

**The Highland Child Protection Committee Commissioning Group Response to:
*The independent review into the circumstances surrounding the death of Danielle Reid by
Dr Jean Herbison***

1 Introduction

- 1.1 Dr Herbison's review relates to the murder of 5 year old Danielle Reid by Lee Gaytor in Inverness in early November 2002.
- 1.2 Dr Herbison was remitted to:
- identify any reasonable precautions whereby the death of Danielle Reid might have been avoided;
 - identify whether there were any defects in any system of working which contributed to the death;
 - examine action taken by agencies following the death of Danielle and up to the discovery of her body;
 - examine how agencies, individually and collectively, have responded following internal management reviews and to comment on the content and outcome of internal management reviews as to whether they cover the relevant issues and any lessons to be learned.
- 1.3 She was asked to provide a report outlining the findings, and make recommendations to improve practice by agencies and the Highland Child Protection Committee.
- 1.4 Dr Herbison's first conclusion, set out in the introduction to her report, is that 'there is little doubt that the violent death of this 5 year old girl was not directly preventable by any of the individuals concerned.'
- 1.5 The findings with regard to the four points listed above are contained in part four of the report, and addressed later here. They reflect Dr Herbison's view that, albeit no individuals employed by the agencies responsible for child protection could have prevented Danielle's death, there were major single agency and inter-agency system failures.
- 1.6 Dr Herbison was engaged to carry out this review in April 2003, and agreed the terms of reference in July 2003. Significant changes in child protection have taken place in Scotland between the commissioning and completion of this work, led by the national reform programme. As part of this, in January – March 2005, one of the first inspections of child protection services in Scotland was carried out in Highland, and concluded that 'children and young people in Highland are well protected'. The Scottish Executive also asked Highland to pilot the new model of integrated children's services planning, and has since asked Highland to pilot the second phase of the national review of the Children's Hearings System. This review, 'Getting it Right for Every Child', will have far reaching implications for all of Scotland's children.
- 1.7 Dr Herbison's report makes 68 recommendations. Many do not relate specifically to Danielle's death or child protection services in Highland, but to Dr Herbison's views about 'continuing high risk situations for children in the future'. These recommendations cover 23 issues, as shown in the summary overleaf. A total of 81 separate actions have been taken to address these issues, and a further 36 actions are ongoing. In relation to national standards, policies and procedures, Highland is compliant with regard to 65 of the 68 recommendations. The further three (with regard to a central

helpline; co-ordinated multi-agency audit; and out of hours medical examinations) form part of the present Child Protection Workplan, and will be fully implemented by September 2006.

Issue	Rec. Number	Compliant	No. of completed actions	No. of ongoing actions
Central helpline should be established	1	No		2
Process of information gathering and sharing about families and individuals	2, 3, 7, 15, 16, 17, 18, 40, 46, 47, 48, 50, 51, 52, 62	Yes	14	4
Implementation of Integrated Assessment Framework	4, 5, 9, 19, 21, 23, 53, 54, 57	*Yes	7	3
Comprehensive and tiered training model	6, 55	Yes	6	1
Multi-agency audit and quality assurance system	8	No	4	1
Tracking of children missing or transferring between universal services	10, 11, 41, 42, 49, 56, 58	Yes	9	5
Multi-agency management of transitions	12, 60, 61	Yes	4	4
Protocol for Critical Incident Reviews	13, 37, 67	Yes	2	2
Children should be seen immediately if there are urgent concerns	14	Yes	2	
Protocol for handover of cases between Social Workers	20	Yes	2	1
Review of Social Work computerised information system	22	Yes	1	1
Decision making should be led by senior staff	24, 25, 26, 30, 32, 34, 39, 63, 65	Yes	14	2
Tracking of offenders	27, 28	Yes	3	1
Police recording systems	29	Yes	1	
Police practice in serious inquiries	31	Yes	1	
Access to specialist Crime Management and Child Protection Police Officers.	33	Yes	1	
Review of Social Work computerised information system	35, 36	Yes		2
Referrals to the Reporter	38, 43	Yes	5	2
Recognition of poor school attendance and frequent address changes as risk factors	44, 45	Yes	2	1
Standardised family health record for Health Visitors	59	Yes	1	
Out of hours cover for medical examinations	64	No		3
Resources for parenting initiatives	66	Yes	2	
Implementation of Review of the Children's Hearings System	68	Yes		1
*Highland commenced a programme for implementation of the Integrated Assessment Framework in 2004. It is now working with the Executive to pilot the framework for Scotland, with roll-out planned in August 2006.				

- 1.8 The various actions that have been completed and that are ongoing, are documented in appendix 1. These include those particular actions that were identified by the internal management reviews undertaken by Highland agencies early in 2003. Appendix 1 also includes comments from relevant external reviews, including the 2005 Child Protection Inspection by the HMIe Services for Children Unit.
- 1.9 Many of Dr Herbison’s recommendations, particularly with regard to the relationship between public agencies and families and individuals, would involve a significant shift in current accepted practice and government policy. Those recommendations listed below are either wholly for central government, or have significant elements that require government consideration.

Recommendations that require national consideration	
Process of information gathering and sharing about families and individuals	3,7,17,18,28,51
Implementation of Integrated Assessment Framework	5,9
Tracking of children missing or transferring between universal services	10,11,41,42,49
Protocol for Critical Incident Reviews	13,37
Tracking of offenders	27
National system for proactive health registration of children	58
Implementation of Review of the Children’s Hearings System	68

- 1.10 Dr Herbison’s recommendations and conclusions are founded on a perspective that she sets out in the introduction to the report, which is that ‘risk to children [cannot] possibly diminish without a change in our thinking about vulnerable children’. She states that Scotland requires cultural and perhaps legislative change, that enables ‘openness and transparency about the needs of our children and a culture of alertness to every child’s needs and vulnerabilities, rather than misplaced defensiveness about intrusion into family life’.
- 1.11 This view of how society should be, underpins the analysis that is provided by Dr Herbison. She calls for a level of state intervention in the lives of children and families, that is greater than that currently sanctioned in legislation or government policy. With regard to child safety and welfare, this includes the view that far greater monitoring and tracking of potentially vulnerable children and families is necessary to help protect all those who are at risk.
- 1.12 Dr Herbison’s review does not take account of the significant change that will take place in Scotland as a consequence of the publication in July 2005 of ‘Getting it Right for Every Child’ (GIRFEC).
- 1.13 ‘Getting it Right for Every Child’ sets out an ambitious agenda that will involve Highland in leading:
- seamless linkage with universal and additional needs assessments, and an assessment model which builds on the information that is already known about children and families;
 - the identification of a lead professional who may not be a Social Worker, to co-ordinate the assessment, identify the need for multi-agency services and lead a single action plan;
 - parallel implementation of new health processes as part of the roll-out of *Health for All Children* (vol.4)
 - referral to the Reporter and the Children’s Hearings System based on two tests - significant need and the requirement for compulsion.

2 Conclusions in relation to 1st point in remit: to identify any reasonable precautions whereby the death of Danielle Reid might have been avoided

- 2.1 Dr Herbison concludes that no individuals employed by any of the agencies responsible for child protection services could have prevented Danielle's death. Dr Herbison, however, is critical of the adequacy of the checks undertaken by the Social Worker who responded to the telephone call from a family member in November 2001, and is critical that no home visit was made and that the child was never seen or spoken to. We have considered this criticism, and measures have been taken to ensure that checks are made with police, and that a home visit which includes seeing the child is made in every case where significant concerns are raised about the safety of a child.
- 2.2 Dr Herbison suggests that: 'had Social Work and Health Services been operating at an optimal level ... there might then have been some possibility of avoiding her death.' She indicates that this was because 'there was potential for liaison with other services which may have resulted in recognition of the potential risk to the child'. These aspects of Dr Herbison's conclusions are based on a misunderstanding of the information held by police and about Danielle's health condition.
- 2.3 The Police had no information in November 2001 about Tracey Reid which would have given rise to concerns. The Northern Constabulary's only contact with Tracey Reid had been just a month earlier, in October, when she had denied her mothers accusation of breaking a window at her house. Lee Gaytor was not a 'visiting adult' in the Reid household at that time, and even if he was, he would not have come within the terms of the Violent Offender and Sex Offender Register (ViSOR) tracking system, as suggested by Dr Herbison.
- 2.4 With regard to health issues, Dr Herbison's repeated references to Danielle's unmet health needs are misleading. Danielle did not have special health needs. Her pre-school medical did not identify the need for any additional health interventions. There is an identified genetic disorder within her family, but she did not share this diagnosis. She did not have health needs that would impact on her education – which would have triggered routine liaison between health and school staff.
- 2.5 Nevertheless, Dr Herbison's conclusion raises legitimate questions about whether, when a child protection concern is raised, there should as a matter of course be subsequent social work supervision of that child. Her conclusion also raises questions in relation to the routine monitoring of individuals with criminal records, suggesting a level of ongoing police monitoring which extends significantly beyond current practice and government policy, and beyond what legislation would allow. These are matters which exceed the remits of the Highland child protection agencies.

