Report of the Chief Executive and Corporate Director of Social Care and Health

1. Purpose of Report

1.1 This report summarises the recommendations of the Victoria Climbié Inquiry Report for Leicester City Council and its partners. It recommends a process for bringing to Cabinet the findings of the self audit that the Chief Inspector of the Social Services Inspectorate has required the Council to complete by 30 April 2003 and for identifying the appropriate action required to address the issues identified by Lord Laming in his report. A similar process is required by the Commission for Health Improvement and H.M. Inspector of Constabulary of local health bodies and Leicestershire Constabulary.

1.2 These issues are also likely to be a major feature of the inspection of Children’s Services by the Social Services Inspectorate scheduled for May 2003.

1.3 The full report has been posted on the Council’s Intranet site. Copies of the full report have been sent to Cabinet members, Scrutiny leads and Chief Officers. They will be placed in the Group Rooms.

2. Summary

2.1 The result of the inquiry into the death of Victoria Climbié was published on 28th January 2003. The 400-page document describes the failure of all the child protection systems across 4 local authorities, 2 police child protection teams, 2 hospitals and the NSPCC to prevent her murder. The report makes 108 recommendations: 46 to be implemented within three months; 36 within six months; and 26 within two years.

2.2 The Government has received the report but not yet published its response. There are indications that most of the practice recommendations will be accepted but that the structural and organisational implications will be considered as part of the preparation of the Green Paper on Children promised in the Spring. The Department of Health has now published guidance on children’s trusts, as an option councils should explore with partner agencies as a way of securing the most effective use of resources to support
vulnerable children. The Chief Executive convened a meeting of relevant agencies at chief executive level to consider related issues, and new work has been commissioned for further deliberation.

2.3 The attached briefing from the Local Government Association (Appendix A) summarises the recommendations. Those with implications for the Council are summarised in the Supporting Information.

2.4 The attached letter from the Chief Inspector at Appendix B describes the process of self-audit required.

2.5 The 108 recommendations from the Inquiry are attached at Appendix C.

3. Recommendations

3.1 Members are asked to:

(a) note the significance of the Victoria Climbié Inquiry Report for the City Council;

(b) comment on and endorse the attached statement reaffirming accountabilities for children from top to bottom in the Council;

(c) consider the findings of the self audit of compliance with the recommendations required by the Social Services Inspectorate in April, prior to submission by 30th April;

(d) receive a further report on the action required across the Council and partner agencies following the self-assessment exercise; and

(e) receive a further report on the potential benefits of a children’s trust for Leicester.

4. Headline Financial and Legal Implications

4.1 Lord Laming is highly critical of Brent and Haringey Councils for failing to fund children’s services adequately; a factor he believes contributed, indirectly, to the failure of their services to protect Victoria Climbié.

4.2 The self-audit process is intended to identify areas that require attention. In addition to the essential growth for children’s services already identified in the Directorate’s Draft Revenue Strategy, a further provision of £200,000 for 2003/04 is to be considered by Members.

4.3 Many of the recommendations, including those about private fostering, will require new legislation. This is expected to be identified in the Green Paper in the Spring.

4.4 Given the status of Lord Laming’s report there are no direct legal implications arising from the report (Guy Goodman, Assistant Head of Legal Services - Tel. 252 7054).
5. **Report Authors to contact:**

Rodney Green, Chief Executive: Tel: 252 6000
Andrew Cozens, Corporate Director of Social Care and Health: Tel: 252 8300
SUPPORTING INFORMATION

1. Report

1.1 The result of the inquiry into the death of Victoria Climbié was published on 28th January 2003. The 400-page report sets out in detail how the voluntary and statutory child protection agencies in four London Boroughs failed to prevent her murder.

1.2 The report contains 108 recommendations that have major implications for local government. In particular Lord Laming criticises a lack of corporate responsibility, alongside serious failures in service delivery.

1.3 The Secretary of State, in his response, set out areas for immediate improvement. These are to be the subject of a self-audit by all councils with social services responsibilities by 30th April 2003. The Green Paper for children at risk will address the issues of further structural change.

1.4 The publication of the Laming Report should be seen in the wider context that includes:-

- the Government's recent proposals to pilot Children's Trusts;
- the City Council's recent Best Value report on Vulnerable Children;
- current OFSTED recommendations on Social Inclusion; and
- a wide range of targets that the Council and other Agencies are seeking to deliver in relation to children at risk.

The Chief Executive has taken the initiative to convene an inter-agency meeting at Chief Executive level involving Health, Police, Connexions, Learning & Skills Council, Education, Social Services and Housing to realign priorities and resources and to explore new ways forward that would generate collaborative advantage. The first
meeting was on 4th February 2003 and further work has been commissioned in an attempt to develop a clearer framework for joint priorities that reaffirms Laming’s key message that protection cannot be separated from welfare. A further meeting has been arranged in a few weeks to take these issues forward.

2. Summary of Lord Laming’s Recommendations

2.1 The key recommendations for Leicester fall into three categories over two timetables. These are:

- Recommendations to Government on Arrangements to Improve Central Government Accountability
- Recommendations at Local Government Level on Arrangements to Improve Accountability and Profile of Safeguarding Arrangements
- Recommendations on Practice in Individual Cases for Social Services

2.2 The timescales are within three months (Timescale 1), six months (Timescale 2) and within two years (Timescale 3).

RECOMMENDATIONS TO GOVERNMENT ON ARRANGEMENTS TO IMPROVE CENTRAL GOVERNMENT ACCOUNTABILITY

Timescale – within 2 years

Rec1: Children and Families Board
Recs. 2/3/4 /5/14: National Agency serving the Board
Rec. 11: Review Law on registration of private foster carers
Rec. 13: Amalgamate Working Together and Framework for Assessment guidance (including replace Child Protection Register changes to information-sharing)
Rec. 16: Review information sharing guidance where concerns about a child’s welfare
Rec. 17: Consider National database for under 16s.

Timescale – 6 months

Rec. 10: Joint Inspections of service quality and inter-agency effectiveness.

RECOMMENDATIONS AT LOCAL GOVERNMENT LEVEL ON ARRANGEMENTS TO IMPROVE ACCOUNTABILITY AND PROFILE OF SAFEGUARDING ARRANGEMENTS

Timescale – 6 months

Rec. 6: Establish Committee of Members for Children & Families (2)
Rec. 7/8/9/15: Management Board for Services reporting to Committee
  - Appoint director (Timescale 3)
  - Establish reliable way of assessing – more than Child Protection (3)
- Consultation with service users (3)
- Budget
- Inter-agency training (2)

Rec. 27: Children’s Services in Authority’s list of priorities and operational plans

Rec. 33: 24 hour telephone referral number – pilots

Rec. 41: Senior managers/councillors to visit intake teams – report findings.

