

To: SOCIAL WORK COMMITTEE		Subject: THE INQUIRY INTO THE DEATH OF CALEB NESS COMMISSIONED BY EDINBURGH AND LOTHIAN'S CHILD PROTECTION COMMITTEE, PUBLISHED OCTOBER 2003
From: DIRECTOR OF SOCIAL WORK		
Date: 15 JANUARY 2004	Ref: MF/AB	

1. PURPOSE OF REPORT / INTRODUCTION

- 1.1. To advise Committee of the findings and recommendations of the Inquiry into the death of Caleb Ness and to consider the implications for North Lanarkshire Council and its partners.

2. BACKGROUND

- 2.1. The Children (Scotland) Act 1995 requires Local Authorities to report to the Scottish Executive on the circumstances of the death of any child, who at the time of their death, was looked after and accommodated by the Local Authority, or whose name had been placed on the Child Protection Register.
- 2.2. Child Protection Committees can arrange to undertake a review of the circumstances of child deaths within their area and to make recommendations about practice and service and policy developments.
- 2.3. Child Protection Committees are multi agency groups which oversee child protection practice, procedures and policy in specified geographical areas, normally a Local Authority Area.
- 2.4. Within North Lanarkshire the Child Protection Committee has been established since Local Government reorganisation in April 1996 (having previously been constituted as Area Child Protection Committees). The North Lanarkshire Child Protection Committee reports to the Children's Services Strategy Group.
- 2.5. The Child Protection Register is a record of all children viewed to be at future serious risk following consideration by a multi-agency review, the Child Protection Case Conference. The North Lanarkshire Child Protection Register is maintained by the Council's Social Work Department.
- 2.6. The findings of the Caleb Ness Inquiry need to be considered within the context of other significant developments which impact on agencies child protection responsibilities such as:
- The National Audit and Review of Child Protection across Scotland (Dec 2002)
 - The findings of the Victoria Climbié Inquiry (February 2003)
 - The findings of the Carla Nicole Bone Inquiry (October 2003)

- The English Green Paper, "Every Child Matters" (following the Victoria Climbié Inquiry) (Nov 2003)
- Getting Our Priorities Right (Feb 2001)

2.7. Each of these reports develops the roles, responsibilities and accountability of all agencies in the area of the safeguarding of children. It is important to recognise that this is occurring at a time when many children's services are experiencing major recruitment and retention difficulties.

2.8. Child protection is a complex area involving a number of agencies. Dr Helen Hammod, Consultant Paediatrician who investigated the circumstances of the death of Kennedy McFarlane on behalf of Dumfries and Galloway Child Protection Committee said in her report "We must accept that however good our systems and processes are, we will not be able to predict or prevent all child deaths at the hand of their carers, just as we cannot prevent all deaths from accident and illness"

3. BACKGROUND TO THE CALEB NESS INQUIRY

3.1. Caleb Ness died aged 11 weeks, on the 18th October 2003. At the time of his death his name had been placed on the Edinburgh and Lothian's Child Protection Register. There were concerns regarding his parents lifestyle eg. substance misuse and the impact of this on his development.

3.2. Caleb's father pled guilty to culpable homicide and is currently serving a prison sentence.

3.3. Following Caleb's death, Edinburgh and Lothian Child Protection Committee commissioned an independent report into Caleb's death. The report of the Inquiry was published in October 2003, following which several social work staff were suspended and the Director of Social Work resigned. The findings of the Inquiry attracted significant media attention.

3.4. The Inquiry reached the conclusion that this had been an avoidable death, having reviewed all the evidence it held the view that neither parent should have had unsupervised care of the child.

3.5. The Inquiry also found that "no single agency was considered to be held responsible, finding fault at almost every level in every agency involved".

3.6. The 25 recommendations in the report were addressed as follows:

• More than one agency	16
• Mostly social work	8
• Mostly Health (Primary Care and University Hospitals Trusts)	11
• Mostly Police	3
• Housing	1

4. KEY FINDINGS OF THE CALEB NESS INQUIRY

4.1. Sadly, some of the issues highlighted in the Caleb Ness report are recurring themes throughout the many reports into child deaths, stretching as far back as the death of Maria Cowell in 1973. These include:

- Issues in respect of communication and information sharing within and between agencies
- A lack of co-ordinated services when more than one agency is involved in a case
- A lack of clear assessment in terms of risk - talking the same language
- Issues of the recording of information by key staff
- A lack of awareness of individual roles and responsibilities

- 4.2. The child protection responsibilities of non child care staff in a number of agencies were also identified as concerns, reflecting a lack of awareness of, and ownership of their child protection roles.
- 4.3. Issues which were specific to the Caleb Ness case related to the child protection processes in place in Edinburgh City. This included the management of Child Protection Case Conferences including the role of the Chairperson, Minute Takers and Care Planning. In respect of a number of concerns identified in relation to child protection case conferences, different arrangements operate within North Lanarkshire.