3 Conclusions in relation to 2nd point in remit: to identify whether there were any defects in any system of working which contributed to the death

- 3.1 Dr Herbison identifies 'material defects' in each of the agencies. She does not indicate any contributory factors to Danielle's death arising from these defects.
- 3.2 Dr Herbison points out that there was no adequate national tracking system in place for children missing from education. While a system is now in place in Scotland, it is not yet uniform across the UK. This is a matter for Scottish and UK governments to address.
- 3.3 Dr Herbison identifies delays in the transfer of health information, albeit this had no bearing on Danielle's death. She further implies the need for a mandatory process to ensure continuity of health provision to vulnerable children. Both points are matters for the Scottish Executive to consider.

- 3.4 Dr Herbison indicates there was a local issue in that the Health Visitor was not made aware that Tracey and Danielle Reid had registered with the Crown Medical Practice, but again this had no bearing on Danielle's death. The action taken to address this issue is included in the appendix.
- 3.5 The Police are criticised for not automatically notifying other agencies of any intelligence pertaining to a violent or potentially violent perpetrator. The Police currently have no right to release such information, unless there are real concerns about public safety, and only where they are clear about who they are sharing it with and for what purpose. Any change to this situation would be a matter for the Scottish Executive to consider.
- 3.6 Dr Herbison makes a number of criticisms of the Social Work Service, relating to risk assessment, training, computer systems and intervention policies. Again, she does not conclude that any of these had any bearing on Danielle's death. Actions that address these criticisms are detailed in the appendix.
- 4 Conclusions in relation to 3rd point in remit: to examine action taken by agencies following the death of Danielle and up to the discovery of her body**
- 4.1 Dr Herbison states that 'the actions of Social Work and Police [following the death of Danielle] indicate weaknesses in working practice. These did not contribute to the death, but require to be addressed to avoid other children being exposed to unnecessary risk'.
- 4.2 She states that there was inadequate follow-up and recording by Social Work, of a concerning call from a close family member in November 2002, after Danielle's death. Revised procedures are now in place for these matters, as indicated within the actions in the appendix.
- 4.3 With regard to the suggested weaknesses in Police actions, there is acknowledgement of poor initial decision making and that the correct procedures were not invoked by the Officers involved. These Officers were subject to internal disciplinary procedures. Dr Herbison also suggests that Public Holiday and Weekend staffing levels caused a failure to respond appropriately and timeously. There is no evidence that staffing levels contributed to any omissions in the Police response on 31st December, 2002.
- 5 Conclusions in relation to 4th point in remit: to examine how agencies, individually and collectively, have responded following internal management reviews and to comment on the content and outcome of internal management reviews as to whether they cover the relevant issues and any lessons to be learned.**
- 5.1 Dr Herbison states that 'internal management reviews were completed timeously by all agencies' and that they had 'slightly different structures and varying levels of detail.'
- 5.2 She summarises the 'salient points' and indicates that the full text of each internal review will be appended to her report. Her analysis of these reviews is contained in three paragraphs. She says that the reviews were conducted with 'reasonable rigour' but that 'some of the recommendations are not far reaching nor does there appear to be detailed enough action points'. The implementation of actions arising from the internal management reviews are dealt with in the appended schedule under the relevant recommendations of the report.

6 Conclusion

- 6.1 Dr Herbison has concluded that there is little doubt that the violent death of this 5 year old girl was not directly preventable by any of the individuals concerned (i.e. staff employed by agencies concerned with child protection). She does, however, make criticisms of the way in which the various agencies dealt with family concerns about the welfare of Danielle, and actions and information sharing before and after Danielle's death. All Dr Herbison's recommendations have been, or are being addressed as part of the action plan to implement the individual agencies internal management reviews, the recent 2005 inspection of child protection in Highland by government inspectors and the implementation of 'Getting it Right for Every Child'.
- 6.2 Dr Herbison also concludes that if agencies had been operating 'at an optimal level' there might have been some possibility of avoiding her death. This is based on her view that Scotland requires cultural and legislative change, for 'openness and transparency about the needs of our children and a culture of alertness to every child's needs and vulnerabilities, rather than misplaced defensiveness about intrusion into family life'. That optimal level on which Dr Herbison bases this conclusion involves greater supervision of children and greater monitoring of potential offenders than is afforded by current policy and legislation. The balance between managing risk by supervision and monitoring of behaviour and intrusion into family life is a matter for our wider society to take a view about, and for government to legislate and set policy on. The government has recently set out its framework for 'Getting it Right for Every Child' and it is this framework that the child protection agencies in Highland are currently implementing.

RELATED COMMENT FROM INTERNAL MANAGEMENT REVIEWS, EXTERNAL AUDIT & INSPECTIONS	COMPLETED / ONGOING	ACTION <i>CPW</i> refers to action points in Child Protection Workplan	TIMESCALE	RESPONSIBLE
Recommendation 1: A central helpline number for Highland should be established to facilitate ease of access for community members who have any concerns about a child. It should be the responsibility of the receiver of the call to ensure the information is passed to the relevant professional.				
The Child Protection Inspection found a number of positive examples where members of the public had contributed to keeping children safe.	<p>While much has been done to increase community awareness about raising child protection concerns, a central helpline number will be introduced.</p> <p>COMPLETED: All parents of nursery and school-aged children have been written to, and given a central number.</p> <p>COMPLETED: A website provides a further key access point for members of the public, and includes leaflets and related documentation.</p> <p>COMPLETED: Central phone and text numbers are available in the telephone directory.</p> <p>ONGOING: <i>CPW10</i> includes a public awareness campaign, and the central helpline number and system will be included.</p> <p>ONGOING: This will be linked to the Council's proposed single point of access service centre.</p>	<p>September 06</p> <p>September 06</p>	<p>Child Protection Dev. Officer</p> <p>Child Protection Dev. Officer</p>	

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Recommendation 2: The professional contacted through the Helpline must seek information from every key agency immediately before deciding upon a course of action (unless there is a need for immediate child protective action).				
<p>Highland Child Protection Guidance is in line with all national guidance, was noted as such in the external review by Anne Black, and commended in the Child Protection Inspection.</p> <p>The Highland Council Internal Management Review (HCMIR) identified that: guidance should be reviewed to make clear the roles and responsibilities of key staff; staff should be informed of the importance of making information available for child protection inquiries and have copies of the guidance; and that staff should contact the Police whenever there are concerns that a child's safety and well being might be compromised or an offence committed.</p> <p>HCMIR also required a review of the separate guidance available to Social Work Service and Education, Culture & Sport Service staff.</p>		<p>The revision of the Child Protection Guidance in November 2003 enabled reaffirmation of clear statements of the roles and responsibilities of all staff when receiving a referral.</p> <p>COMPLETED: The procedures make clear, when contact is made through a helpline or any similar process, what processes should be followed.</p> <p>COMPLETED: The new procedures were the focus of a series of pan-Highland seminars over late 2003/early 2004, attended by around 1000 staff from agencies across Highland.</p> <p>COMPLETED: The separate guidance available to Social Work Service and Education, Culture & Sport Service staff has been reviewed.</p> <p>ONGOING: Implementation of 'Getting it Right for Every Child' (GIRFEC) in 2006, in partnership with the Scottish Executive, will involve further refinement of these processes. (<i>CPW1</i>)</p>	August 06	Chief Officers