**Timescale – within 2 years**

Rec. 47: Specialist out of hours services

**RECOMMENDATIONS ON PRACTICE IN INDIVIDUAL CASES – SOCIAL SERVICES**

**Recording**

**Timescale - 3 months**
Recs. 12; 23; 25; 35; 38; 45; 48; 51; 58

**Timescale – 6 months**
all stress recording.

Rec. 34

Key issues are:
- Basic information
- Manager recording showing supervision/review
- Recording if failed visits/timescales not met
- Audit trails of transfer of cases (internally and to another Local Authority)
- Chronologies.

**Focus on speaking with child**

**Timescale – 3 months**
Recs. 18; 25; 26; 35; 40; 63

**Timescale – 6 months**
all specifically refer to direct contact with the child.

Rec. 54

Key issues are:
- Using interpreters
- Timescales of child being seen
- Seeing child alone
- Maintaining contact if case cannot be allocated.
Assessment/Information gathering

**Timescale – 3 months**
Recs. 22; 25; 35; 40; 51; 56; 61; 63)

**Timescale – 6 months** (Recs. 37; 57) all look at responsibilities to assess situations proactively where “deliberate harm” is suspected.

Key issues are:
- Checks with other agencies/seeking views
- Ensuring social worker is part of hospital discussions
- Collating histories
- Querying opinions assertively /listening to Child Protection advisors
- Responding to concerns from another agency
- Seeing child and carer
- Steps if no-one at home when visited
- Checking “accommodation”
- Clarity of purpose of home visits
- Manager’s role in setting tasks
- Access to information from other countries
- Legal advice on emergency action
- Notifying Education if the child is not in school.

Planning/Review

**Timescale – 3 months**
Recs. 22; 25; 26; 40; 48; 51; 56; all emphasise plans of action being drawn up and a system to review whether actions are carried out for any child where there are concerns of deliberate harm.

Key issues are:
- Manager approval to actions planned
- No case closed unless plan is in place
- Transfer to another agency
- Checking back on action plans from strategy meetings.

Allocation of work

**Timescale – 3 months**
Recs. 53; 55)

**Timescale – 6 months** (Recs. 43; 52; 54) all deal with allocation to social workers.

Key issues are:
- Not allocating in name only
- Managing unallocated cases
- Allocation to sufficiently skilled workers (e.g. trained to do Section 47 assessments).
Systems to prevent cases getting lost

**Timescale - 3 months**
Recs. 23; 24; 38; 39; 42; 50

**Timescale – 6 months**
between systems or Rec. 54

deal with preventing children getting lost agencies.

Key issues are:

- Notifying/transfer arrangements between Authorities
- Transfer arrangements between teams
- Systems to check email/post for absent staff
- Arrangements for unallocated cases.

**Skilling and supporting staff**

**Timescale - 3 months**
Rec. 25; 26; 45; 48; 53 all explicitly refer to manager input. Recs. 20; 31; 37; 43 are about skilling staff.

Key issues are

- Trained frontline staff dealing with Section 47 inquiries
- Responsibility for assessment and possibly others
- Induction and continued training
- Specific audit of current Section 47 staff.

**Management and Management information**

Key issues are:

**Timescale - 3 months**
Rec. 30 Random inspections of files by senior managers

**Timescale - 6 months**
Rec. 28 Position statement on front door system and an action plan
Rec. 29 Management information about work of duty teams
Rec. 60 Hospital teams line managed by Children & Families managers

**Timescale - within 2 years**
Rec. 32 Single electronic database

3. **Financial and Legal Implications**

3.1 Lord Laming is highly critical of Brent and Haringey Councils for failing to fund children’s services adequately; a factor he believes contributed, indirectly, to the failure of their services to protect Victoria Climbié.

3.2 The self-audit process is intended to identify areas that require attention. In addition to the essential growth for children’s services identified in the Directorate’s Draft Revenue Strategy for 2003/04, a further provision of £200,000 has been added.

3.2 Many of the recommendations, including those about private fostering, will require new legislation. This is expected to be identified in the Green Paper in the Spring.
4. **Other Implications**

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5. **Background Papers – Local Government Act 1972**

The Victoria Climbié Inquiry: Lord Laming (2003)

6. **Report Authors**

Rodney Green, Chief Executive: Tel: 252 6000  
Andrew Cozens, Corporate Director of Social Care and Health: Tel: 252 8300
The Victoria Climbie Inquiry
28 January 2003

Introduction
The result of the inquiry into the death of Victoria Climbié was published today. The 400 page document sets out in detail a catalogue of failure across the statutory and voluntary sector. The report has 108 recommendations all of which come with clear timescales for action.

There are major implications for local government, which is criticised for a lack of corporate responsibility as well as serious failings in service delivery. The full list of recommendations is attached to this briefing.

The Secretary of State in his response to the report set out areas for immediate action and said that the Green Paper for children at risk would address the issues of further structural change. This briefing details the key issues from the report and highlights the areas requiring local government action.

Background
Chaired by Lord Laming the report details the circumstances surrounding the care and murder of Victoria Climbié. The report looks in detail at the failure of systems and staff across agencies. As Lord Laming says in his report “Staff doing this work require a combination of professional skills and personal qualities not least of which are persistence and courage.”

Key messages from the report.
The report dismisses the idea of a national child protection agency, reinforcing a key message of ‘Serving Children Well’ that you cannot separate protection from welfare.

Lord Laming recommends the establishment of a new accountability structure both nationally and locally.

National Accountability
At a national level a ministerial children and families board should be established, chaired by a cabinet minister. This board should have ministerial representation from governments departments concerned with the welfare of children and families.

A new National Agency for Children and Families would be established reporting to the Ministerial board. The post of chief executive of the new agency would incorporate the responsibilities of the post of a Children’s Commissioner for England. The new agency would
• assess, and advise the ministerial Children and Families Board about, the impact on children and families of proposed changes in policy;
• scrutinise new legislation and guidance issued for this purpose;
• advise on the implementation of the UN Convention on the Rights of the Child;
• advise on setting nationally agreed outcomes for children and how they might best be achieved and monitored;
• ensure that legislation and policy are implemented at a local level and are monitored through its regional office network;
• report annually to Parliament on the quality and effectiveness of services to children and families, in particular on the safety of children.

Local Accountability
At a local level local authorities with social services responsibilities are recommended to establish within the next six months two new structures. First a Committee of Members for Children and Families with lay members drawn from the management committees of each of key services. The Committee must ensure the services to children and families are
properly co-ordinated and that interagency work is effectively managed.

