Liam Johnson Review

Report of Panel of Inquiry

MEMBERSHIP OF THE PANEL

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C O N T E N T S

TERMS OF REFERENCE

On the 13th June 1989 Mr [redacted] was convicted at the Central Criminal Court of the manslaughter of his youngest son, Liam. This Review was established under the auspices of the Islington Area Child Protection Committee to inquire into the case. Its terms of reference were

1. to investigate the events leading up to and the circumstances surrounding the death of Liam Johnson on the 25th December 1987;

2. to examine the work with Liam Johnson and his family of the commissioning and other agencies and their respective staff in relation to his welfare;

3. to examine the co-ordination of services to Liam Johnson and his family by the commissioning and other agencies and the adequacy of the liaison between them;

4. to consider the form and management of the Case Review conducted by the Islington Child Protection Committee agencies shortly after Liam Johnson's death and the adequacy of the exchange of information among them;

5. arising therefrom to make such recommendations as the Panel deem appropriate upon the adequacy of present guidance on the conduct of such investigations;

6. to consider the effects if any on the work of the agencies with members of his family and otherwise of the delay between Liam

Johnson's death and the criminal proceedings and to make such recommendations in this regard as the Panel deem appropriate;

7. to inquire into any matter relating to the above as the Panel may think fit;

8. to report with such recommendations arising out of the above as the Panel may deem appropriate including the conduct of child abuse inquiries.

While these terms of reference have at times helped to restrain us from exploring interesting but peripheral issues, we have not otherwise found them to be restrictive.

CHAPTER 1

INTRODUCTION

1.1. It was decided that the Review should conduct all its proceedings in private, but with a commitment that its report would be published. It was not established as a totally confidential inquiry in the sense that we were not required to hold our proceedings in a completely neutral venue, nor to prevent witnesses from accidentally meeting one another whilst waiting to give evidence. Within that constraint, we have tried to ensure that the evidence given to the Panel in confidence has remained so.

1.2. This has obvious implications for our procedures. It renders inappropriate the common procedure in public inquiries whereby people are legally represented and have the opportunity to cross-examine witnesses who give evidence. We have permitted participants to have someone with them while they gave evidence if they wished. Many have chosen to do so, with Trade Union representation being the preferred choice.

1.3. We have tried to conduct our procedure as informally and fairly as possible and have tried to give participants the opportunity to deal with any adverse criticism or matters which were raised after they had given evidence and which required further comment.

1.4. Some concern has been expressed about the fact that we have not served any "Salmon" letters, i.e. letters which draw to participants' attention in advance areas of possible concern or criticism so that they are able to deal with those criticisms when they give evidence. It did not appear to us from our preliminary reading of the documents that there was any individual

whose conduct cried out for the service of such a letter. There are probably few cases in any professional sphere which if raked over in detail years afterwards with the benefit of hindsight would not produce things which might have been done better or differently or where practice could have been improved. To serve Salmon letters about those sorts of matters, in our view, inevitably produces a high level of anxiety and an understandably defensive attitude in the recipients. They mean that the inquiry begins on the premise that there are "people who are to blame". We have tried instead to encourage participants to look constructively at the issues raised in this case, and at ways in which practice might be improved. In order that no-one should feel that they had been taken by surprise, or had an inadequate opportunity of dealing with the matters raised by the Panel, or had not done themselves justice or omitted something vital, we invited all witnesses to write or talk to us again if they wished. Some have done so, most have not.

THE EVIDENCE

1.5. We have had, of course, no power to compel witnesses to attend or require them to produce documents. Most have done so in response to requests by letter or telephone that they should contact us. We sat over a 7 week period, during August and September, hearing oral evidence on the equivalent of 22 full working days. We heard the oral evidence of 75 witnesses, some more than once. We have received 5 detailed written submissions and a vast amount of written material.

1.5. We would like to record that we have received the fullest co-operation from all sides. There was only one professional witness (from Sheffield) whom we wished to see and who refused to give evidence to us. We were also unable to persuade a number of the friends and neighbours who were interviewed by the police in connection with the

criminal proceedings to give evidence to us. Their reluctance is understandable but it does mean that our report lacks the dimension of the general public's perception of the events and services provided by the agencies whose conduct is under review.