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Recommendation 3: All agencies should review policies and practice to ensure appropriate staff have speedy access to information which may be necessary for adequate early multi-agency needs/risk assessment. This will include e.g. information from Social Workers within Criminal Justice, Addiction Workers, Education staff, General Practitioners, Police, Professionals working with adults who have mental health problems and Professionals working in Accident & Emergency departments.				
<p>HCIMR identified the need for consideration, including as part of national developments, of whether information might be most effectively accessed via a single record.</p> <p>The Child Protection Inspection found that information sharing between professionals was mainly good. Important information was shared sensibly. There were some inconsistencies and shortcomings including occasional inappropriate use of confidentiality as a reason for not sharing information within health. There was lack of awareness among some staff, where child protection was not their central role.</p>	<p>These processes were reviewed as part of the revision of the Child Protection Guidance in November 2003, and subject to a series of multi-agency seminars over late 2003/early 2004.</p>	<p>COMPLETED: The Child Protection Guidance makes clear that all staff have responsibilities to share appropriate information across agencies. For example: 'Criminal Justice workers, social workers in mental health, substance abuse, hospital social workers and child and adolescent mental health staff must work in close collaboration with their colleagues in children and families services about vulnerable children at risk of abuse. All have a duty to contribute to the assessment of risk and to the child protection plan notwithstanding the fact that it might be to adults that they have been providing a service.'</p> <p>ONGOING: These processes are now under further review as part of the implementation of GIRFEC. This will involve a single record, and account will be taken of the further development and possible integration of eCare and eHealth systems. (<i>CPW1</i>)</p> <p>ONGOING: These processes will be further audited. (<i>CPW11</i>)</p>	<p>August 06</p> <p>December 06</p>	<p>Chief Officers</p> <p>Child Protection Dev. Officer</p>

RELATED COMMENT FROM INTERNAL MANAGEMENT REVIEWS, EXTERNAL AUDIT & INSPECTIONS	COMPLETED / ONGOING	ACTION <i>CPW</i> refers to action points in Child Protection Workplan	TIMESCALE	RESPONSIBLE
Recommendation 4: Urgent implementation of a standardised multi-agency needs/risk assessment tool is required. This should not be delayed awaiting further useful Scottish Executive direction.				
<p>The Child Protection Inspection found that assessment of risks and needs was weak overall, although good assessments had been undertaken in some cases and plans were being advanced to improve the situation. While risk assessments were usually carried out, the thoroughness, quality and timeliness of them were variable.</p>	<p>Highland is committed to the introduction of an Integrated Assessment Framework across all agencies, and is working with the Scottish Executive to ensure this is developed on the basis of research and best practice, and can be rolled out across the rest of the country.</p>	<p>COMPLETED: Highland has had a dedicated Team and reference group working on the implementation of the Integrated Assessment Framework since 2004. This includes external consultants who have been involved in the development and implementation of the Department of Health framework.</p> <p>COMPLETED: Risk assessment is a standard component of multi-agency training. An associate of Dundee University provided enhanced risk assessment training for practitioners and all front line managers in the Social Work Service.</p> <p>ONGOING: Further to the publication of 'Getting it Right for Every Child', and in recognition of the progress made within Highland towards integrated services, the authority has been asked to work with the Scottish Executive to lead the national implementation of the Integrated Assessment Framework as part of GIRFEC. (<i>CPW1</i>)</p>	<p>August 06</p>	<p>Chief Officers</p>

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Recommendation 6: Training of all staff should be mandatory according to the tiered model as proposed by the Child Protection Reform Team. This training should include frontline child care workers; managers; those working with adults/adolescents and clerical/administrative staff.			
<p>HCIMR required further audit of child protection training, and that shortfalls should be addressed immediately, as part of a comprehensive programme.</p> <p>The Child Protection Inspection found that all the agencies had given considerable priority to training and significant numbers of staff received training each year, much of it multi-agency and mostly well evaluated.</p>	<p>COMPLETED: Highland CPC's Training Strategy has been based on a tiered model since 2002, and is regularly audited. There are designated staff to support training in each of the lead agencies, and additional funding has been available since 2003 to ensure that appropriate training is accessible to the various target groups.</p> <p>ONGOING: The CPC is reviewing the Training Strategy, taking account of the developing work of the Child Protection Reform Team's Training Sub-group, chaired by Highland Council's Director of Education, Culture & Sport. (<i>CPW14</i>)</p>	March 06	Child Protection Dev. Officer
Recommendation 7: Training should ensure a change of culture within the respective organisations such that issues of vulnerability are identified very early; referred appropriately and information shared freely between all involved at the earliest stage of concern about a child's welfare.			
<p>The Child Protection Inspection identified preventive and early intervention services as a key strength, providing high levels of support to most children and families who needed it.</p> <p>Multi-agency early intervention planning arrangements, and some specific Early Years Services, are commended in the Scottish Executive's 'Sure Start Mapping 2004'.</p>	<p>One of the three core strategic themes in Highland's Children's plan involves 'co-ordinating needs assessment and intervention and targeting services, such that children and young people get the support that is determined by their needs, when they need it, and whereby there are organized processes that promote early intervention.'</p> <p>COMPLETED: Focused investment in Early Years Services, along with Early Years Liaison Groups and support to voluntary sector organisations, has enhanced the capacity to achieve effective early interventions with young children.</p> <p>COMPLETED: Highland CPC's Training Strategy is based on these principles, which are underpinned by the Child Protection Guidance.</p> <p>ONGOING: The CPC is reviewing the Training Strategy, taking account of the developing work of the Child Protection Reform Team's Training Sub-group. (<i>CPW14</i>)</p>	March 06	Child Protection Dev. Officer

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Recommendation 8: Managers within each of the services concerned should develop rigorous and robust audit systems within each agency where there has been any concern re. a child's welfare. Inter-agency audit systems must be developed to identify gaps in appropriate information sharing, documentation and intervention.				
<p>The Child Protection Inspection found that there were some good approaches to reviewing and evaluating work in protecting children and young people. However, overall, these approaches were not sufficiently robust or systematic and there were significant weaknesses.</p>	<p>The Highland Child Protection Committee has identified multi-agency audit and quality assurance as one of its key priorities.</p> <p>COMPLETED: Highland has a well-established process of management and critical incident review.</p> <p>COMPLETED: Audits of practice have taken place on a regular basis in each agency, and have been reported through the appropriate governance structures and the CPC.</p> <p>COMPLETED: Highland CPC published a multi-agency self-evaluation in January 2004.</p> <p>COMPLETED: In January – March 2004, Highland was subject to the most far-reaching inspection of child protection services that had taken place in Scotland, and this led to the adoption of an action plan as part of the Child Protection Workplan.</p> <p>ONGOING: <i>CPW11</i> involves a strategy to ensure co-ordinated, multi-agency approach to audit and quality assurance across the CPC; the review of child protection management information; and an increased focus on monitoring of commissioned services.</p> <p>ONGOING: Northern Constabulary has started a Force-wide audit of individual cases which have been dealt with under Child Protection Procedures and Child Protection Committee guidelines.</p>		<p>June 06</p> <p>Ongoing</p>	<p>Child Protection Dev. Officer</p> <p>Chief Constable</p>

RELATED COMMENT FROM INTERNAL MANAGEMENT REVIEWS, EXTERNAL AUDIT & INSPECTIONS	COMPLETED / ONGOING ACTION <i>CPW</i> refers to action points in Child Protection Workplan	TIMESCALE	RESPONSIBLE
Recommendation 9: Each agency should review their documentation when there is ‘concern about a child’s welfare’. It should be standardised and have a clear Action Plan allocated to a named individual/s. Documentation should include exact descriptive detail re. index child and extended family, as well as logical formulated opinion and Action Plan. It should be signed off at respective levels of responsibility/accountability.			
	<p>Each agency reviewed their documentation as part of the revision of the Child Protection Guidance in November 2003.</p> <p>COMPLETED: The co-ordinating Social Work Service documentation has also been updated.</p> <p>COMPLETED: There has been a further recent review of the Northern Constabulary OP48 document.</p> <p>COMPLETED: A standardised Family Health Record is part of each child's record.</p> <p>ONGOING: This documentation is now under further review as part of the implementation of GIRFEC. (CPW1)</p> <p>ONGOING: Implementation will be audited. (CPW11)</p> <p>ONGOING: The outcomes from the national Health Record pilot will be incorporated into Hall 4 implementation.</p>	<p>August 06</p> <p>December 06</p> <p>Late 06</p>	<p>Chief Officers</p> <p>Child Protection Dev. Officer Child Health Commissioner</p>