The second new structure is a local authority chief executive chaired Management Board for services to children and families. This management board must include senior officers from each of the key agencies and establish strong links with community based organizations, ensure that staff are appropriately trained and will be responsible for the work currently undertaken by the Area Child Protection Committee.

The Management Board should appoint a director responsible for ensuring that inter-agency arrangements are appropriate and effective, and for advising the Management Board so that staff and resources can be used in the most flexible and effective way.

The local arrangements would be supported by the government inspection regime which would monitor the quality of the services provided and the effectiveness of the interagency arrangements.

The report’s recommendations can be split into several areas:

**Best practice**
It reinforces known best practice standards across all agencies when responding to child protection matters with strong remarks about the need
- to speak to children
- to keep written records
- to communicate with all concerned
- to undertake a thorough assessment
- for supervision of workers

and the need for some amendments to current guidance to ensure that legal advice is sought before emergency action is taken and is available 24 hours a day. The report recommends amendments to Working Together to ensure Police carry out exclusively any criminal investigation elements in a case of suspected injury or harm.

**Closer Links Between Family Support And Child Protection**
It proposes closer links between family support/prevention (section 17) and child protection (section 47) with proposals about combining Working Together and the National Assessment Framework into a single set of guidance.

**Accountability And Performance Management**
It recommends changes to how accountability is ensured across all agencies reinforcing the role of senior managers. Responsibilities of directors of social services are spelt out in relation to quality assurance, and performance management. In particular recommending review visits to duty teams by directors and council members, workload management systems and that senior managers ensure that no case is closed until a plan for the ongoing protection and welfare has been agreed.

**Training**
A range of recommendations refer to the need for training and the skill level needed for child protection work and serious concerns about recruitment and retention of skilled staff. The report also clearly sets out a recommendation for multi agency multi professional training.

**New Proposals Include**
- the need for a specialist child protection response to be available 24 hours a day 7 days a week.
- the need to have clear systems for accessing information from other countries
- Part 8 reviews to be carried out by the new national agency for children and families
- the government to explore the potential of a national children’s database.

**LGA key messages**
- The LGA believes that many of the recommendations in this report, if implemented, could transform the lives of children.
Local government is central to providing the conditions for children to grow to their full potential in safety. The structural recommendations fit well with the recommendations in Serving Children Well. Throughout the report Lord Laming talks of the need to involve children and families in the planning and delivery of services.

- The new local children and families committee and management board have similar functions to the children's strategic partnership board described in the Serving Children Well. We welcome this strengthened role for local government and the recognition that it is at the local level that solutions can be built to meet the specific needs of local children, families and communities.

- We welcome the fact that the local authority is the accountable body but believe placing specific personal responsibility on the council leader, elected mayor or cabinet member with the relevant portfolio, would strengthen this. The personal responsibility is important as it gives a clear point of accountability to both local people and other agencies. ONE individual must carry the responsibility for ensuring that the necessary processes for co-ordination and delivery are in place between the agencies. The timescales for establishing these new arrangements are challenging.

- We fully support the recommendations in relation to staff training and support. We would suggest that these would be further strengthened by unified workforce planning across agencies and sectors to address the long term recruitment and retention problems faced in social work and other services.

- The LGA fully support Lord Laming in his recommendations about ensuring that best practice in child protection is routinely followed and supported at local level. We believe that the proposal to combine Working together and the National Assessment Framework into a single set of guidance will help this as it will lead to greater clarity for front line staff.

- The recommendation for the establishment of a specialist child protection response to be available 24 hours a day, 7 days a week raises particular challenges for local government not least in terms of capacity.

- Most of all the LGA supports Lord Laming in his statement that the single most important change in the future must be the drawing of a clear line of accountability from top to bottom about who is responsible for the well being of vulnerable children.

Further information
Full copies of the report can be obtained from [www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm](http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm)
From the Chief Inspector, Denise Platt CBE

ARRANGEMENTS FOR CHECKING SOCIAL SERVICES COMPLIANCE WITH THE PRACTICE RECOMMENDATIONS OF THE VICTORIA CLIMBIE INQUIRY REPORT

Your Chief Executive will have received today a letter from Alan Milburn, the Secretary of State for Health, about the publication of the Victoria Climbié Inquiry report. I am writing to explain the role of the Social Services Inspectorate in assisting you to take appropriate action to address issues that Lord Laming has identified in the recommendations in his report.

Next week I will send you an audit framework to assist you to self audit your council’s compliance with the recommendations. This framework will provide a structure for you to use when you undertake this self-assessment process. You will need to return your self-assessment to the SSI. The Social Services Inspectorate will be responsible for ensuring that all local councils have completed their self-assessment. We will report to the Secretary of State on the outcome of the exercise. We will use the audit framework to support future inspection of children’s services and other follow up work with your council.

The audit framework will group the recommendations under key practice and management issues: referral; assessment; allocation; recording; guidance; training and governance. We will then set out the criteria that we will use to assess whether your self-assessment shows that appropriate action has been taken to address the recommendations. We will also link recommendations to legislation and guidance where this is relevant. You will need to send your self-assessment to us by 30 April 2003 telling us what action you have taken and what else you plan to do to meet the recommendations.

A similar letter is going to your local health bodies from the Commission for Health Improvement as the audit processes are complementary across health and social care.

Yours sincerely

Denise Platt, CBE

CC Chief Executives

Ci(2003)1
28th January 2003

Appendix B
Recommendations

This section brings together the recommendations that are to be found in the Report. The way in which local authorities name committees and officers can vary. For ease of reference, the recommendations are expressed in the terms of the Local Authorities Personal Social Services Act 1970. To the left of each recommendation is an indication of the timescale for action:

1 means the recommendation should be implemented within three months.
2 means the recommendation should be implemented within six months.
3 means the recommendation should be implemented within two years.

Of the 108 recommendations in this Report, 46 are under ‘1’ and a further 36 are under ‘2’. This means that some 82 of the recommendations could be acted upon within six months.

The paragraph numbers that follow the recommendations are cross-references to the paragraphs in this Report in which they can be found.

