Councillors: Amin, Corrick, Davies, Hare and Rice

Apologies: None

Also Present: Sylvia Chew and Iain Lowe

MINUTE NO.	SUBJECT/DECISION	ACTON BY
CSPAP C1	APOLOGIES FOR ABSENCE	
	None	
CSPAP C2	URGENT BUSINESS	
	There were no items of urgent business.	
CSPAP C3	DECLARATIONS OF INTEREST	
	None.	
CSPAP C4	MINUTES	
	The minutes of the 11 April 2011 were agreed as an accurate record of the meeting.	
CSPAP C5	MATTERS ARISING	
	It was noted that Graham Badman, the Chair of the LSCB, had been unable to attend this meeting due to annual leave arrangements. Members were informed that he had been invited to the next meeting of the Committee on the 13 September. Members were asked to consider an earlier start time to the meeting to enable the attendance of this key partner to provide information on the role of the LSCB and how various safeguarding groups fit together. His input would also aid a wider discussion on the safeguarding context in Haringey. The meeting would also include a presentation from the Deputy Director for Children and Families on the safeguarding plan and a separate report on the safeguarding monitoring framework. It was agreed to ask the Chair of the LSCB if he could attend at 6.30pm. It was further agreed that the previous action of inviting a representative from health to this discussion should be followed up.	Clerk

CSPAP C6

THE MUNRO REVIEW OF CHILD PROTECTION

The Committee noted that Eileen Munro had been commissioned by the Coalition government to undertake a review of child protection and make recommendations on how the system could be improved. Munro had compiled two previous reports, the first report was a system analysis of the current child protection system and how it had evolved and been shaped by key driving forces. The second report had looked at how the system could be reformed to keep focus on the child's experiences from needing help to receiving it. The final third report from Munro brought together the issues arising from the first two reports. The Independent Member of the Committee had compiled a summary of Munro's final report which contained proposals for changes to the child protection system. The key components of these recommendations were developing social work capacity; ensuring children were communicated with, and that the child was at the centre of the organisations process.

The Committee further learned that Munro had found the current Child Protection system to be reactive instead of proactive. The performance management culture had the impact of an organisation focussing on process and targets rather than outcomes for children and families. Also the current system did not take account of a child's experiences. The following key recommendations from the Munro report were set out by the Independent Member:

- A new system for child protection which is child focused
- The family is the best place to bring up children
- Helping children and families involves working with them Social workers will enter the field of social work with the aim of helping families and the system should allow the social worker to do this in a better way.
- Early help is better for children prevention and early intervention is the best way to help children in the long run
- Children's needs and circumstances are varied so the system should be flexible and offer variety good professional practice is informed by knowledge of the latest theory and research workforce needs to be informed by the latest knowledge and research -
- Uncertainty and risk are features of the work there was a need to assist social workers exercise their authority
- The measure of success of child protection systems is whether children receive effective help. - There should be a focus on principles that underpin good practice and it should be clear what children services and social workers are accountable for. There should also be better ways of helping staff working in child protection understand when the systems should be improved.

The review also outlined the following areas for reform:

Value given to professional expertise

- Clarification on accountabilities and creation of a learning system
- Shared responsibility for the provision of early help
- Developing social work expertise
- Organisation supporting effective social work practice

In considering the information from the Munro report the Independent Member advised the Committee that it was important to keep in mind that there was not an exemplary children's service structure for local authorities to follow. The best way forward for local authorities was being aware of and making use of the best aspects of each others organisational forms

The Munro report also contained details of how the recommendations could be implemented; these were set out in pages 11 and 12 of the agenda pack. It was noted that a Government's response to the review had just recently been published and was agreed that this information would be circulated to Committee Members.

A proposal, in the Munro report, pertinent to the remit of the Committee was for local authorities to set local performance indicators . This would include the local authority setting timescales for when initial assessments and core assessment were completed and deciding what other areas of children's work should be monitored.

The Committee noted the recommendation for serious case reviews to not be marked by Ofsted and learned that the council were already trialling other SCR methodologies with thought also being given to the timescales around completion of SCR's.

The Committee felt that clarification would be needed in future on which level of the Children's services management structure the principal child and family social worker would be placed. It was noted that to be a Deputy Director of Children and Families service already required a social work qualification. However it was envisaged that this would be a separate post in the structure.

In response to a query on the current reporting lines of the LSCB's annual report, it was noted that the report was due to be signed off by the LSCB at their meeting in September and considered by the Children's Trust at their meeting in October.

A recommendation of the Munro report outlined the protection of the discrete roles held by the Cabinet Member for Children's services and Director of Children's services. The Committee commented that this would be an important recommendation for the local authority to keep in mind particularly at a time when other local authorities were examining the possibilities of merging their Children's and Adults services.

CSPAP C7 **AUDIT PLAN 2011-2012**

SC

The Committee had, since its inception, undertaken a number of audits into safeguarding practice. They had been useful in highlighting practice issues for both Members and officers and had been part of changing practices and improving communication with service users and other agencies. The Independent Member of the Committee completed the audits on behalf of the Committee.

There was an audit plan put forward for the Committee to consider which proposed that referrals to the safeguarding team from a particular week in July were examined by the Independent Member and her findings reported back to the Committee in September. The Chair agreed that referrals received in the week beginning the 11th July be examined.

HC

It was agreed that there would be a domestic violence related audit that would focus around under two year olds living in households where domestic violence was a feature. The findings of this would be reported to the November the 3rd meeting.

HC

There would be a follow report on the progression of the case referrals considered in July to the December 12th meeting.

HC

At the January meeting the Committee would consider an audit of cases where the child was subject to a child protection plan. It was agreed to decide the audit theme for the March meeting in the new year.