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<p>Recommendation 10 & 11: Greater emphasis/priority should be given to children where there is any concern, who have been removed from School or Health Primary Care Registers (the two Universal Service Providers).</p> <p>Proactive systems must be put in place urgently to ensure adequate tracking of vulnerable children. If this, by necessity, requires tracking of the parents of vulnerable children then this should be embedded in legislation, as well as being routine practice of practitioners involved.</p>				
		<p>Highland has implemented as far as it can, but key elements of these recommendations are for national consideration.</p> <p>COMPLETED: Highland Council introduced new procedures for children missing from education as part of the revision of the November 2003 Child Protection Guidance, and these have largely been adopted as a national process.</p> <p>COMPLETED: This information, as well as all new entrants at the start and during each school year, is shared between Highland Council and NHS Highland.</p> <p>COMPLETED: Highland Council has a robust approach to applications for children to be home-educated, in line with national guidance and legislation.</p> <p>COMPLETED: Highland Council has audited practice to ensure it is in line with the 'Safe & We'll' guidance.</p> <p>COMPLETED: NHS Scotland has progressed Missing Family Alerts, and linked this to the children missing from education guidance, alongside issues of sharing information and national tracking processes.</p> <p>ONGOING: <i>CPW12</i> requires each child on long-term exclusion to have a support plan, and an identified officer to maintain an overview of individual children.</p>	<p>Director of ECS</p>	<p>September 06</p>

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<p>Recommendation 12: Transition points e.g. Pre-Birth to Birth, Birth to Pre-School, Pre-school to School, School to School Leaving, must be looked at closely on an inter-agency basis.</p> <p>Inter-agency protocols should be established to ensure:-</p> <p>12.1 Full, early appropriate information is provided by each to another</p> <p>12.2 There is a reduction in duplication/assessment yet enhancement of overt, co-owned and coordinated documentation which is in the best interests of the individual child.</p> <p>This should be audited regularly (yearly) to ensure objective child centered inter-agency decision making which culminates in better outcomes for the child and family.</p>			
	<p>These processes are now under further review as part of the implementation of GIRFEC, including implementation of the integrated assessment framework. (<i>CPW1</i>)</p> <p>COMPLETED: Transition points for children in need are managed through Liaison Group processes.</p> <p>COMPLETED: A Council protocol has been introduced for transitions between children’s services and adult services.</p> <p>COMPLETED: Pathway plans have been developed for children with a range of diagnoses.</p> <p>COMPLETED: A central Social Work & Health children affected by disability has been established.</p> <p>ONGOING: Linkage is being made between the Council transition document and NHS Highland processes within the pathway plans.</p> <p>ONGOING: A dedicated project is considering transition into adulthood for young people with ASD.</p> <p>ONGOING: The CPC is about to consider procedures that link the guidance relating to child protection and vulnerable adults.</p>	<p>August 06</p> <p>December 06</p> <p>February 06</p>	<p>Senior Manager (ASL)</p> <p>Director of Social Work</p> <p>Chief Officers</p>

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<p>Recommendation 13: Detailed Protocols should exist locally for all agencies (both single agency and inter-agency) in relation to alerting critical incidents e.g. near miss child deaths, complex child cases, procedures not followed and deaths of children. The single and inter-agency information/summary and action plans should openly be shared on an anonymised basis with other agencies to learn inter-agency lessons and to effect appropriate change in the best interests of children. The Child Protection Committee should oversee the changes required to effect this and implementation of this recommendation.</p>			
<p>The Child Protection Inspection found good approaches and procedures for reviewing critical cases.</p>	<p>This has been implemented, but further account will be taken of the outcome of the national review of this matter, to which Highland has contributed.</p> <p>COMPLETED: Procedures for such reviews were included in the revision of the Child Protection Procedures in November 2003. COMPLETED: A further protocol has been introduced for the review of critical cases where an adult has mental health needs, that takes specific account of any implications for children if that adult is a parent.</p> <p>ONGOING: Take account of publication of national findings on Critical Incident Reviews.</p>	<p>At publication</p>	<p>Chief Officers</p>

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<p>Recommendations 14 and 15: When there is any contact with regard to “concern about a child”, the Social Work Department should ensure that the child is seen immediately if the call seems urgent and certainly otherwise within 24 hours. The child may be seen by any competent child care professional working within any of the agencies but the information must be fed back to the Social Work Department.</p>				
<p>Timescales must be set for gathering of initial information subsequent to calls of concern about a child. A decision in relation to further action must be made within a maximum period of forty-eight hours, preferably twenty-four hours (assuming the child is not considered to be in immediate danger)</p>				
<p>HCIMR required that specific timescales were set, with linkage between manual and computerised systems, for documenting information and action.</p> <p>The Child Protection Inspection found that there was good awareness among professionals of when children needed help, and that help was usually available when children needed it. When there were immediate or serious concerns that a child might be experiencing harm, social work services and the police took effective action</p>	<p>COMPLETED: Further to HCIMR, the Director of Social Work reaffirmed in an operational instruction, the need to see children in 24 hours where there were immediate concerns about their safety.</p> <p>COMPLETED: The November 2003 Child Protection Guidance states that ‘all children about whom concerns have been expressed will be seen by a social worker, unless the referrer or another professional has seen the child. If a child is not seen the reasons for this should be clearly recorded on the same working day. This decision [about whether or not the referral will be dealt with by means of a child protection inquiry or by the provision of other services] should be made as soon as possible but not later than 24 hours of the receipt of any referral.’ An appendix of the Guidance summarises this pathway and the various further timescales.</p>			
<p>Recommendation 16: Standardised criteria must be set in relation to prioritisation of home visits.</p>				
	<p>COMPLETED: Cases that may indicate concerns about the safety of children are responded to within Child Protection Guidance as indicated above. Other cases are managed as part of children in need processes.</p> <p>ONGOING: Implementation of GIRFEC will ensure that all new concerns about children are assessed within the Integrated Assessment Framework. This will take account of what is already known about a child, before consideration of whether and when any home visit by a social worker might take place. (<i>CPW1</i>)</p>		<p>August 06</p>	<p>Chief Officers</p>

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Recommendation 17: All information held throughout Social Work Services pertaining to a vulnerable child or family must be readily accessible to enable optimal needs and risk assessment.			
<p>The Child Protection Inspection found that there was evidence of considerable improvement in social work record keeping. Greater attention needed to be given to ensure that computerised records and databases were recorded consistently and accessed readily on a 24 hour basis. Some professionals working mainly with adults lacked confidence in identifying child abuse.</p>	<p>COMPLETED: Implementation of the November 2003 Child Protection Guidance was planned with managers across all Social Work Services, and staff from all sectors continue to be involved in training.</p> <p>COMPLETED: The Guidance and associated Social Work Service Child Protection Procedure makes clear that all social work records should be checked as part of a full evaluation of the information available about any child who is referred.</p> <p>COMPLETED: The Child Protection Guidance makes clear that records of child protection concerns must be made within 24 hours.</p> <p>COMPLETED: Further to the internal management review, the Emergency Social Work Standby Team record enquiries and referrals on the same day and communicate details to the appropriate Social Work Team by the start of the next working day.</p> <p>ONGOING: Implementation of GIRFEC will be linked to a review of systems and processes, and improved tools for assessment of children's safety and welfare, within services for adults. (CPW1)</p>	<p>August 06</p>	<p>Chief Officers</p>