1.7. As we have stated, we have tried to keep the evidence given to the Panel confidential. We are aware that many of the witnesses who gave evidence to the Panel have themselves disclosed both the fact that they have done so and the evidence given. It is clear that there has been considerable disclosure about the general issues in which the Panel were interested.

1.8. Although there was a considerable measure of agreement about much of the evidence we heard, we have inevitably had to resolve conflicts in the evidence of witnesses with different recollections of events. We have tried to synthesize the evidence we have received to give as accurate a picture as we can of the key events, without necessarily indicating at each point where the evidence conflicted. Our promise of confidentiality has meant that we have not disclosed the source of a particular allegation, where that was made orally to us, unless it is in the interests of that witness to do so, or if the witness had already given that piece of evidence publicly.

1.9. The main exception to that is the father himself. He has co-operated fully with our inquiry. In fairness to him it seemed right to point out where he challenged the evidence of other witnesses and disagreed with their account. This could not be done without it being obvious what our source was. He has therefore consented to our disclosing his involvement and evidence where appropriate.

1.10. There is another area in relation to which complete confidentiality is inappropriate. That is the medical evidence. All the expert medical witnesses who gave oral evidence to us had already given evidence in the father's criminal trial. Prior to the start of the criminal trial, there was a clear conflict between the evidence of the Pathologist for the Crown, whose view was that the injuries had been caused by violent shaking and the Defence Pathologist who thought the injuries were consistent with the father's account of a fall. Very shortly before the trial began, one of the Defence experts pointed out that whereas both pathologists had previously examined the case on the basis that all the injuries were caused on the same occasion, in fact the two most serious injuries were caused at different times. One consequence of this was that during their oral evidence at the trial the opinions of the experts moved rather closer together than their pre-trial positions might suggest. All were cross-examined at some length.

1.11. As will be clear from Paragraphs 3.151 to 3.163 below, the medical evidence in this case is complex and the injuries unusual. We therefore decided that instead of asking the medical witnesses to see us individually, we would bring them together in order that they might discuss the case freed from the constraint of appearing on one side or the other. We have necessarily set out a composite of their views and opini[redacted] We have not thought it necessary to preserve quite the same [redacted] of confidentiality in relation to expert evidence [redacted] in relation to the evidence of other witnesses. We [redacted] are grateful to all of them for giving up their time for our benefit. In the circumstances we have not felt it necessary to obtain any expert evidence of our own.

HINDSIGHT

1.12. We have tried to bear in mind throughout our inquiry that all the witnesses have spoken to us with the benefit of hindsight and that our own perception is inevitably coloured by that most useful attribute. We have also borne in mind that this was not the only case with which any of the agencies involved had to deal.

1.13. We have also tried to avoid judging the actions of individuals with the benefit of hindsight. It has seemed to us only right that criticism of the conduct of individuals should be based upon their judgment and actions in the light of the information which they knew or ought to have known at the time.

1.14. We have also borne in mind in reaching judgments that all the witnesses are several years more experienced than they were when they were making these decisions. In the case of those who were already established practitioners in their field this is obviously less important than in the case of those who were relatively inexperienced at the time when they were dealing with this case.

RACE

1.15. The [redacted] in the present case was [redacted], the [redacted] of each of the children, and his co-habitee were [redacted] L and his brothers were all therefore [redacted] Concern was expressed both to the Area Child Protection Committee and to the Panel that none of its members were black. Since the constitution of the Panel was not a matter for us, we have invited those who have made the criticisms to give us the benefit of their views and advice as to the approach we should adopt. We have found their comments measured, constructive and helpful. They obviously cannot give us the perception of the

agencies' work that a black person with their shared experience of institutionalised racism would have. They have sharpened our awareness of problems and issues. We acknowledge, however, that from their perspective, this report may be fundamentally flawed.

1.16. There is undoubtedly a shortage of suitably qualified black workers within the agencies. The reasons for this are outside the scope of this report. A number of those who dealt with the family were "non-white" but the majority were. This is particularly true within the neighbourhood office of Social Services. At the time there was only one black worker and she was part time. Ideally they would have liked a black male worker to work with the father, particularly in the period following L's death. So far as we can tell, however, the father himself has never expressed a wish to have a black worker, but he may well have preferred to do so. It simply was not possible.

