious case review and should be realised through implementation of the recommendations provided

2.2 LESSONS LEARNED

2.2.1 The overall lessons emerging from the involvement of all agencies are that:

- The *aggregated* impact on children of apparently minor concerns is as important as a few more dramatic incidents especially when those concerns are viewed from the perspective of the children
- To monitor such aggregation requires an appreciation of its importance and the means to recognise it i.e. clear and accurate records, effective *reflective* supervision and a willingness and efficiency about the sharing of relevant information across professions
- Distracting behaviours and hostility from parents can reinforce ambivalence about challenge and professional optimism, as well as a natural professional reluctance to disrupt marginally or episodically 'good enough' parenting
- The direct and indirect impact on small children of chronic mental health difficulties and the long term use of expensive illicit drugs (in addition to tobacco and alcohol) must not be marginalised
- The evaluation of a series of minor concerns, parental hostility and distracting behaviours, mental health issues and drug / alcohol use and the impact on the children needs to be undertaken in the context of an understanding of the parents' formative experiences
- Formulaic compliance with prescriptive pro formas, however timely and useful for local or national performance indicators, is no substitute for open minded, challenging and *child centred* enquiries

3 RECOMMENDATIONS

3.1 INTRODUCTION

3.1.1 Mindful of the Department for Education research report[1] that focused on recommendations from serious case reviews, the panel sought to minimise their number and maximise their specificity and achievability. A number of recommendations made by individual management review authors were rejected as being redundant e.g. some had already been actioned and embedded or because they were insufficiently related to the evidence within this case.

3.1.2 In many instances, the recommendations follow that of Lord Laming (Victoria Climbie Inquiry report 2003) concerning the need to do simple things well. Information gathering, understanding the child's perspective, analysis and challenge through the supervision process were and are the basic tools underpinning the assessment process without which comprehensive plans to safeguard children cannot be made

3.1.3 The serious case review panel has found it necessary to formulate the following recommendations, most reproduced from individual management reviews and in many cases modified to render them more realistic, several more identified by the overview author and/or panel and five additional recommendations which emerged from the health overview. These have all been divided into those requiring action by:

- Waltham Forest's Safeguarding Children Board or
- The agency specified

3.2 WALTHAM FOREST SAFEGUARDING CHILDREN BOARD (LSCB)

3.2.1 The LSCB should seek from the chief executive / director of each partner agency a written assurance that s/he is confident that existing archive arrangements enable the retrieval of relevant historical records; and if such an assurance cannot be given that current arrangements are reviewed so as to ensure within 6 months, records are sufficiently secure and retrievable for operational use in their respective settings and to be made available for formal case reviews [letter to be sent by 31.12.11].

3.2.2 The LSCB should:

- Ask the chief executive of Waltham Forest to obtain written confirmation from all relevant departments that senior managers are aware of and have acted to make all relevant staff aware of the duties introduced by s.10 and s.11 Children Act 2004 and expectations of the London Child Protection Procedures [by 31.12.11]

[1] A study of recommendations arising from serious case reviews 2009-2010 Brandon etc al DFE RR157

- Seek a comparable confirmation from the chief executives / directors of all other agencies specified in s.10 and s.11 of the Children Act 2004 [by 31.12.11]

3.2.3 The LSCB should ensure that staff across all agencies are aware of the need to take account of the formative experiences of adults (including their experience of parenting) and the child's experience of being cared for within their family environment when undertaking assessments, making plans or otherwise working with children and their families. Actions related to this recommendation would include seminars / training programmes; evidence of impact through case audit programme [ongoing programme from 30.04.12]

3.2.4 The LSCB should note that vulnerable children can be further safeguarded if hospital A&E departments have access to up to date information about children who are the subject of a protection plan. Accordingly, the LSCB should:

- Discuss with partner agencies / neighbouring authorities how a 'real time' list of children subject to protection plans can be made available to local A&E departments on a sub-regional basis; and
- Write to the London Safeguarding Children Board to propose that it consider how a 'real time' list of children resident in London Authorities and subject to protection plans can be made available to A&E departments across the London area. [initiate discussions and letter by 31.01.12]

3.3 OUTER & NORTH EAST LONDON (ONEL) COMMUNITY SERVICES [NELFT IS NOW ACCOUNTABLE FOR IMPLEMENTATION]

GP SERVICES

3.3.1 The GP practice should review the way it records child health surveillance appointments and ensure that clinical measurements are recorded in the medical records and that the triplicate sheets in the 'Red Book' are also scanned into the records [by 31.01.12].

3.3.2 The GP practice, with the explicit consent of mother, should request a review of her psychiatric condition to establish if she does have a formal diagnosis and to consider if it is appropriate to treat her with anti-psychotic medication [by 31.12.11].