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Recommendation 18: Whenever there is any call in relation to concern about a child <u>all</u> key agencies must be contacted to gather any relevant information before a final decision is made in relation to action (unless the need for action is obvious)				
The Child Protection Inspection found that police officers or social workers investigating a child's circumstances at the point of referral did not routinely seek advice or further information about the child from health professionals.		The Child Protection Guidance makes clear that: 'if any member of an agency suspects that abuse has happened, or is happening or is likely to happen contact should be made with the social work service or the police. The social work service and the police provide staff 24 hours a day to investigate suspected or actual cases of child abuse.... Good communication between agencies is essential in child protection work. The need to make sure children are properly protected means agencies must share information promptly and effectively when necessary.' ONGOING: <i>CPW1</i> reaffirms the requirement to involve Health staff in early discussions about concerns about children, and that there is a 'review of current processes, and any necessary amendment to procedures'.	March 06	Child Protection Dev. Officer
Recommendation 19: it is essential that all social workers determine needs and risks to any child according to a standardised needs and risk assessment tool which is also used by other agencies.				
		ONGOING: Highland is working with the Scottish Executive to implement the Integrated Assessment Framework as part of GIRFEC. (<i>CPW1</i>)	August 06	Chief Officers
Recommendation 20: An appropriate chain of handover of cases from one Social Worker to another must be adequately proceduralised. Training must be provided in relation to adequate continuity of care and this must be embedded in social work practice.				
		COMPLETED: There is a formal process in the Social Work Service recording procedures, which requires the line manager to confirm that she agrees 'that this case should be closed and confirm that there is no statutory requirement for Social Work intervention and that there are no known high risk factors'. COMPLETED: Volume training has taken place with Social Work Service staff on updated recording procedures. This includes the standard use of chronologies. ONGOING: The Social Work Service is updating the management procedures for the transfer of cases between Social Workers.	March 06	Head of Operations (SW)

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Recommendation 21: Standardised pro formas should be prepared and should be completed by social workers in relation to any call relating to “concern about a child”. A care pathway should be systematically followed in relation to these cases. The care pathway should be auditable by both Social Work and referring agencies.			
	<p>COMPLETED: The Child Protection Guidance states clearly the roles and responsibilities of Social Work staff in responding to concerns about a child, which are auditable through case files. These processes are further documented in the associated Social Work procedure. Appendix J of the multi-agency Guidance summarises the pathway and the relevant timescales.</p> <p>ONGOING: Highland is working with the Scottish Executive to implement the Integrated Assessment Framework as part of GIRFEC. This will include a clear pathway with recording processes and a standard child record. (<i>CPW1</i>)</p>	August 06	Chief Officers
Recommendation 22: The capability of Social Work computerised support systems must be urgently reassessed. Once an adequate computerised support system is available (which should be made available urgently) staff must be trained in relation to input of standardised information and trained in accessibility to information from all departments throughout Social Work Services; including Criminal Justice and Community Care as well as Children and Families Services.			
	<p>While the Social Services Information Database is has full capability for caseload management, further reporting and management processes, as well as better integration with other agencies, would be achievable through a modernised system.</p> <p>ONGOING: Highland Council is commissioning a new electronic information system, which will have a planned implementation process.</p> <p>ONGOING: The new SW information system will contribute to the associated pan-Highland and national eCare developments as these roll out.</p>	<p>End 2006</p> <p>With eCare developments - prov. 2007</p>	<p>Director of Social Work</p> <p>Director of Social Work</p>

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Recommendation 23: It should be made absolutely clear by senior management that there is no pressure to ‘de-register’ children. It should equally be made clear that allocation of Social Workers should be purely on the basis of standardised assessment of needs and risk which should be completed for all children where there is a ‘child welfare concern’ (whether they are on a Child Protection Register or not).				
<p>The Child Protection Inspection found that new provision such as children’s services workers had strengthened the role of social work services. However, qualified social workers were less likely to be available to intervene early, both because of the demands of more complex cases and because of staff shortages in some areas. A welfare concern sometimes had to wait a considerable time before a social worker was allocated.</p> <p>Highland has consistently had more children per thousand on the child protection register than the Scottish average. In 2001/02 the Highland rate was 2.7, compared to a Scottish average of 2.0. In 2004/05, the Highland rate had increased slightly to 3.0, compared to a Scottish average of 2.3.</p>	<p>The Child Protection Guidance is based on best practice models and needs assessment. There has never been implicit or explicit pressure to ‘de-register children’.</p>	<p>COMPLETED: Highland has however over a period of years registered more children than many other authorities, and in particular has registered more children for ‘emotional abuse’. Appropriate work has been undertaken to understand the reasons for this, including a series of inter-agency seminars and a major conference, and an audit of cases and procedures by external consultant Ann Black, with conclusions that do not concur with Dr Herbison’s.</p> <p>COMPLETED: Between 2003 and 2005, the Social Work Service has appointed Senior Family Liaison Officers, Children’s Services Workers and Early Years Workers across every Area of the authority, to support the robust management of children in need cases. This involves an increase of 20% in the number of qualified staff working with children and families, at 123 Social Workers.</p> <p>ONGOING: Implementation of GIRFEC will further align workload management processes within the Social Work Service to needs assessments and ongoing work with children. (<i>CPW1</i>)</p>	<p>August 06</p>	<p>Chief Officers</p>

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Recommendation 24: The most experienced workers with vulnerable families should be involved in determining, at a very early stage, how much information has been sought, what information still requires to be sought, and what inter-agency plan should be put in place with regards to these families. This should not be left to untrained workers or junior staff and should not be dependent on a rather ad hoc supervision system.				
<p>HCIMR reaffirmed the responsibilities of Social Work managers in child protection inquiries.</p> <p>The Social Work Trainee scheme won a CoSLA Quality Award in 2005.</p>		<p>COMPLETED: The Child Protection Guidance and associated Social Work Service Child Protection Procedure make clear that it is the responsibility of senior staff to: ensure all referrals are allocated and responded to; make or co-ordinate enquiries following a referral; evaluate all the information gathered and decide what action is necessary to meet the child's immediate needs and reduce the risk of further harm; ensure referrals are appropriately signed off where full implementation of the procedures and a case conference is not deemed necessary; make recommendations whether cases should proceed to case conference and when consideration may need to be given to emergency measures; supervise and support the social worker during the assessment and investigation.</p> <p>COMPLETED: Highland Council appointed five Senior Child Protection Practitioners and a Child Protection Policy Officer in 2003 to enhance the level of specialist knowledge and advice available to staff across the authority.</p> <p>COMPLETED: Social Work Trainees are managed and supervised within an explicit support structure.</p> <p>COMPLETED: Highland Council has approved an enhanced social work structure in the Inverness area, involving additional management, senior practitioner and front line staff, and a realignment of boundaries and working processes as part of the further integration of services.</p> <p>ONGOING: Implementation of GIRFEC and the enhanced structure in Inverness will both involve a re-examination of referral processes.</p>	August 06	Chief Officers

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Recommendation 25: Senior supervision of Social Work staff must be rigorous and well documented with copies provided in every case to both the senior social worker and the social worker involved.			
The Child Protection Inspection found that staff in social work did not always receive sufficient support or line management in supervision.	<p>COMPLETED: The Social Work Service procedure on supervision states that it must be held at least 4 weekly (2 weekly for staff in their first year) and recorded with copies provided within 14 days.</p> <p>ONGOING: Supervision practice in the Social Work service is audited, and will be included in quarterly reports to the Chief Executive.</p>	February 06	Director of Social Work
Recommendation 26: A review of potential evolving breakdown in trust/communication between social work senior management and frontline staff and vice versa is advisable.			
<p>The Child Protection Inspection found that leadership of the individual organisations was mainly good. Chief Officers were generally visible, energetic and enthusiastic in their commitment to continuous improvement of child protection services. Practice on the ground had not always kept pace with the objectives of chief officers. Some front line staff were concerned by the pace of change, feeling that there was insufficient appreciation amongst senior managers of the demands they experienced.</p> <p>The Social Work Services Inspectorate Annual Report in 2003 identified good support for social work staff. Annual staff surveys by the Highland Council do not indicate lack of confidence of senior managers in Social Work. Neither did the 2003 Peer Group Review, or the 2005 Audit Scotland Best Value Study.</p>	<p>COMPLETED: Support for frontline staff has been a longstanding priority in the Social Work Service Plan. In relation to this, the Director of Social Work initiated a series of consultations with staff in 2004 and continues to lead this process. There is an ongoing Support for Frontline Staff Action Plan. Highland has also been an active participant in the related national ADSW initiative.</p> <p>COMPLETED: The Director of Social Work, Head of Operations and Area Service Managers meet frontline staff in each Area of Highland on an annual basis. This process complements regular visits to individual services.</p>		