ISABEL THOMPSON

1.16. We cannot leave this section without paying a tribute to our outstanding administrative assistant and clerk, Isabel. Her skill and flair in organisation has been invaluable. She charmed witnesses into attendance, persuaded recalcitrant holders of documents to part up with them and tended to all the practical needs of the Panel. We could not have managed without her and we are extremely grateful for all her hard work.

CHAPTER 2

"THE CHILD IS DEAD: LONG LIVE THE INQUIRY!"

2.1. L died, in circumstances which we describe more fully in Chapter 3, on Christmas Day 1987. His father was subsequently convicted of manslaughter. L had never been in the care of the London Borough of Islington. His name was never put on the Child Protection (previously known as the Non-Accidental Injury (NAI)) Register. His development was normal. [redacted] At no time during L's lifetime was it ever suggested that his father had assaulted him. He was not neglected or ill-cared for.

2.2. Yet, on his father's conviction, the Minister of State called for an Inquiry, according to Press reports, in the following terms:-

> "I want to know why this child died. Surely he was entitled to more protection from the authorities than he received. Something went very wrong. We must find out precisely what."

Underlying this attitude is a dangerous assumption - that all violence to children is predictable and preventable. The reality is very different.

2.3. It seems as though we have reached a stage at which when any tragedy occurs, particularly one involving the death of a child, there is an immediate demand for a public inquiry. Frequently this is a response to ill-informed media pressure. Where the Local Authority have

assumed statutory responsibility for the child or the child was known to be at risk, such calls are at least understandable. We examine the wisdom of them in Chapter 18 below. But if we have reached a stage at which even limited contact with Social Services is sufficient to raise a hunt for scapegoats, the implications for these services are appalling.

2.4. We have been asked to investigate [redacted] and we have done so as thoroughly as we [redacted]. Had our investigations revealed that L [redacted] of poor or negligent practice by the [redacted] we would unhesitatingly have criticised [redacted] any serious errors of judgment in the way [redacted] the professionals, and particularly those in Social Services, handled the case. There is no evidence that "something went very wrong."

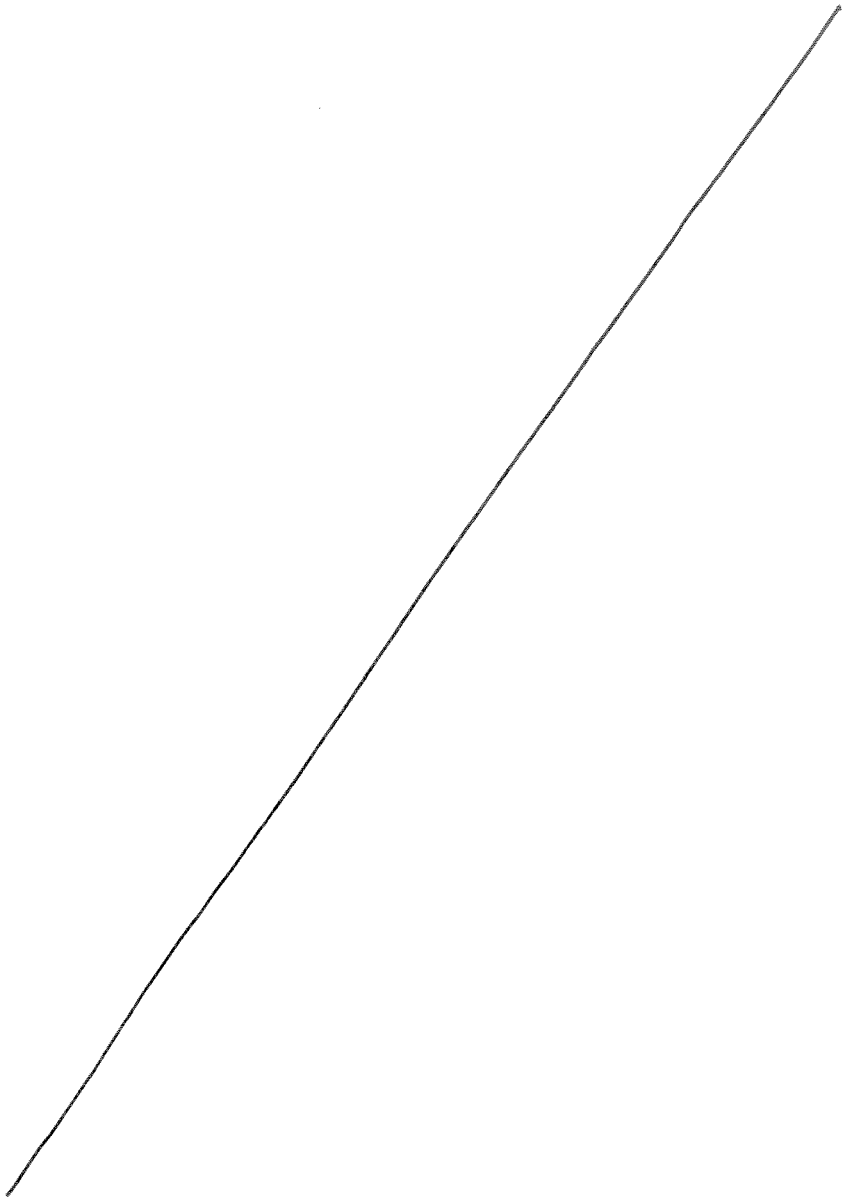
2.5. Those who take the trouble to read the facts as we found them to be, and our comments upon them, will we hope reach similar conclusions. We have obviously identified areas where practice and procedures could be improved and made recommendations in respect of them.