3.3.3 The GP practice should review its internal safeguarding procedures to ensure that all the clinicians have an appropriate understanding of the role that domestic violence can play in child protection issues and that they understand the guidance available in the London Child Protection procedures [by 29.02.12].

3.3.4 The GP practice should ensure that allegations of assault made by patients are fully considered and that, particularly for children and vulnerable adults, thought is given to the need for either Children's /

Adults' Social Care or Police referral and that this is noted in the records [by 31.12.11]

3.3.5 The GP practice should consider its approach to provision of contraception and sexual health services to children under 16 so as to ensure that issues about competence are considered and *fully recorded* [by 31.01.12].

3.3.6 The GP practice should review its systems and processes for summarising records to ensure the protocols are precise enough and introduce a quality assurance process that looks at a sample of summarised records for accuracy [by 31.01.12]

OTHER HEALTH STAFF

3.3.7 So as to be assured that its children's services staff are knowledgeable about the indicators of abuse and able to undertake high quality health visiting assessments that identify risk and result in the development of a health care plan in response to identified need, ONEL Community Services must (action plan provides details):

- Ensure that 100 % of staff have attended the mandatory safeguarding training at levels 1-3 commensurate with their role [by 30.04.12]
- Ensure that 100 % of staff involved in the provision of clinical care to the family to have attended the mandatory safeguarding training at levels 1-3 commensurate with their role [by 30.04.12]
- Complete a records audit to include children identified as requiring routine and enhanced health visiting services to look at initial assessments (thus ensuring that risks have been identified and actioned within local and national policy and procedures) [by 30.04.12]
- Brief all relevant staff in relation to lessons learned from the serious case review [by 31.01.12]

3.3.8 So that ONEL Community Services can be assured that all cases in which there are concerns about parenting capacity are discussed within a safeguarding supervisory framework and that a 'specific, measurable, achievable, realistic and timely' care plan is in place, the agency must:

- Provide child protection supervisors with an update by 31.03.12
- Develop a tool to enable an annual audit of the uptake of child protection supervision and documentation
- Undertake an audit of child protection supervision (action plan provides details) [by 30.04.12]
- Quality assure child protection supervision sessions by use of named and designated professionals for child protection [by 31.04.12]

3.3.9 The agency must:

- Update the record keeping standard for all its services to reflect the use of the Assessment Framework and ensure coherent and consistent recordings of significant events [by 30.04.12]
- Examine the system of recording child health clinic attendances on the Rio system by the health visiting service [by 30.06.12]

ADDITIONAL RECOMMENDATIONS OF HEALTH OVERVIEW AUTHOR

3.3.10 Single agency training on implementation of s.10 and s.11 Children Act 2004, information sharing; and an audit of contractual compliance with independent providers [by 31.05.12].

3.3.11 Review / audit plans for vulnerable children, including those at risk for a consistent approach to responding to risk and thresholds of intervention; training via the LSCB programme to include assessment of need and risk to be accessible to all (including independent) providers and an escalation policy to be made available to include managing disagreement about risk between services [by 31.04.12]

3.3.12 Directory of contacts within the service of specialists to be made available to staff; induction to include training on accessing these services as well as an introduction to the organisations' responses to children in need / at risk; specialists to introduce themselves and explain their role [31.03.12].

3.3.13 Mandatory training on principles of recording as specified in the health overview to be provided and records and reports to be routinely audited for compliance [by 31.05.12].

3.3.14 Review policies and procedures relevant to safeguarding children and advise on their updating; provide training to staff on delivering safeguarding supervision; review induction and ensure it includes how to access and use safeguarding supervision [by 31.05.12].

3.4 WALTHAM FOREST CHILDREN'S SOCIAL CARE (CHILDRENS SOCIAL CARE)

3.4.1 The quality of case recording was poor and needs to substantially improve with specific focus on the issues raised through this serious case review. Clear expectations about the quality of recording and what should be included need to be provided to staff and reiterated through management oversight and audit [by 31.01.12].

3.4.2 The quality of analysis in assessments has been weak with a lack of consideration given to the role of fathers and parents' past parenting history. Additional support and training needs to be targeted at front line workers analysis skills and a clear risk assessment model developed and implemented [by 31.03.12]

3.4.3 Case closures and step down arrangements to universal services were highlighted in this review, as well as the Ofsted unannounced inspection. Clarity about management sign off and accountability need be confirmed; arrangements to ensure that other agencies are aware of the case closure / step down and monitoring of these cases must be developed [completed].