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Recommendation 27: The 'ViSOR' system should be fully implemented urgently throughout Scotland in order to track violent, dangerous and sex offenders.			
	<p>COMPLETED: ViSOR was introduced to Northern Constabulary during February, 2005. It is now fully operational within the Force Sex Offender Unit.</p> <p>ONGOING: Network ViSOR throughout the Force on an encrypted network as the material it carries is classified as confidential.</p>	End of 2006	Chief Constable
Recommendation 28: All police information in relation to violent offenders, including Police intelligence, should be made readily available to other agencies at the earliest stage, especially to agencies who have major responsibilities in the care and protection of children (e.g. Social Work, Health, Education)			
The Child Protection Inspection found the knowledge, commitment and joint working of professionals whose task was Child Protection as a key strength and that information sharing was mainly good.	<p>COMPLETED: The Northern Constabulary has an information sharing protocol with the Highland Council and NHS. This was incorporated into the review of the Child Protection Guidance.</p> <p>COMPLETED: The Northern Constabulary has run a series of multi-agency information sharing days</p>		
Recommendation 29: An improved recording system must urgently be put in place which provides and audit trail of decisions and clear accountability. This is particularly required in relation to supervisors from Sergeant through to Superintendent level.			
	<p>A formal recording system exists for both missing persons and child protection enquiries.</p> <p>COMPLETED: OP/51/07 Missing Person Log and OP/56/37 Child Protection Case Review Sheet are firmly embedded within Force Reference Documents and are subject to at least annual review.</p>		

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Recommendation 30: Intensive training is required such that Police Officers are clear on processes that they should follow, e.g. in relation to reports such as occurred on Hogmanay. Appropriate escalation of enquiry very much depends on the understanding and interpretation of facts as they are reported. This in particular applies to Police supervisions/managers.			
	Northern Constabulary accepts that the decision making of some individual officers was less than satisfactory. COMPLETED: Individual Officers who were assessed to have made errors in terms of policing were dealt with through the structured Force discipline procedures.		
Recommendation 31: Northern Constabulary must urgently review the gap which exists between policy and practice. This is particularly in relation to serious inquiries, including Missing Persons, Child Protection and potential murder inquiries.			
	The Constabulary has reviewed the situation and taken management action, and does not conclude there is a gap between Force policy and practice. COMPLETED: Individual Officers who were assessed to have made errors in terms of policing were dealt with through the structured Force discipline procedures.		
Recommendation 32: C.I.D. coverage on Public Holidays should be reviewed to ensure that the presence of at least Detective Inspector to review crimes, missing persons and other reports normally assessed on other days of the year.			
	COMPLETED: A review of the CID coverage on Public Holidays took place. It was found that there was sufficient CID coverage in place at the time and that it continues to be sufficient on Public Holidays.		
Recommendation 33: The Crime Management Unit and the Central Child Protection Unit should have Duty Officers performing usual routine tasks 365 days of the year.			
	COMPLETED: The Force is satisfied with the current level supplied. A Child Protection Officer is on-call 24/7/365.		

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Recommendation 34: The Area Commander briefing meeting should occur 365 days of the year.			
<p>A 2005 independent review of the implementation of the National Intelligence Model within Northern Constabulary found that the briefing and tasking process was effective.</p> <p>Her Majesty's Inspectorate of Constabulary for Scotland Primary Inspection 2005 commented that the Force makes good use of the National Intelligence Model and Tasking and Co-ordinating Meetings are held daily within each Area Command.</p>	<p>COMPLETED: Daily tactical and tasking meetings take place within each Area Command, Operational Support and Crime Support. Weekly or fortnightly tactical and tasking meetings take place in the Area Commands which are fed to a monthly Force tactical tasking and co-ordinating group meeting.</p>		
Recommendation 35: The entire computerised IMPACT system must be reviewed urgently and adapted to allow continuity of documentation by all involved and appropriate audit.			
	<p>ONGOING: A Command and Control system has partially replaced IMPACT. An ongoing replacement programme exists in relation to the IMPACT computer system.</p>	No set date	Chief Constable
Recommendation 36: An automatic flagging system for 'daily reports' should be introduced. The system must be auditable in terms of inputs and changes to input.			
	<p>ONGOING: A Command and Control system has partially replaced IMPACT. An ongoing replacement programme exists in relation to the IMPACT computer system.</p>	No set date	Chief Constable
Recommendation 37: A more standardised robust process should be drawn up for Police Management Reviews. All relevant detail, including notes, contemporaneous notes in various files and notebooks as well as formal statements should be gleaned and presented to the independent reviewer.			
	<p>ONGOING: It is understood that guidance will be included in the national findings on Critical Incident Reviews.</p>	At publication	Chief Constable
Recommendation 38: The speed with which an OP/48/1 form is delivered to the Reporter must be increased. It should be made available			

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to the Reporter within twenty-four hours of the incident.			
	<p>COMPLETED: Further guidance has been provided on the use of OP/48/1's.</p> <p>ONGOING: The submission time in relation to OP/48/1's are audited monthly and the results are given to respective Area Commanders.</p> <p>ONGOING: The referral process to the Reporter is currently being reviewed as part of 'Getting it Right for Every Child' to which Northern Constabulary are committed with partner agencies.</p>	<p>Will continue to be ongoing</p> <p>August 06</p>	<p>Chief Constable</p> <p>Chief Officers</p>
Recommendation 39: The senior officers on duty overnight should perceive their duties to be of equal weight and responsibility to those officers of similar rank during day time hours. Documentation should be equivalent and detailed in relation to rationale, decision-making and action.			
	This is established practice.		
Recommendation 40: Police should be involved in all discussions at an early stage in relation to potential concern about a child's welfare. This should not only occur once there are 'Child Protection concerns'.			
The Child Protection Inspection found that assessment of risks and needs was weak overall, although good assessments had been undertaken in some cases and plans were being advanced to approve the situation.	<p>Northern Constabulary will at all times discuss and child's welfare with partner agencies wherever there is potential risk to a child or criminality.</p> <p>COMPLETED: The Child Protection Guidance makes clear that all Officers have responsibilities to share appropriate information across agencies.</p> <p>COMPLETED: Highland has had a dedicated team and reference group working on the implementation of the Integrated Assessment Framework since 2004. The Police are involved in this group.</p>		
Recommendation 41: A robust national system to timeously track transfer of pupil records must be established in the United Kingdom.			

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<p>HCIMR required the Education, Culture & Sport Service to establish a policy that triggered enquiries about children missing from education within 10 days.</p>	<p>Highland has implemented as far as it can, but this is for national consideration.</p> <p>COMPLETED: The Scottish Children Missing from Education system was implemented in August 2005, further to practice that became operational in Highland in November 2003.</p>		
<p>Recommendation 42: There must be immediate transfer of information between Education and Health and between Health and Education, if it becomes known that a child has potentially moved from the area.</p>			
	<p>COMPLETED: An operational instruction was issued by the Director of Education, Culture & Sport in September 2005, to confirm that enrolment data should be shared with School Nurses, and that the Pupil Transfer Form should be used to inform them of children who change schools, including those who leave the area. This built on the practice established in November 2003.</p> <p>COMPLETED: Improvements in tracking of children and families across primary health care is being developed nationally and includes communication with partner agencies. School nurses already utilise the children missing from education system.</p> <p>ONGOING: Consideration is taking place about how the children missing from education system might extend into pre-school.</p>	<p>August 06</p>	<p>Joint Head of Service</p>
<p>Recommendation 43: When referrals to Social Work and to the Reporter to the Children's Hearing are made by Education staff, this should</p>			