General recommendations

3 Recommendation 1 With the support of the Prime Minister, a ministerial Children and Families Board should be established at the heart of government. The Board should be chaired by a minister of Cabinet rank and should have ministerial representation from government departments concerned with the welfare of children and families. (paragraph 17.97)

3 Recommendation 2 The chief executive of a newly established National Agency for Children and Families will report to the ministerial Children and Families Board. The post of chief executive should incorporate the responsibilities of the post of a Children’s Commissioner for England. (paragraph 17.97)

3 Recommendation 3 The newly established National Agency for Children and Families should have the following responsibilities:
• to assess, and advise the ministerial Children and Families Board about, the impact on children and families of proposed changes in policy;
• to scrutinise new legislation and guidance issued for this purpose;
• to advise on the implementation of the UN Convention on the Rights of the Child;
• to advise on setting nationally agreed outcomes for children and how they might best be achieved and monitored;
• to ensure that legislation and policy are implemented at a local level and are monitored through its regional office network;
• to report annually to Parliament on the quality and effectiveness of services to children and families, in particular on the safety of children. (paragraph 17.97)

3 Recommendation 4 The National Agency for Children and Families will operate
through a regional structure which will ensure that legislation and policy are being
implemented at a local level, as well as providing central government with up-to-date
and reliable information about the quality and effectiveness of local services.
(paragraph 17.97). The Victoria Climbié Inquiry

3 Recommendation 5 The National Agency for Children and Families should, at their
discretion, conduct serious case reviews (Part 8 reviews) or oversee the process if they decide
to delegate this task to other agencies following the death or serious
deliberate injury to a child known to the services. This task will be undertaken
through the regional offices of the Agency with the authority vested in the National
Agency for Children and Families to secure, scrutinise and analyse documents and
to interview witnesses. I consider it advisable that these case reviews are published,
and that additionally, on an annual basis, a report is produced collating the Part 8
review findings for that year. (paragraph 17.97)

2 Recommendation 6 Each local authority with social services responsibilities
must establish a Committee of Members for Children and Families with lay
members drawn from the management committees of each of the key services.
This Committee must ensure the services to children and families are properly
co-ordinated and that the inter-agency dimension of this work is being managed
effectively. (paragraph 17.97)

2 Recommendation 7 The local authority chief executive should chair a
Management Board for Services to Children and Families which will report to the
Member Committee referred to above. The Management Board for Services to
Children and Families must include senior officers from each of the key agencies.
The Management Board must also establish strong links with community-based
organisations that make significant contributions to local services for children and
families. The Board must ensure staff working in the key agencies are appropriately
trained and are able to demonstrate competence in their respective tasks. It will
be responsible for the work currently undertaken by the Area Child Protection
Committee. (paragraph 17.97)

3 Recommendation 8 The Management Board for Services to Children and
Families must appoint a director responsible for ensuring that inter-agency
arrangements are appropriate and effective, and for advising the Management
Board for Services to Children and Families on the development of services to meet
local need. Furthermore, each Management Board for Services to Children and
Families should:
• establish reliable ways of assessing the needs and circumstances of children in
  their area, with particular reference to the needs of children who may be at risk
  of deliberate harm;
• identify ways of establishing consultation groups of both children and adult users
  of services. (paragraph 17.97)

2 Recommendation 9 The budget contributed by each of the local agencies
in support of vulnerable children and families should be identified by the
Management Board for Services to Children and Families so that staff and
resources can be used in the most flexible and effective way. (paragraph 17.97)

2 Recommendation 10 As part of their work, the government inspectorates should inspect both the quality of the services delivered, and also the effectiveness of the inter-agency arrangements for the provision of services to children and families. (paragraph 17.97)

3 Recommendation 11 The Government should review the law regarding the registration of private foster carers. (paragraph 17.97)

18 Recommendations

1 Recommendation 12 Front-line staff in each of the agencies which regularly come into contact with families with children must ensure that in each new contact, basic information about the child is recorded. This must include the child’s name, address, age, the name of the child’s primary carer, the child’s GP, and the name of the child’s school if the child is of school age. Gaps in this information should be passed on to the relevant authority in accordance with local arrangements. (paragraph 17.97)

3 Recommendation 13 The Department of Health should amalgamate the current Working Together and the National Assessment Framework documents into one simplified document. The document should tackle the following six aspects in a clear and practical way:
• It must establish a ‘common language’ for use across all agencies to help those agencies to identify who they are concerned about, why they are concerned, who is best placed to respond to those concerns, and what outcome is being sought from any planned response.
• It must disseminate a best practice approach by social services to receiving and managing information about children at the ‘front door’.
• It must make clear in cases that fall short of an immediately identifiable section 47 label that the seeking or refusal of parental permission must not restrict the initial information gathering and sharing. This should, if necessary, include talking to the child.
• It must prescribe a clear step-by-step guide on how to manage a case through either a section 17 or a section 47 track, with built-in systems for case monitoring and review.
• It must replace the child protection register with a more effective system. Case conferences should remain, but the focus must no longer be on whether to register or not. Instead, the focus should be on establishing an agreed plan to safeguard and promote the welfare of the particular child.
• The new guidance should include some consistency in the application of both section 17 and section 47. (paragraph 17.111)

3 Recommendation 14 The National Agency for Children and Families should require each of the training bodies covering the services provided by doctors, nurses, teachers, police officers, officers working in housing departments, and social workers to demonstrate that effective joint working between each
of these professional groups features in their national training programmes. (paragraph 17.114)

2 Recommendation 15 The newly created local Management Boards for Services to Children and Families should be required to ensure training on an inter-agency basis is provided. The effectiveness of this should be evaluated by the government inspectorates. Staff working in the relevant agencies should be required to demonstrate that their practice with respect to inter-agency working is up to date by successfully completing appropriate training courses. (paragraph 17.114)

3 Recommendation 16 The Government should issue guidance on the Data Protection Act 1998, the Human Rights Act 1998, and common law rules on confidentiality. The Government should issue guidance as and when these impact on the sharing of information between professional groups in circumstances where there are concerns about the welfare of children and families. (paragraph 17.116)

3 Recommendation 17 The Government should actively explore the benefit to children of setting up and operating a national children's database on all children under the age of 16. A feasibility study should be a prelude to a pilot study to explore its usefulness in strengthening the safeguards for children. (paragraph 17.121)

The Victoria Climbié Inquiry
374Social care recommendations

1 Recommendation 18 When communication with a child is necessary for the purposes of safeguarding and promoting that child’s welfare, and the first language of that child is not English, an interpreter must be used. In cases where the use of an interpreter is dispensed with, the reasons for so doing must be recorded in the child’s notes/case file. (paragraph 6.251)

1 Recommendation 19 Managers of duty teams must devise and operate a system which enables them immediately to establish how many children have been referred to their team, what action is required to be taken for each child, who is responsible for taking that action, and when that action must be completed. (paragraph 4.14)

2 Recommendation 20 Directors of social services must ensure that staff in their children and families’ intake teams are experienced in working with children and families, and that they have received appropriate training. (paragraph 4.16)

1 Recommendation 21 When a professional makes a referral to social services concerning the well-being of a child, the fact of that referral must be confirmed in writing by the referrer within 48 hours. (paragraph 4.59)