3.4.4 Supervision was highlighted as poor in this review. A system should be put in place to ensure regular supervision is held, as well as ensuring that all cases are regularly reviewed during this process. Compliance with this requirement should be monitored and supervision audits put in place including quality of management oversight [in place and ongoing].

3.4.5 The issue of disguised compliance should be the subject of training and development for all social workers about 'hard to engage' families. It should be a feature of learning the lessons from this review and be disseminated to all front line staff within 3 months of its completion [by 31.03.12].

3.4.6 The impact of the joint protocol with NELFT about safeguarding families affected by parental mental health problems to be reviewed by Social Care and NELFT Managers and reported to WFSCB. [by 31.03.12].

3.4.7 Unless subsequently resolved, the allegations made at the time and repeated by the community paediatrician about SW 2 need to be addressed, investigated and appropriate action taken [by 31.01.12].

3.4.8 Further efforts should be made to establish whether mother and maternal grandmother did in 2000 report sexual abuse by the then foster carer and if one or other did, to evaluate the response given and take any proportionate further action [by 31.01.12]

3.4.9 The arrangements for routine case audits should be reviewed with the aim of capturing a more holistic and informed view of quality than is apparent by an examination only of a core assessment [by 31.03.12]

3.5 NORTH MIDDLESEX UNIVERSITY HOSPITAL (NMUH)

3.5.1 So as to ensure that the learning from this serious case review is embedded across NMUH, there should be:

- Ongoing training for staff for child protection with the inclusion for midwives of antenatal indicators of abuse or neglect toward the unborn child. The vulnerable women training should continue to be in place for maternity staff to increase knowledge, awareness

and understanding in the areas of domestic violence, mental health, teenage pregnancy and substance misuse (action plan provides details) [immediate and ongoing]

- Regular child protection supervision for midwives in community to discuss high risk cases, this should be supported by policy and training for the 'named staff' in the delivery of supervision to ensure that quality supervision is provided (action plan provides details) [with effect from February 2012]

3.6 WHIPPS CROSS UNIVERSITY HOSPITAL (MIDWIFERY)

3.6.1 There needs to be a review of the vulnerability checklist and action to be taken when vulnerability is identified (this is currently being undertaken following the introduction of the 'vulnerable team', now known as the Ruby team within a revised community midwifery structure [by 31.12.11].

3.6.2 When there has been previous involvement with Children's or Adults' Social Care and especially when there are previous child protection concerns, the midwife must liaise directly with the Children's Social Care team to discuss the family and arrange appropriate support [by 30.11.11]

3.6.3 When a history of mental health has been recognised, a referral should be completed to the 'Perinatal Mental Health Service', so as to trigger an initial assessment of the mental health status of the mother from a specialist in mental health [by 31.12.11].

3.6.4 When a mother discloses past or present cannabis use, the midwife should ask questions relating to amount used, reasons and request urine for toxicology; additional support and advice on appropriate and safe methods for relaxation should be explored [by 31.1211].

3.6.5 If a woman fails to attend her hospital antenatal appointments hospital staff should inform the community midwife who can then arrange a home visit and plan follow up antenatal care and support [by 31.10.11]

3.6.6 The importance of returning post natal records following discharge by midwifery services should be discussed with all mothers / families and:

- The 'no return rate' should be reviewed by community managers and a review of current practice be initiated if the problem that arose in this case is judged prevalent enough [by 30.04.12].
- If the records are not returned following repeated requests the community midwife needs to escalate this to the line manager [immediate]
- A record of all records not returned should be collected by the community midwifery team [by 31.03.12]

3.7 WHIPPS CROSS UNIVERSITY HOSPITAL (MEDICAL SERVICES)

3.7.1 So as to ensure that the learning from this serious case review is embedded across the agency, Whipps Cross Hospital must ensure that assessments of injuries in children and young people include exploration of the cause of injury by:

- Making orthopaedic consultants aware of this requirement [by 31.01.12]
- Auditing compliance with the above [by 31.03.12]
- Reinforcing 'safeguarding children' as a routine differential diagnosis when children and young people present with injuries [by 31.01.12] .
- Checking all orthopaedic consultants and their teams are up to date with level 2 safeguarding training [by 31.12.11]
- Reviewing record keeping process for orthopaedic team during out-patient consultations to enable a Trust decision on acceptability of the current system [by 31.12.11]

3.7.2 All staff who come into contact with children/young people must be made aware that assessments and records must include details of who accompanies a child/young person to the hospital, their relationship to the child/young person, and who has parental responsibility for her/him must be recorded in the hospital notes [by 31.11.11] and compliance must be evaluated by an audit [by 31.12.11]