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<p>be automatically notified to the Health staff involved, in particular School Nursing staff and/or School Doctors, in the first instance. Likewise, if Health refer to the Reporter/Social Work, this should be notified to Education. This should be made easier by a report form, which has multiple copies set to the respective agencies, and indeed to a named contact within respective agencies.</p>				
	<p>This has been implemented.</p> <p>COMPLETED: While there may be initial consultation between teaching staff and school health staff, the Guidance makes clear that child protection concerns should normally be raised immediately with the Social Work Service, and further enquiries will then be co-ordinated through that agency.</p> <p>COMPLETED: Child welfare concerns are routed to the Social Work Service through established liaison arrangements that involve the Health Service in joint decision making. Education staff would routinely involve Health Services wherever there are health related issues.</p> <p>COMPLETED: It is established policy that referrals to the Reporter from Health and Education should be joint (with Social Work) and based on inter-agency liaison arrangements.</p> <p>COMPLETED: Where there are child protection concerns, but a referral has not already been made to the Reporter, the Reporter will accept the documentation from a child protection case conference as a new referral.</p> <p>ONGOING: Implementation of GIRFEC will ensure that all concerns about children are assessed within the Integrated Assessment Framework and managed through an explicit pathway. It is envisaged that the test for appropriateness of compulsory measures would continue to be effected as part of liaison arrangements. This will involve standardised recording processes including a child record. (<i>CPW1</i>)</p>	<p>August 06</p>	<p>Chief Officers</p>	
<p>Recommendations 44 & 45: It is crucial that figures on poor attendance of children and frequent changes of address of children should be</p>				

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<p>added to the current list of risk factors raising concern about potential Child Protection issues.</p>				
<p>Schools should become increasingly alert to erratic attendance and to the emergence of particular patterns of non-attendance, which should flag concern in relation to a child's welfare. Adequate systems to for early identification of these factors should be put in place urgently.</p>				
<p>HCIMR reaffirmed that Headteachers should investigate any pattern of absence, and follow up as necessary with other agencies.</p>	<p>COMPLETED: There is a formal alert process within the Education, Culture & Sport Service that is triggered where a pattern of absence is established over a period of time.</p> <p>COMPLETED: Absence from school, is a routine factor for referral through staged intervention processes, including to a liaison group.</p>	<p>ONGOING: The Integrated Assessment Framework will confirm poor attendance at school and frequent changes of address as among the risk factors that may cause concern about a child's welfare or safety. (<i>CPW1</i>)</p> <p>ONGOING: Consideration will be given to the formalisation of checks on these risk factors when new pupils join schools, having come from outwith the Highland area.</p>	<p>August 06</p> <p>August 06</p>	<p>Chief Officers</p> <p>Director of Education, Culture & Sport</p>
<p>Recommendation 46: All contacts concerning information about vulnerable children, by any agency to the Education services, should be made with the teacher and/or head teacher and not with administrative staff.</p>				
	<p>COMPLETED: The Child Protection Guidance makes clear that the designated person with responsibility for child protection In a primary school is the head teacher. In secondary schools the designated person is the head teacher or the member of the senior management team who has responsibility for 'support for learning'. This is reinforced in all school staff training.</p>			
<p>Recommendations 47 & 48: Education staff must be trained to impart information readily with other agencies, preferably within a system</p>				

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of designated contacts. This should not be personality dependent, nor should it depend on whether the child is already within the current formalised 'Child Protection' process.				
The Child Protection Inspection found that Liaison Groups used positive, solution focused approaches well to establish programmes of support for pupils experiencing a wide range of difficulties. There was a staged approach to intervention and planning leading from liaison groups, through area children's forums to child protection case conferences and children's hearings.	COMPLETED: There are established liaison arrangements in Highland for discussion between Education staff and other agencies about child welfare concerns. School staff are expected to be fully involved in needs and risk assessment.	COMPLETED: The process and responsibilities of staff with regard to child protection concerns are documented in the Child Protection Guidance, and reinforced in training. COMPLETED: The Education, Culture & Sport Service has introduced the role of Child Protection Champions, to support school staff who wish to discuss any issues they may have in progressing concerns about the safety of a child.		
Recommendation 49: Nationally, urgent attention must be given to an improved system of transfer of notes in relation to a child's Health and Welfare. Delays of transfer between Health Board areas in Scotland are simply unacceptable.				
The NHS Internal Management Review (NHSIMR) required that requests for medical records from outwith the area should be followed up to ensure they are received.	COMPLETED: The National Missing Family Alert protocol has been developed and has established protocols to link with the children missing from education guidance; albeit, this refers only to sharing information about children where there are deemed to be concerns about the risk of 'significant harm'.	ONGOING: NHS Highland is reviewing processes for transfer and tracking of records in line with current systems across Scotland and the rest of the UK.	August 06	Director of Community Care
Recommendation 50: Information must be readily available from all elements of the Health Care System when a concern is raised about a				

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child's welfare. This includes information from Adult Mental Health Services, Adult Learning Disability Services, Addiction Services, General Practice and Accident & Emergency Departments. There should be no impediment to the free flow of such information to enable adequate needs and risk assessment.			
NHSIMR required that all referrals to Community paediatricians be acknowledged.	<p>COMPLETED: Local and national Child Protection Guidance makes clear the requirement to share information across the Service when there are concerns about possible risk to children. Where parental permission is not granted to share information about welfare concerns, professionals must make judgments about the implications for a child's welfare or safety.</p> <p>COMPLETED: All referrals to Community Paediatricians are acknowledged.</p> <p>ONGOING: Implementation of GIRFEC, in partnership with the Scottish Executive, will involve further refinement of these processes. (CPW1)</p>	August 06	Chief Officers
Recommendation 51: Early sharing of Health information must be routine. Scottish Executive may have to consider legislative change to allow disclosure of vital Health information particularly pertaining to the parents/carers as well as the child in the interests of protection of vulnerable or at risk children.			
	The Child Protection Guidance makes clear that information should be shared. This recommendation implies further developments that are for national consideration, in part reflecting the work progressed since the HMIE Child Protection Inspection pilots.		
Recommendation 52: Training will be necessary to change the culture within Health Services to ensure that this information is not withheld until there are formal 'Child Protection' procedures.			
	<p>COMPLETED: Training makes clear the need to share appropriate information on an intra- and inter-agency basis.</p> <p>COMPLETED: Health staff, particularly Health Visitors, Midwives and School Nurses, but also adult services are involved in liaison arrangements with other agencies.</p>		
Recommendation 53: Health Professionals should be full participants in completing multi-agency standardised needs/risk assessment			

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documentation in relation to any child where there is concern. This should be completed at the earliest possible opportunity with a time scale not greater than twenty-five days (obviously within days if the case is more urgent)				
	<p>COMPLETED: These processes are identified as a priority for all health professionals. GPs are entitled to back-fill/payment to attend case conferences.</p> <p>ONGOING: GIRFEC will involve the implementation of the Integrated Assessment Framework alongside Hall 4 implementation. This will include consideration of timescales. (<i>CPW1</i>)</p>		August 06	Chief Officers
Recommendation 54: A standardised referral form from all Health Professionals to Social Work should not only be made available but audited at regular intervals. Training requires to be undertaken to bridge the gap currently between policy and practice in this area.				
	<p>The new guidance and subsequent training has emphasised the need to make use of the standard documentation.</p> <p>COMPLETED: Audit confirms the improved use of the standardised form to confirm concerns, that should have been reported initially in the most effective and efficient manner (usually verbally).</p> <p>COMPLETED: The Accident & Emergency Department at Raigmore Hospital and the Keeper of the Register have agreed a process for sharing information and ensuring more effective access at the point of admission to A&E, which will be further developed across Highland's emergency centres in line with ICT developments.</p>			
Recommendation 55: It is imperative that key Health Professionals, in relation to the care of children mandatorily attend training events				

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and are audited in relation to practice. This should include e.g. General Practitioners, Medical Health Professionals (who are currently attending very few training events in Highland)			
	<p>Highland Child Protection Committee's Training Strategy has been based on a tiered model since 2002, and is regularly audited.</p> <p>COMPLETED: There are designated health staff to undertake training, which is mandatory in respect of induction.</p> <p>COMPLETED: Mental health workers are involved in single agency and inter-agency training.</p> <p>COMPLETED: A support structure has been introduced to enhance training opportunities for General Practitioners, which includes GP designated persons in each Community Health Partnership.</p> <p>COMPLETED: One-day child protection training for GPs has been run annually for a number of years, and a similar annual half-day course for GP Principals as part of GP refresher training.</p> <p>COMPLETED: Medical personnel in acute services have been included in the rolling child protection training programme since 2004.</p>		
Recommendation 56: At a point of registration with the General Practitioner, the Health Visitor should immediately be informed. There should be free flow of information between General Practitioner and Health Visitor at all times, particularly in relation to a child where there is any Child Welfare concern.			
NHSIMR required that GPs inform Health Visitors of new children moving into the area.	<p>This has been implemented.</p> <p>COMPLETED: The Area Medical Committee, which is a sub-committee of the NHS Board, has been tasked with reaffirming this with General Practitioners.</p> <p>ONGOING: Implementation will be audited</p>	May 06	Director of Community Care
Recommendation 57: There should be a 'flagging' system, preferably computerised, for potentially vulnerable children within the Primary			