1 Recommendation 22 If social services place a child in temporary accommodation, an assessment must be made of the suitability of that accommodation and the results of that assessment must be recorded on the child’s case file. If the accommodation is unsuitable, this should be reported to a senior officer. (paragraph 4.77)
1 Recommendation 23 If social services place a child in accommodation in another local authority area, they must notify that local authority’s social services department of the placement. Unless specifically agreed in writing at team manager level by both authorities or above, the placing authority must retain responsibility for the child concerned. (paragraph 4.82)

1 Recommendation 24 Where, during the course of an assessment, social services establish that a child of school age is not attending school, they must alert the education authorities and satisfy themselves that, in the interim, the child is subject to adequate daycare arrangements. (paragraph 4.143)

1 Recommendation 25 All social services assessments of children and families, and any action plans drawn up as a result, must be approved in writing by a manager. Before giving such approval, the manager must ensure that the child and the child’s carer have been seen and spoken to. (paragraph 4.152)

1 Recommendation 26 Directors of social services must ensure that no case involving a vulnerable child is closed until the child and the child’s carer have been seen and spoken to, and a plan for the ongoing promotion and safeguarding of the child’s welfare has been agreed. (paragraph 4.183)

2 Recommendation 27 Chief executives and lead members of local authorities with social services responsibilities must ensure that children’s services are explicitly included in their authority’s list of priorities and operational plans. (paragraph 5.4)

18 Recommendations

2 Recommendation 28 The Department of Health should require chief executives of local authorities with social services responsibilities to prepare a position statement on the true picture of the current strengths and weaknesses of their ‘front door’ duty systems for children and families. This must be accompanied by an action plan setting out the timescales for remedying any weaknesses identified. (paragraph 5.9)

2 Recommendation 29 Directors of social services must devise and implement a system which provides them with the following information about the work of the duty teams for which they are responsible:
• number of children referred to the teams;
• number of those children who have been assessed as requiring a service;
• number of those children who have been provided with the service that they require;
• number of children referred who have identified needs which have yet to be met. (paragraph 5.24)

1 Recommendation 30 Directors of social services must ensure that senior managers inspect, at least once every three months, a random selection of case files and supervision notes. (paragraph 5.27)

2 Recommendation 31 Directors of social services must ensure that all staff who work with children have received appropriate vocational training, receive a thorough induction in local procedures and are obliged to participate in
regular continuing training so as to ensure that their practice is kept up to
date. (paragraph 5.30)

3 Recommendation 32 Local authority chief executives must ensure that only one
electronic database system is used by all those working in children and families’
services for the recording of information. This should be the same system in use
across the council, or at least compatible with it, so as to facilitate the sharing of
information, as appropriate. (paragraph 5.46)

3 Recommendation 33 Local authorities with responsibility for safeguarding children
should establish and advertise a 24-hour free telephone referral number for use by
members of the public who wish to report concerns about a child. A pilot study
should be undertaken to evaluate the feasibility of electronically recording calls to
such a number. (paragraph 5.71)

2 Recommendation 34 Social workers must not undertake home visits without being clear
about the purpose of the visit, the information to be gathered during the
course of it, and the steps to be taken if no one is at home. No visits should be
undertaken without the social worker concerned checking the information known
about the child by other child protection agencies. All visits must be written up on
the case file. (paragraphs 5.108 and 6.606)

1 Recommendation 35 Directors of social services must ensure that children
who are the subject of allegations of deliberate harm are seen and spoken to
within 24 hours of the allegation being communicated to social services. If this
timescale is not met, the reason for the failure must be recorded on the case file.
(paragraph 5.127)

1 Recommendation 36 No emergency action on a case concerning an allegation
of deliberate harm to a child should be taken without first obtaining legal advice.
Local authorities must ensure that such legal advice is available 24 hours a day.
(paragraph 5.128)
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2 Recommendation 37 The training of social workers must equip them with the
confidence to question the opinion of professionals in other agencies when
conducting their own assessment of the needs of the child. (paragraph 5.138)

1 Recommendation 38 Directors of social services must ensure that the transfer
of responsibility of a case between local authority social services departments is
always recorded on the case file of each authority, and is confirmed in writing
by the authority to which responsibility for the case has been transferred.
(paragraph 5.152)

1 Recommendation 39 All front-line staff within local authorities must be trained
to pass all calls about the safety of children through to the appropriate duty team
without delay, having first recorded the name of the child, his or her address, and
the nature of the concern. If the call cannot be put through immediately, further
details from the referrer must be sought (including their name, address and contact
number). The information must then be passed verbally and in writing to the duty team within the hour. (paragraph 5.169)

1 Recommendation 40 Directors of social services must ensure that no case that has been opened in response to allegations of deliberate harm to a child is closed until the following steps have been taken:
   • The child has been spoken to alone.
   • The child’s carers have been seen and spoken to.
   • The accommodation in which the child is to live has been visited.
   • The views of all the professionals involved have been sought and considered.
   • A plan for the promotion and safeguarding of the child’s welfare has been agreed. (paragraph 5.187)

2 Recommendation 41 Chief executives of local authorities with social services responsibilities must make arrangements for senior managers and councillors to regularly visit intake teams in their children’s services department, and to report their findings to the chief executive and social services committee. (paragraph 5.193)

1 Recommendation 42 Directors of social services must ensure that where the procedures of a social services department stipulate requirements for the transfer of a case between teams within the department, systems are in place to detect when such a transfer does not take place as required. (paragraph 6.7)

2 Recommendation 43 No social worker shall undertake section 47 inquiries unless he or she has been trained to do so. Directors of social services must undertake an audit of staff currently carrying out section 47 inquiries to identify gaps in training and experience. These must be addressed immediately. (paragraph 6.12)

1 Recommendation 44 When staff are temporarily promoted to fill vacancies, directors of social services must subject such arrangements to six-monthly reviews and record the outcome. (paragraph 6.29)

1 Recommendation 45 Directors of social services must ensure that the work of staff working directly with children is regularly supervised. This must include the supervisor reading, reviewing and signing the case file at regular intervals. (paragraph 6.59)

1 Recommendation 46 Directors of social services must ensure that the roles and responsibilities of child protection advisers (and those employed in similar posts) are clearly understood by all those working within children’s services. (paragraph 6.71)

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3 Recommendation 47 The chief executive of each local authority with social services responsibilities must ensure that specialist services are available to respond to the needs of children and families 24 hours a day, seven days a week. The safeguarding of children should not be part of the responsibilities of general out-of-office-hours teams. (paragraph 6.181)
1 Recommendation 48 Directors of social services must ensure that when children and families are referred to other agencies for additional services, that referral is only made with the agreement of the allocated social worker and/or their manager. The purpose of the referral must be recorded contemporaneously on the case file. (paragraph 6.263)

1 Recommendation 49 When a professional from another agency expresses concern to social services about their handling of a particular case, the file must be read and reviewed, the professional concerned must be met and spoken to, and the outcome of this discussion must be recorded on the case file. (paragraph 6.289)