5. NORTH LANARKSHIRE POSITION

- 5.1. Child Protection Committee members have received copies of the summary report for consideration and necessary action within their own agencies.
- 5.2. The Chief Executive has written to all Departmental Directors and the Senior Officers of those agencies who are members of the Child Protection Committee to review committee membership and the responsibilities and training needs of staff. This should include key, relevant partner agencies.
- 5.3. The Child Protection Committee has developed an Action Plan to implement the recommendations of the National Audit of Child Protection "It's Everyone's Job to Make Sure I'm Alright" This requires to be implemented by all Department's and agencies as appropriate.
- 5.4. North and South Lanarkshire Child Protection Committees have developed inter-agency procedures for working with families where parental substance misuse is a factor. These have been developed following publication of the Scottish Executive's "Getting Our Priorities Right" document published February 2001 which addresses the issues of parental substance misuse and its possible impact on children, their care and overall development. The procedures and training will be launched in February 2004.
- 5.5. Departments such as Community Services and Housing and Property Services have developed Departmental Child Protection Procedures and established working groups which help raise awareness of Child Protection within their respective Departments.
- 5.6. Six child protection local area networks have been developed around the six social work area teams to encourage a range of agency staff who work together in the area of child protection share best practice and improve communication.
- 5.7. Social Work has a lead role in child protection. Work undertaken includes:
 - The establishment of a Departmental working group to progress the recommendations of the various reports
 - An audit of existing child protection cases with an action plan following identification of "lessons learned"
 - The Head of Social Work Services meeting with managers to identify and address key areas such as training, I.T and the Child Protection Committee process
 - A major recruitment and retention initiative with a focus on qualified social workers
 - The development of a Departmental targeted training programme
- 5.8. Central to the safeguarding of children is the exchange of good quality information. The Scottish Executive has agreed to fund a pilot in Lanarkshire, involving the two Councils and partner agencies, which will progress the electronic exchange of information between agencies / the single shared assessment building on the recognised "Champions" role which the Department has for older people across Scotland. This pilot will assist the Council and its partners meet some of the recommendations from the National Child Protection Audit on the sharing of information.

- 5.9. The twelve chairs of the Child Protection Committees of the previous Strathclyde Region meet on a regular basis to exchange best practice. Work is currently underway to develop public information leaflets recognising some of the recommendations of "It's Everyone's Job to Make Sure I'm Alright"
- 5.10. A Co-ordinator has been appointed to support the work of the Child Protection Committee, the post being funded by the Department of Social Work, Housing and Property Services and Community Services as well as NHS Lanarkshire. The NHS Primary Care Trust has appointed a Child Protection Adviser.
- 5.11. Whilst much work is underway in North Lanarkshire to safeguard children, more needs to be done. This is the responsibility of individual Departments and Agencies supported by the Child Protection Committee.

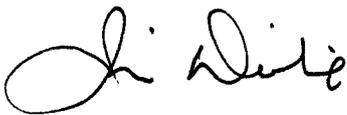
6. FINANCIAL / PERSONNEL / LEGAL AND POLICY IMPLICATIONS

- 6.1 The developments identified in the report will assist the Council and its partners address many of the recommendations of recent reports into child deaths.
- 6.2 As expectations and responsibilities increase in the area of Child Protection it will be necessary to review the resources available to support the Child Protection Register and the Child Protection Committee. A bid has been made to the Changing Children's Services Fund for additional resources.

7. RECOMMENDATIONS

7.1 Committee is asked to:

- (i) Request that further reports be presented to Committee in respect of Child Protection in North Lanarkshire
- (ii) Remit the report for consideration by:
 - Policy and Resources Committee
 - North Lanarkshire Partnership
 - Health and Care Partnership
 - Community Safety Forum
- (iii) Otherwise note the contents of the report



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2 December 2003

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