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Care setting.			
	<p>A flagging system for each Health Visitor has always existed in 'cause for concern' processes</p> <p>ONGOING: Hall 4 will be implemented as part of GIRFEC, and account will be taken of the further development and integration of eCare and eHealth systems. (CPW1)</p>	August 06	Chief Officers
Recommendation 58: When a potentially vulnerable child leaves the Practice there should be a National system in place to proactively ensure that the child is registered with another Practice within a period of fourteen days. This will require the cooperation of other agencies and the DHSS.			
	<p>This recommendation is largely for national consideration.</p> <p>COMPLETED: The National Missing Family Alert (MFA) protocol has been developed and linked to children missing from education guidance; albeit, this refers only to sharing information about children where there are deemed to be concerns about the risk of 'significant harm' – which allows for a 3 month period between registering with one GP and another.</p> <p>COMPLETED: The MFA also allows for immediate referral to police as deemed appropriate by the health professionals involved – supervised by the nurse consultant for child protection within each NHS Area.</p> <p>ONGOING: The MFA will be audited as a system.</p>	From February 06	Scot. Exec. Health Dept. Working Gp/ Child Protection Lead Nurse
Recommendation 59: Documentation of Health Visitors should be standardised and should include information in relation to the family			

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and extended family. Various models are available, including the family plan and home score.			
NHSIMR required standardised family health documentation.	<p>Family assessment was always undertaken, but a standardised tool has been introduced.</p> <p>COMPLETED: A standardised Family Health Record is part of each child's records.</p> <p>ONGOING: Hall 4 will be implemented as part of GIRFEC, and account will be taken of the further development and integration of eCare and eHealth systems. This will take account of a national Health Visitor record that will be piloted in 2006 and evaluated by Strathclyde Caledonian University.</p>	August 06	Chief Officers
Recommendation 60: At the crucial transition point between Pre-School and School Health Services, the Health Visitor should meet the School Nurse fact to face and report detail in relation to individual cases. This should also be fully reported by transfer of documentation. It is important that Health Visitors continue to document in records up until the first day of school terms so there is no gap in coordination of care.			
NHSIMR required the audit of handovers between Health Visitors and School Nurses.	<p>This is established policy.</p> <p>ONGOING: Handovers between Health Visitors and School Nurses will be audited in 2006, for the second consecutive year.</p>	March 06	Child Protection Lead Nurse
Recommendation 61: Further appraisal should take place in relation to the adequacy of contact between School Health Service and in particular, the Pre-School Education Service to allow early free flow of information and build up of relationships to enable integrated working in the child's best interests.			
	<p>COMPLETED: Health Visitors and School Nurses are involved in liaison arrangements with school staff and other agencies.</p> <p>ONGOING: The co-ordinated implementation of Hall 4 and GIRFEC will involve a review of existing liaison processes. (CPW1)</p>	August 06	Chief Officers
Recommendation 62: There should be a Central Health Number such that Social Work and Police can contact to obtain <u>all</u> appropriate			

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Health information in relation to a child where there is concern and/or discuss the need for appropriate Health assessment of the child. This discussion should also determine who should carry out such an assessment, where that should be and at what time it should be conducted i.e. whether it is urgent/non urgent.			
	<p>Child Protection Guidance indicates the appropriate process for information sharing between agencies.</p> <p>ONGOING: These processes are now under further review as part of the implementation of GIRFEC. (<i>CPW1</i>)</p> <p>ONGOING: These processes will be further audited. (<i>CPW11</i>)</p>	<p>August 06</p> <p>December 06</p>	<p>Chief Officers</p> <p>Child Protection Dev. Officer</p>
Recommendation 63: Accountability structures require to be rigorously audited to ensure that all Health Professionals are absolutely clear as to their line management accountability in relation to vulnerable and at risk children.			
<p>The Child Protection Inspection found that leadership of the individual organisations, including NHS Highland, was mainly good and effective, although staff in health did not always receive sufficient support or line management.</p> <p>NHS Highland's framework for child protection is cited in NHS Greater Glasgow's Review of Child Protection as a model to emulate.</p>	<p>COMPLETED: Lead Nurse for child protection supports Designated Persons - health professionals with dedicated and protected time - have been resourced and identified for every CHP and local authority area. This system supports all health staff, including GPs. There are also designated GPs.</p> <p>COMPLETED: A lead paediatrician for child protection supports other paediatricians; paediatricians have an identified Lead Consultant to support their work.</p> <p>COMPLETED: The new GMS contract enables the monitoring of quality and outcomes.</p> <p>ONGOING: In response to HMle Child Protection Inspection, NHS Highland will audit current accountability structures, particularly in relation to dedicated time for reflective supervision.</p>	<p>Ongoing</p>	<p>Director of Community Care</p>
Recommendation 64: Systematised out-of-hours cover for specialist medical examination of children referred by Social Work and/or Police needs to be provided urgently. Other staff members should be trained to deliver an adequate rota cover.			
<p>The Child Protection Inspection found that the forensic medical service had not worked well in some cases, and that arrangements for providing medical examinations should be reviewed and improved.</p>	<p>ONGOING: Adequate rota cover for a systemized out-of-hours service is being put in place.</p> <p>ONGOING: <i>CPW7</i> is that arrangements for providing forensic medical examinations should be reviewed and improved.</p> <p>ONGOING: <i>CPW8</i> requires clear and agreed implementation of 'A Shared responsibility' guidance for other medical examinations.</p>	<p>February 06</p> <p>April 06</p> <p>June 06</p>	<p>Director of Community Care</p> <p>Chief Constable</p> <p>Chief Executive, NHS Highland</p>
Recommendation 65: Discussion should continue to ensure there is a General Lead Practitioner within each Community Health			

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Partnership on vulnerable and at risk children. These individuals will be an invaluable resource to other General Practitioners.			
	<p>COMPLETED: There is a trained Lead GP within each Community Health Partnership for vulnerable and at risk children.</p> <p>COMPLETED: There is a Child Protection Lead within each Community Health Partnership management team for vulnerable and at risk children, who sits on the NHS Child Protection Action Group.</p>		
Recommendation 66: More resources require to be given in relation to positive parenting initiatives in relation to vulnerable children. There should be further resources made available from Health, but this in future should be resourced in the main from inter-agency child protection resources.			
<p>The Child Protection Inspection found that there was a wide range of helpful parenting programmes and support groups available.</p> <p>One of the three core strategic themes in Highland's Children's plan involves 'providing sustainable community based services that support families to best look after their own children.'</p>	<p>COMPLETED: A range of parenting programmes has been established across Highland over the last five years.</p> <p>COMPLETED: A Parent Programme Co-ordinator was appointed in 2005, to ensure effective use of these programmes, and develop further evidence-based materials. This post is replicated at a local level in a number of areas.</p>		
Recommendation 67: A robust process must be put in place for any Health Professional to alert, if necessary, a critical incident in relation to process failures re: service to a vulnerable or at risk child. This process should dovetail with Inter-Agency Critical Incident Analysis.			
	<p>COMPLETED: There is a clear process for all Health Professionals to alert managers to the need for a critical incident review. It is a management decision, and with regard to the inter-agency procedures it is the decision of the Chair of the CPC, as to whether a review should take place.</p>		
Recommendation 68: The current review of the Children's Hearing system should be asked to consider the matters raised by this inquiry, and in particular the role of the Principal Reporter as a focal point for reporting concerns about a child potentially in need or at risk.			
	<p>Highland is working with the Scottish Executive to implement GIRFEC, with full involvement of SCRA.</p> <p>ONGOING: These matters can be considered with the Scottish Executive as part of implementation of GIRFEC in Highland.</p>	August 06	Chief Officers