1 Recommendation 50 Directors of social services must ensure that when staff are absent from work, systems are in place to ensure that post, emails and telephone contacts are checked and actioned as necessary. (paragraph 6.318)

1 Recommendation 51 Directors of social services must ensure that all strategy meetings and discussions involve the following three basic steps:
- A list of action points must be drawn up, each with an agreed timescale and the identity of the person responsible for carrying it out.
- A clear record of the discussion or meeting must be circulated to all those present and all those with responsibility for an action point.
- A mechanism for reviewing completion of the agreed actions must be specified. The date upon which the first such review is to take place is to be agreed and documented. (paragraph 6.575)

2 Recommendation 52 Directors of social services must ensure that no case is allocated to a social worker unless and until his or her manager ensures that he or she has the necessary training, experience and time to deal with it properly. (paragraph 6.581)

1 Recommendation 53 When allocating a case to a social worker, the manager must ensure that the social worker is clear as to what has been allocated, what action is required and how that action will be reviewed and supervised. (paragraph 6.586)

2 Recommendation 54 Directors of social services must ensure that all cases of children assessed as needing a service have an allocated social worker. In cases where this proves to be impossible, arrangements must be made to maintain contact with the child. The number, nature and reasons for such unallocated cases must be reported to the social services committee on a monthly basis. (paragraph 6.589)

1 Recommendation 55 Directors of social services must ensure that only those cases in which a social worker is actively engaged in work with a child and the child’s family are deemed to be ‘allocated’. (paragraph 6.590)

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1 Recommendation 56 Directors of social services must ensure that no child known to social services who is an inpatient in a hospital and about whom there are child protection concerns is allowed to be taken home until it has been established by social services that the home environment is safe, the concerns of the medical staff have been fully addressed, and there is a social work plan in place for the ongoing promotion and safeguarding of that child’s welfare. (paragraph 6.594)

2 Recommendation 57 Directors of social services must ensure that social work staff are made aware of how to access effectively information concerning vulnerable children which may be held in other countries. (paragraph 6.619)

1 Recommendation 58 Directors of social services must ensure that every child’s case file includes, on the inside of the front cover, a properly maintained chronology. (paragraph 6.629)

2 Recommendation 59 Directors of social services must ensure that staff working with vulnerable children and families are provided with up-to-date procedures, protocols and guidance. Such practice guidance must be located in a single-source document. The work should be monitored so as to ensure procedures are followed. (paragraph 8.7)

2 Recommendation 60 Directors of social services must ensure that hospital social workers working with children and families are line managed by the children and families’ section of their social services department. (paragraph 8.19)

1 Recommendation 61 Directors of social services must ensure that hospital social workers participate in all hospital meetings concerned with the safeguarding of children. (paragraph 8.27)

2 Recommendation 62 Where hospital-based social work staff come into contact with children from other local authority areas, the directors of social services of their employing authorities must ensure that they work to a single set of guidance agreed by all the authorities concerned. (paragraph 8.53)

1 Recommendation 63 Hospital social workers must always respond promptly to any referral of suspected deliberate harm to a child. They must see and talk to the child, to the child’s carer and to those responsible for the care of the child in hospital, while avoiding the risk of appearing to coach the child. (paragraph 8.100) Healthcare recommendations

1 Recommendation 64 When a child is admitted to hospital and deliberate harm is suspected, the nursing care plan must take full account of this diagnosis. (paragraph 9.35)

2 Recommendation 65 When the deliberate harm of a child is identified as a possibility, the examining doctor should consider whether taking a history directly from the child is in that child’s best interests. When that is so, the history should be taken even when the consent of the carer has not been obtained, with the
reason for dispensing with consent recorded by the examining doctor. *Working Together* guidance should be amended accordingly. In those cases in which English is not the first language of the child concerned, the use of an interpreter should be considered. (paragraph 9.39)

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1 Recommendation 66 When a child has been examined by a doctor, and concerns about deliberate harm have been raised, no subsequent appraisal of these concerns should be considered complete until each of the concerns has been fully addressed, accounted for and documented. (paragraph 9.60)

2 Recommendation 67 When differences of medical opinion occur in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views. When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion and, if necessary, obtaining a further opinion. (paragraph 9.65)

1 Recommendation 68 When concerns about the deliberate harm of a child have been raised, doctors must ensure that comprehensive and contemporaneous notes are made of these concerns. If doctors are unable to make their own notes, they must be clear about what it is they wish to have recorded on their behalf. (paragraphs 9.72 and 10.30)

1 Recommendation 69 When concerns about the deliberate harm of a child have been raised, a record must be kept in the case notes of all discussions about the child, including telephone conversations. When doctors and nurses are working in circumstances in which case notes are not available to them, a record of all discussions must be entered in the case notes at the earliest opportunity so that this becomes part of the child’s permanent health record. (paragraph 9.95)

2 Recommendation 70 Hospital trust chief executives must introduce systems to ensure that no child about whom there are child protection concerns is discharged from hospital without the permission of either the consultant in charge of the child’s care or of a paediatrician above the grade of senior house officer. Hospital chief executives must introduce systems to monitor compliance with this recommendation. (paragraphs 9.101 and 10.145)

2 Recommendation 71 Hospital trust chief executives must introduce systems to ensure that no child about whom there are child protection concerns is discharged from hospital without a documented plan for the future care of the child. The plan must include follow-up arrangements. Hospital chief executives must introduce systems to monitor compliance with this recommendation. (paragraphs 9.101 and 10.146)

1 Recommendation 72 No child about whom there are concerns about deliberate harm should be discharged from hospital back into the community without an identified GP. Responsibility for ensuring this happens rests with the hospital
consultant under whose care the child has been admitted. (paragraph 9.105)

2 Recommendation 73 When a child is admitted to hospital and deliberate harm is suspected, the doctor or nurse admitting the child must inquire about previous admissions to hospital. In the event of a positive response, information concerning the previous admissions must be obtained from the other hospitals. The consultant in charge of the case must review this information when making decisions about the child’s future care and management. Hospital chief executives must introduce systems to ensure compliance with this recommendation. (paragraph 10.36)

1 Recommendation 74 Any child admitted to hospital about whom there are concerns about deliberate harm must receive a full and fully-documented physical examination within 24 hours of their admission, except when doing so would, in the opinion of the examining doctor, compromise the child’s care or the child’s physical and emotional well-being. (paragraph 10.41)

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1 Recommendation 75 In a case of possible deliberate harm to a child in hospital, when permission is required from the child’s carer for the investigation of such possible deliberate harm, or for the treatment of a child’s injuries, the permission must be sought by a doctor above the grade of senior house officer. (paragraph 10.73)