AS

CSPAP C8

OFSTED INSPECTION MILESTONE REPORT

The Committee considered the progress against key tasks and milestones for safeguarding and children in care following the most recent Ofsted inspection.

In relation to action 1.2, arising from the Ofsted recommendation that the attendance of children at child protection review medicals should be reviewed and monitored, Paediatricians were now able to review Framework I files and speak with social workers to ensure that they were aware of the these appointments. This would to help ensure the child's attendance at these important medical review meetings. The Head of First Response, as a secondary monitoring measure, was also examining, on a quarterly basis, the attendance levels at these appointments.

Assurance was sought by the Committee that children with a disability were being given equal attention by the service following communication in the report that quite low numbers of children with disabilities were subject to child protection plans. The Committee were informed that staff from the disabilities team participated on a regular basis with the First Response team, the multi agency team which considered all referrals and contacts related to concerns about children, to provide

advice on referrals relating to disabled children. There had also been training with staff on helping identify children with disabilities that were experiencing abuse. There were detailed results available to the Committee on a recent benchmarking exercise, conducted by the which had looked at the number of children with disabilities subject to child protection plans. There was also a current pilot project between the DCT and First Response team to monitor the referral route for disabled children. Phil De Leo the, Head of Services to Children & Young People with Additional Needs & Disabilities, would be asked to provide an email explaining the work of the service in working with disabled children and identifying abuse. The Committee were asked to take account of the added complexities of working with communicating with disabled children. To increase the Committee's understanding of this service's communication initiatives, it was suggested that the Head of Services to Children & Young People with Additional Needs & Disabilities could be invited to a future meeting of the Committee to discuss this work.

SC

AS

Attached to action 23 was the milestone to embed and enable a culture committed to supervision. The Committee were assured that supervisions were undertaken at least very four weeks with a social worker and additional sessions also held if needed. Information on the latest progress with this milestone would be emailed to Committee Members.

SC

The Committee considered the areas for improvement identified from the inspection of safeguarding and looked after children undertaken in February. A key point noted by the Committee was that all assessment work had the input of a fully qualified social worker. The actions relating to case recording, staff supervision partnership working, quality control and assessments were crucial given that the First Response team was expecting an unannounced visit by Ofsted in the near future. The Committee noted that unannounced inspections of children's services were one of the recommendations of the Munro report. This was accepted by the Children's service as a positive move as it would save management time given to preparing for inspections.

The Committee noted some positive funding news about the support to young people who go missing. There was £300,000 of funding made available over the next 3 years to 3 London local authorities, Islington, Camden and Haringey through an externally funded joint project with Aviva (formerly Norwich union), the Railway Children international charity and Barnardos. This London Investment Programme had been brought together to improve the quality of preventive and direct work that can be undertaken with children and young people placing themselves at risk by going missing from care or from home. The project would fund the set up of a new team of staff employed through Barnardos and based part time in Barnardos and part time in each of the 3 host authorities. The Committee noted that Haringey would have staff from this project based in Station Road for two days a week.

CSPAP C9

EXECUTIVE SUMMARY OF SERIOUS CASE REVIEW ON FAMILY Q

The Committee received a presentation from the Head of Service for First Response about the key findings of a serious case review into a domestic violence incident in which a father had caused the death of a mother which had led to a family of children coming into the care of the local authority. The executive summary of the serious case review was considered by the Committee, this was also published on the LSCB website. The consideration of this case provided the Committee with an understanding of the impact of domestic violence on children. The Committee considered the: background and circumstances around the case, the agencies involved, the communication lines between agencies. Members further noted that the lack of a full picture held by the agencies involved in the domestic violence case had led to a series of misunderstandings. Members noted the recommendations of the review, which included a joined up approach to domestic violence across the partnership.

In terms of meeting child protection requirements, there had been key practices implemented following the recommendations of the review with partners now looking in more detail at domestic violence incidences to ascertain whether there were children or unborn children in the household. There was more recognition that, children may not be experiencing physical abuse and therefore be signalled to services through the usual routes of schools or health services. The SCR highlighted that children could be passive recipients of domestic violence and will develop mechanisms for dealing with this which will not explicit and therefore detectable by schools, General Practitioners or other services. Partners were taking on board this advice from the SCR and when there were reports of domestic violence received, with children in the household, there was now an immediate referral to children's social care teams. The Committee noted that often domestic violence was under reported, however there would follow a review of Merlin, this was the police notification system where referrals were held which did not reach a crime threshold.

The serious case review had highlighted issues about the involvement of Adult Health and Mental Health Services and the connections they make with children services and other agencies. The Committee discussed the health links in the case and comment was made on the amount of responsibility and pressure placed on General Practitioner's to identify underlying issues when meeting patients and then making necessary referrals to adults and children related services. In this case the father had not been registered with a GP in his adult life but had contact with mental health services, probation and MARAC. These services were reported in the SCR to have been adult focused and not communicated their work with the father to Children's services. The Committee discussed the type of focus given by services and agencies to males and to their responsibility in the family unit. There had been a recent article on the paradox of father presence and absence in child welfare which

	the Head of First Response agreed to circulate to Committee Members. The Committee sought understanding about linkages between Adult services databases and Social Care databases to understand how contacts made with Adult and Children's social care services could be shared. They were informed that there was currently discussion about Adult Mental Health services data and Probation data being shared and accessed by the MASH (Multi Agency Screening Team) based in First Response. The Committee were also asked to keep in mind that the thresholds of information required in adult service database would be different to the level of information held in the children's social care database.	
CSPAP C10	EXCLUSION OF THE PRESS AND PUBLIC	
CSPAP C11	ANY OTHER BUSINESS	
	The date of the next meeting 13 th September 2011.	

Cllr Reg Rice

Chair