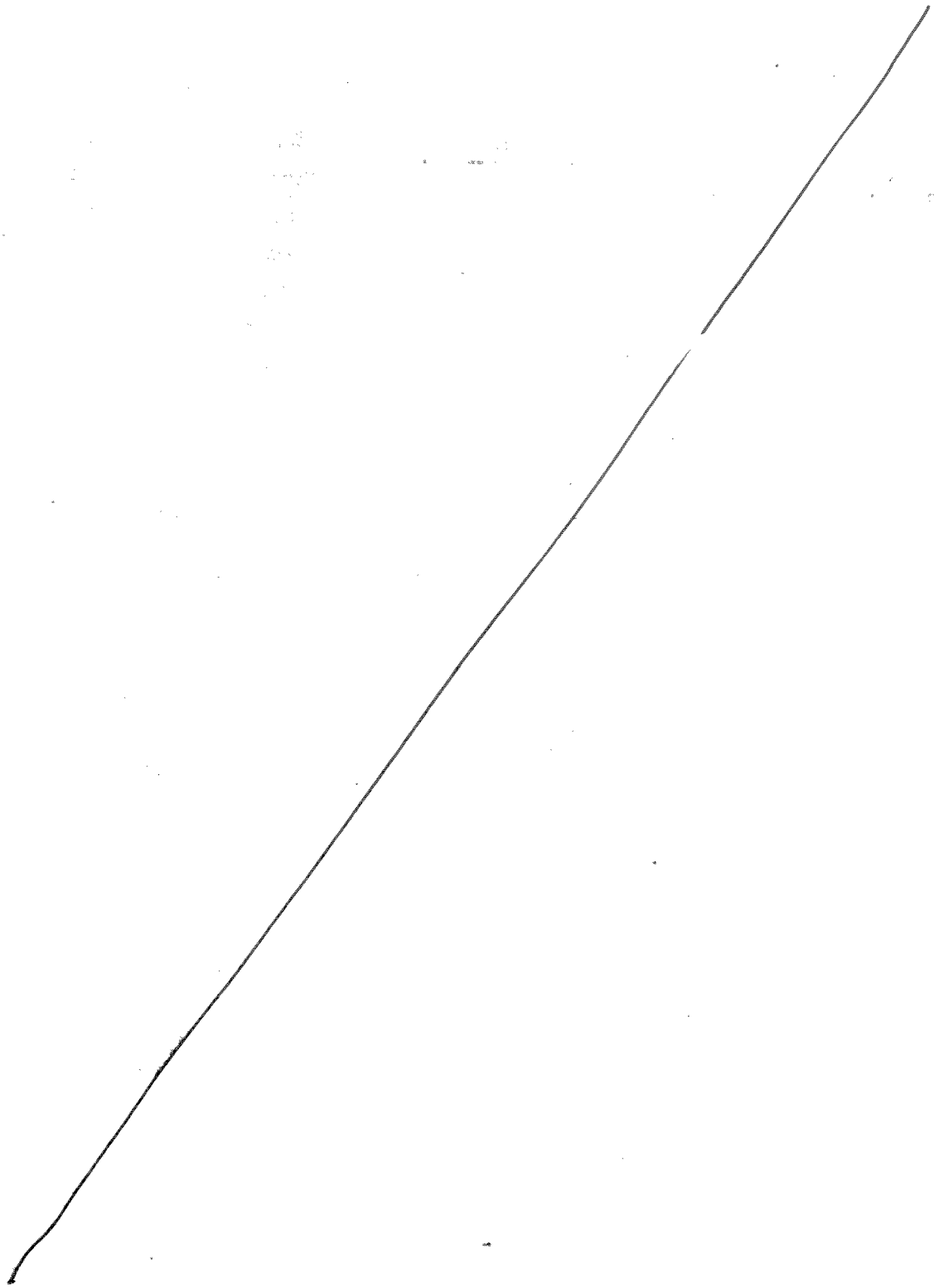
2.6. Those who do not take the trouble to read the report will undoubtedly dismiss it as a "whitewash". It is not.