1 Recommendation 76 When a child is admitted to hospital with concerns about deliberate harm, a clear decision must be taken as to which consultant is to be responsible for the child protection aspects of the child’s care. The identity of that consultant must be clearly marked in the child’s notes so that all those involved in the child’s care are left in no doubt as to who is responsible for the case. (paragraph 10.105)

1 Recommendation 77 All doctors involved in the care of a child about whom there are concerns about possible deliberate harm must provide social services with a written statement of the nature and extent of their concerns. If misunderstandings of medical diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood. (paragraph 10.162)

1 Recommendation 78 Within a given location, health professionals should work from a single set of records for each child. (paragraph 11.39)

1 Recommendation 79 During the course of a ward round, when assessing a child about whom there are concerns about deliberate harm, the doctor conducting the ward round should ensure that all available information is reviewed and taken account of before decisions on the future management of the child’s case are taken. (paragraph 11.39)
1 Recommendation 80 When a child for whom there are concerns about deliberate harm is admitted to hospital, a record must be made in the hospital notes of all face-to-face discussions (including medical and nursing ‘handover’) and telephone conversations relating to the care of the child, and of all decisions made during such conversations. In addition, a record must be made of who is responsible for carrying out any actions agreed during such conversations. (paragraph 11.39)

2 Recommendation 81 Hospital chief executives must introduce systems to ensure that actions agreed in relation to the care of a child about whom there are concerns of deliberate harm are recorded, carried through and checked for completion. (paragraph 11.39)

2 Recommendation 82 The Department of Health should examine the feasibility of bringing the care of children about whom there are concerns about deliberate harm within the framework of clinical governance. (paragraph 11.39)

2 Recommendation 83 The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease. (paragraph 11.53)

3 Recommendation 84 All designated and named doctors in child protection and all consultant paediatricians must be revalidated in the diagnosis and treatment of deliberate harm and in the multi-disciplinary aspects of a child protection investigation. (paragraph 11.53)

3 Recommendation 85 The Department of Health should invite the Royal College of Paediatrics and Child Health to develop models of continuing education in the diagnosis and treatment of the deliberate harm of children, and in the multi-disciplinary aspects of a child protection investigation, to support the revalidation of doctors described in the preceding recommendation. (paragraph 11.53)

3 Recommendation 86 The Department of Health should invite the Royal College of General Practitioners to explore the feasibility of extending the process of new child patient registration to include gathering information on wider social and developmental issues likely to affect the welfare of the child, for example their living conditions and their school attendance. (paragraph 12.29)

3 Recommendation 87 The Department of Health should seek to ensure that all GPs receive training in the recognition of deliberate harm to children, and in the multi-disciplinary aspects of a child protection investigation, as part of their initial vocational training in general practice, and at regular intervals of no less than three years thereafter. (paragraph 12.29)

3 Recommendation 88 The Department of Health should examine the feasibility of introducing training in the recognition of deliberate harm to children as part of
the professional education of all general practice staff and for all those working in primary healthcare services for whom contact with children is a regular feature of their work. (paragraph 12.29)

2 Recommendation 89 All GPs must devise and maintain procedures to ensure that they, and all members of their practice staff, are aware of whom to contact in the local health agencies, social services and the police in the event of child protection concerns in relation to any of their patients. (paragraph 12.29)

2 Recommendation 90 Liaison between hospitals and community health services plays an important part in protecting children from deliberate harm. The Department of Health must ensure that those working in such liaison roles receive child protection training. Compliance with child protection policies and procedures must be subject to regular audit by primary care trusts. (paragraph 12.57)

Police recommendations

1 Recommendation 91 Save in exceptional circumstances, no child is to be taken into police protection until he or she has been seen and an assessment of his or her circumstances has been undertaken. (paragraph 13.17)

1 Recommendation 92 Chief constables must ensure that crimes involving a child victim are dealt with promptly and efficiently, and to the same standard as equivalent crimes against adults. (paragraph 13.24)

1 Recommendation 93 Whenever a joint investigation by police and social services is required into possible injury or harm to a child, a manager from each agency should always be involved at the referral stage, and in any further strategy discussion. (paragraph 13.52)

1 Recommendation 94 In cases of serious crime against children, supervisory officers must, from the beginning, take an active role in ensuring that a proper investigation is carried out. (paragraph 13.55)

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3 Recommendation 95 The Association of Chief Police Officers must produce and implement the standards-based service, as recommended by Her Majesty’s Inspectorate of Constabulary in the 1999 thematic inspection report, Child Protection. (paragraph 13.66)

2 Recommendation 96 Police forces must review their systems for taking children into police protection and ensure they comply with the Children Act 1989 and Home Office guidelines. In particular, they must ensure that an independent officer of at least inspector rank acts as the designated officer in all cases. (paragraph 13.68)

2 Recommendation 97 Chief constables must ensure that the investigation of crime against children is as important as the investigation of any other form of serious crime. Any suggestion that child protection policing is of a lower status than other forms of policing must be eradicated. (paragraph 14.15)
1 Recommendation 98 The guideline set out at paragraph 5.8 of *Working Together* must be strictly adhered to: whenever social services receive a referral which may constitute a criminal offence against a child, they must inform the police at the earliest opportunity. (paragraph 14.46)

3 Recommendation 99 The *Working Together* arrangements must be amended to ensure the police carry out completely, and exclusively, any criminal investigation elements in a case of suspected injury or harm to a child, including the evidential interview with a child victim. This will remove any confusion about which agency takes the ‘lead’ or is responsible for certain actions. (paragraph 14.57)

3 Recommendation 100 Training for child protection officers must equip them with the confidence to question the views of professionals in other agencies, including doctors, no matter how eminent those professionals appear to be. (paragraph 14.73)

3 Recommendation 101 The Home Office, through Her Majesty’s Inspectorate of Constabulary, must take a more active role in maintaining high standards of child protection investigation by means of its regular Basic Commands Unit and force inspections. In addition, a follow-up to the *Child Protection* thematic inspection of 1999 should be conducted. (paragraph 14.132)

3 Recommendation 102 The Home Office, through Centrex and the Association of Chief Police Officers, must devise and implement a national training curriculum for child protection officers as recommended in 1999 by Her Majesty’s Inspectorate of Constabulary in its thematic inspection report, *Child Protection*. (paragraph 15.16)

3 Recommendation 103 Chief constables must ensure that officers working on child protection teams are sufficiently well trained in criminal investigation, and that there is always a substantial core of fully trained detective officers on each team to deal with the most serious inquiries. (paragraph 15.24)

3 Recommendation 104 The Police Information Technology Organisation (PITO) should evaluate the child protection IT systems currently available, and make recommendations to chief constables, who must ensure their police force has in use an effective child-protection database and IT management system. (paragraph 15.40)