3.7.3 In responding to children who self harm:

- As part of the nursing assessment, a background check must be undertaken with Children's Social Care to determine if the child/young person is known to that service
- Following the Psychiatric assessment of such a child/young person a discussion must take place between hospital staff and the psychiatrist to consider child protection and the need for a referral to Children's Social Care
- When a referral is needed to safeguard the child/young person this must be made by the hospital staff
- The named nurse for safeguarding children (or deputy) must be informed of all children who attend A&E or are admitted
- Consideration must be given to routinely asking all female self harmers of a relevant age whether they are pregnant [all by 30.11.11]
- Relevant training must be provided for A&E and paediatric staff [all by 31.03.12]

3.7.4 Review the assessment process in the 'Early Pregnancy Assessment Unit' to ensure a holistic approach which incorporates physical, psychological, emotional and social implications of pregnancy [by 30.11.11]

3.7.5 Ensure that all relevant ward and 'Early Pregnancy Assessment Unit' staff are up to date with 'level 2' safeguarding training [by 31.12.11].

3.7.6 WXUH must ensure that the procedure for children and young people who fail to attend out-patient appointments becomes embedded in practice by:

- All clinic leads for the out patient department being made aware of the relevant follow up procedure [by 31.12.11]
- An audit of compliance with the above [by 29.02.12]

3.8 NORTH EAST LONDON NHS FOUNDATION TRUST (NELFT)

3.8.1 Access and psychiatric liaison teams must undergo 'level 3' child protection training, so that each individual member understands their responsibilities with respect to NELFT and national policies [by 31.03.12].

3.8.2 All NELFT staff must be reminded of the necessity of completing an initial risk assessment and thereafter updating after each risk incident [by 29.02.12].

3.8.3 All clinicians must review a patient's prior history & at each new episode and there should be a psychiatric summary placed in the 'progress notes' on the RiO database [complete].

3.9 ASCHAM HOUSING

3.9.1 Information regarding vulnerable households (including safeguarding) to be shared effectively and efficiently between the London Borough of Waltham Forest council departments and Ascham Homes (action plan offers methodology) [by 30.04.12]

3.9.2 Future information sharing between agencies and improve multi-agency working with the family to be improved by adding family's name to 'vulnerable adults' list [completed].

3.9.3 All staff to be reminded of the importance of the using the aggressive customer list and displaying information appropriately [completed].

3.9.4 Victims of domestic violence are directed to appropriate advice and support in a timely way by development of a reporting mechanism and monitoring arrangements (action plan provides details) [by 31.10.11]

3.9.5 All staff and contractors to be aware of their role and responsibilities in regard to safeguarding and how to make appropriate referrals to the Social Needs Panel role-appropriate training and briefings (action plan provides details) [completed]

3.9.6 Ascham Homes 'Safeguarding Vulnerable Adults and Children policy' to be reviewed (internally and by WFSCB) to ensure fit for purpose [completed].

3.10 METROPOLITAN POLICE SERVICE

3.10.1 The MPS IMR contained no recommendations for service improvements.

3.11 EARLY YEARS SERVICES

3.11.1 All staff in early years and education settings should:

- Be reminded of the importance of seeking information about children considered to be vulnerable so as to undertake appropriate monitoring and best safeguarding practice [by 29.02.12]
- When a child is referred to an early years setting and it is known there are possible risk factors within the family or that the family is vulnerable, request information from partner agencies to ensure that there is a clear understanding of that risk and how it should be responded to, monitored and managed [29.02.12].

3.11.2 Early Years should re-issue its 'escalation policy' to all early years settings and schools and consider how it will monitor its implementation and effectiveness [complete].

3.11.3 LBWF should issue guidance to all early years settings in the borough outlining the requirement for information about children to be shared with receiving settings or schools at the point of transfer so that their practice is in line with that required of schools [by 29.02.12].

3.11.4 LBWF should issue guidance to early years settings and schools about a formal process for the oversight and management of non-statutory attendance of children who are referred for placements due to their level of vulnerability and their family's needs [by 29.02.12].

3.12 ENVIRONMENTAL HEALTH

3.12.1 Environmental Health should:

- In consultation with relevant individual in Children's Social Care and Mental Health Services, train staff in child protection awareness and procedures and information sharing [as recommended during a recent Ofsted inspection] (action plan provides details) [by 31.03.12]
- Train 'dog enforcement officers' in understanding the links between abuse of dogs and child abuse (action plan provides details) [by 30.11.11]
- Introduce to the list of agenda items in management team meetings a heading of 'safeguarding' (action plan provides details) [complete]
- Review induction training so that all new staff including contractors / agencies understand child protection procedures (action plan provides details) [complete]

19.01.12

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