CHAPTER 3

THE FACTS

THE PARENTS:





pages 12 - 26 INCLUSIVE HAVE
BEEN REDACTED IN THEIR
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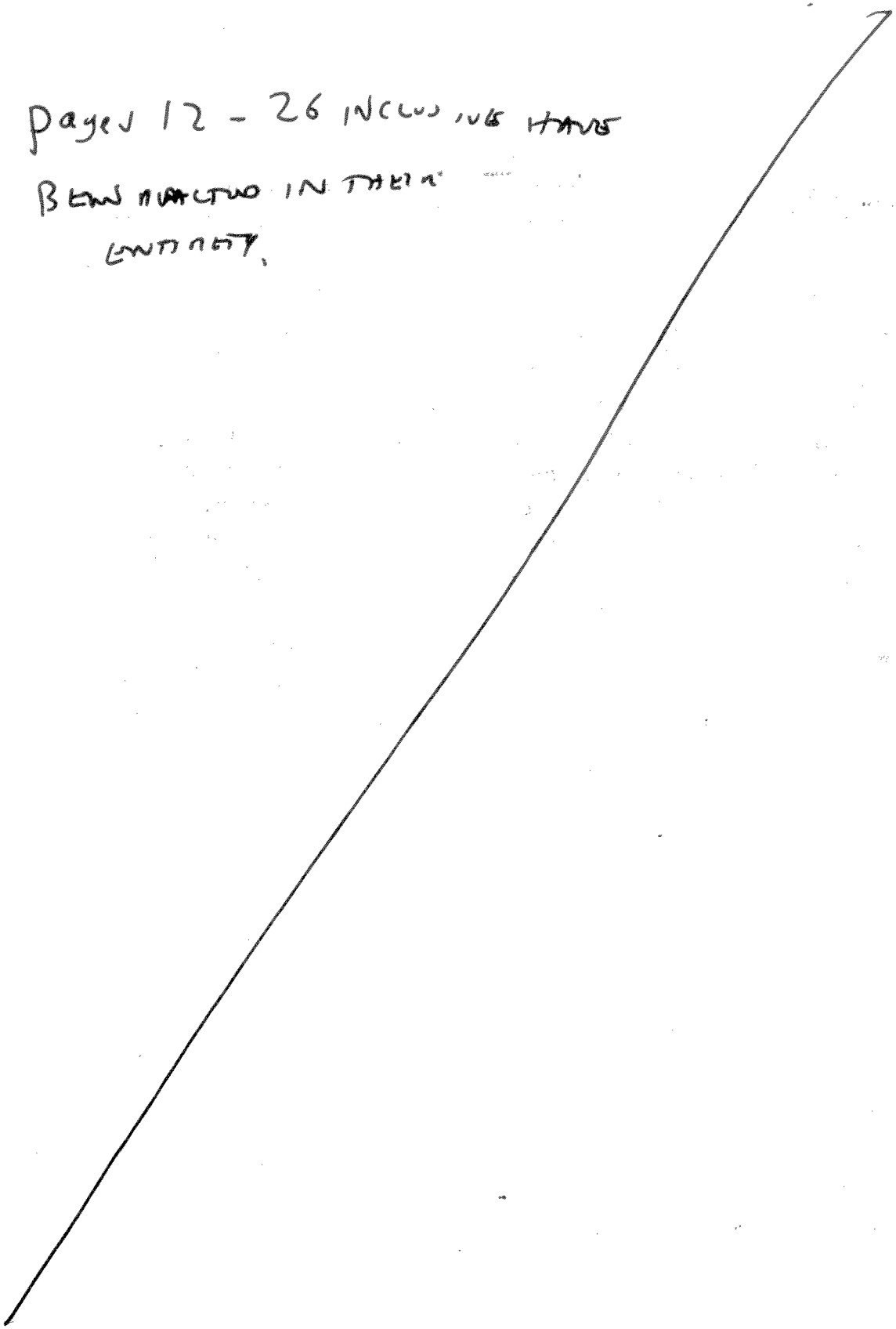