2 Recommendation 105 Chief constables must ensure that child protection teams are fully integrated into the structure of their forces and not disadvantaged in terms of accommodation, equipment or resources. (paragraph 15.45)

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2 Recommendation 106 The Home Office must ensure that child protection policing is included in the list of ministerial priorities for the police. (paragraph 15.46)
2 Recommendation 107 Chief constables and police authorities must give child protection investigations a high priority in their policing plans, thereby ensuring consistently high standards of service by well-resourced, well-managed and well-motivated teams. (paragraph 15.46)

2 Recommendation 108 The Home Office, through Centrex, must add specific training relating to child protection policing to the syllabus for the strategic command course. This will ensure that all future chief officers in the police service have adequate knowledge and understanding of the roles of child protection teams. (paragraph 15.53) 384
LEICESTER CITY COUNCIL
CHILD PROTECTION: SUMMARY OF ACCOUNTABILITIES

The Leader of the Council
- Ensure that the Council gives priority to safeguarding children coherently and consistently in service planning and resource allocation.
- Designate one Cabinet member with responsibility for safeguarding children.
- Ensure the Council appoints a Corporate Director to carry social services responsibilities and ensure that the Cabinet receives advice from him/her on all relevant matters.

The Cabinet Lead for Social Services (and/or with designated responsibility for Safeguarding Children)
- Ensure that the Council's social services responsibilities are properly considered, supported and monitored by the Cabinet.
- Work with the Corporate Director of Social Care and Health to ensure the Department is adequately funded and staffed to deliver these priorities, in and out of office hours.
- Act as the Cabinet champion for safeguarding children.
- Ensure that the Council fulfils its responsibilities as "corporate parent" of Looked After Children.

The Chief Executive
- Ensure the Council has developed local strategic objectives, priorities and targets for child protection that complement those set nationally.
- Make sure statutory inter-agency arrangements are in place (including Area Child Protection Committee, Multi-Agency Public Protection Panel) and ensure there is an open culture between local agencies and good direct communications between senior managers so that they accept and address concerns brought to their attention.
- Receive regular briefings that identify the strengths and weaknesses of the Council's services and the action required to address them.

The Corporate Director of Social Care and Health
- Ensure that the Department has management and accountability structures that deliver safe and effective services, with particular reference to the Children Act 1989, The Framework for the Assessment of Children in Need and their Families and Working Together to Safeguard Children.
- Ensure that the Department has access to a range of effective, efficient and flexible services that protect and support families.
- Ensure there is an effective Area Child Protection Committee that co-ordinates services and ensures that children are protected in all settings including hospitals.
- Ensure the effective management and use of the Child Protection Register by relevant agencies.
- Ensure staff are well trained, supported and managed.

The Corporate Director of Resources, Access & Diversity
- Ensure expert legal advice is available to the Council on its child care responsibilities.
• Ensure that robust arrangements are in place for pre and post recruitment checks are undertaken for all appropriate people working with children in the Council and the services it arranges and funds.

The Corporate Director of Education & Lifelong Learning
• Ensure the safeguarding of children in all educational provision, whether pre-school day care, primary, secondary or residential schools.
• Make sure all schools have policies and procedures for child protection.
• Ensure measures are in place to promote good attendance; to manage behaviour and tackle bullying and other forms of harassment; to provide effective personal, social and health education.
• Specific attention should be given to groups at risk of low achievement, including children in the public care and with special needs; the attendance, behaviour and provision for pupils out of school, within the context of a general approach to educational inclusion.
• Ensure the LEA is a core member of the ACPC and that maintained schools, staff and governors are fully integrated in, and familiar with, child protection procedures.

All Corporate Directors
• Should be committed to protecting children and should communicate that commitment throughout the organisation.
• Ensure their services are provided in a way that ensures the safety of all children.
• Ensure all staff in services with contact with children and/or their parents have a consistent understanding of the thresholds for sharing information with and referral to Social Care & Health/ Police.

Scrutiny Committee Members
• Take all necessary steps to scrutinise the Council's arrangements for safeguarding children, with particular reference to:
  • the adequacy of funding
  • staff levels and morale
  • the Department's performance, including unallocated cases
  • the care, education, health and achievements of Looked After Children.

Children's Homes Visiting Panel
• All party group to fulfil councillors' responsibilities to visit children's homes.
• Cabinet Lead is responsible for bringing matters raised by the Panel to the Corporate Director and Cabinet's attention.

(Note: the scope of the Panel could be expanded to include visits to other frontline children's services in line with the recommendations of the Laming Report, pending the Government's formal response to the structural changes proposed).

Quality Protects Members Group
• Responsible for overseeing the preparation of the Quality Protects Management Action Plan and recommending its approval to Cabinet and the Council.
All Councillors

- Should be aware of how and when to refer child welfare concerns to Social Care and Health/Police and how, after the referral has been registered, that there are subsequent constraints on staff sharing information as set out in the Council's Political Conventions.
- Should be aware of their responsibilities as "corporate parents" of Looked After Children.

Area Child Protection Committee

- The inter-agency group with responsibility for agreeing how the different services and professional groups should co-operate to safeguard children in Leicester, and for making sure that arrangements work effectively to bring about good outcomes for children.

Service Directors for Children's Services

- Ensure that children are protected, and they and their families benefit from effective referral, assessment, planning and review processes, which result in appropriate services being provided to respond to the identified developmental needs of the child.
- Maintain positive and constructive relationships through the ACPC with partner agencies.
- Ensure that staff are provided with up-to-date procedures, protocols and guidance and that systems are in place to ensure they are followed.
- Ensure arrangements are in place for the safe transfer of responsibility between local authorities.
- Ensure clarity in the role of child protection advisers.
- Ensure supervision and staff development processes are in place.
- Ensure performance measures are in place to ensure services are safely, efficiently and cost-effectively delivered.

Service Managers

- Ensure systems are in place to enable team managers to establish how many children have been referred to their team, what action is required to be taken for each child, who is responsible for taking action, and when that action must be completed and has been completed.
- Ensure that all cases of children assessed as needing a service have an allocated worker.
- Ensure that staff follow procedures, protocols and guidance and that casework is checked regularly.
- Report regularly to Service Directors on the quality and performance of their services.

Team Leaders

- Make sure when cases are allocated, that the practitioner is clear about what has been allocated, what action is required, and how that action will be reviewed and supervised.
- Setting and monitoring standards for recording and managing case files.

Child Care Practitioners

- Follow the Council's child protection procedures.
- Maintain records of their work.
- Keep up to date through training and other professional development opportunities.

Other Practitioners

- Pass all concerns about child protection to the appropriate duty team without delay.