AUGUST 1984 TO DECEMBER 1985

3.35. L was born in Nether Edge Hospital, Sheffield on the 1st August 1984, suffering from slight jaundice. The mother breast fed him for a few days then bottle fed him.

whereabouts. During these inquiries the health visitor learned of L's hospital admission. On the 27th September the mother and boys were seen by the health visitor and the doctor at the clinic in Scarborough. [redacted] was walking and playing with other children. L had an umbilical hernia which the mother was advised about.

3.39. On the 3rd October, on a referral from the GP, L was admitted to Scarborough Hospital with diarrhoea and vomiting for 3 days. While he was in hospital the mother and [redacted] were seen by the health visitor in Sheffield. [redacted] was apparently well. The mother was pleasant, co-operative and was taken by the health visitor to her flat. She said that she had returned to Sheffield for a visit. The health records were transferred to Scarborough. Scarborough Hospital had an excellent paediatric liaison service and the local health visitor was notified within 3 days of L's discharge.

3.40. On the 19th October 1984, L was readmitted with the same complaint and was in hospital until the 22nd. The medical view was that this did not really require hospital admission. He was noted to take feeds greedily. Following his discharge, L was seen at the clinic by a different health visitor. The diarrhoea was resolved. The mother missed a further appointment on the 5th November but was seen on the 7th. L was vomiting after feeds. The mother was worried about [redacted] potty training. He was described as a shy little boy.

3.41. When the mother and [redacted] were seen again at the clinic on the 13th November L was still vomiting and was distressed. [redacted] which led to the move. She said he did not know her whereabouts. She had recently obtained a flat and wanted to exchange the Sheffield accommodation for a Council flat in Scarborough. The health visitor contacted Scarborough Social Services who agreed to give

support. The GP wrote to the hospital about L's continued vomiting. Three days later L had a satisfactory 3 months check-up apart from posseting. An appointment had been made for the mother to see the paediatrician but she did not keep it nor did she keep the following appointment at the hospital. She was seen twice at the clinic in December when she said that she was going to stay with her father in Sheffield for Christmas.

3.42. On the 27th December 1984 the mother was seen by the Sheffield health visitor. L was still vomiting after nearly every feed. Otherwise he seemed well. [redacted] was well

30.

PAGES 30, 31, 32, 33, 34

3.51. Two social workers investigated. The mother had just returned. Her initial reaction was that her family were doing this because they hated the childrens' father and knew she was seeing him again. She was very defensive about the possible injuries to the children and claimed initially that marks on L's back were his mongolian blue spot (a birth mark). Both boys were stripped. L had a healed scar about ½ an inch wide straight across his back at the level of his shoulder blades. The mother explained that he had accidentally touched a metal strip on the fire which was hot. The explanation was credible. [redacted] became distressed when taking off his clothes, crying about "going to daddy's". There were no marks on him. During further discussion the mother said that she had been with the father in London and he was due up that day. [redacted]. Both social workers felt that the mother was being evasive. The children looked physically healthy but were very anxious and demanding. The social workers advised immediate allocation. A child abuse case conference was not convened as the mother's explanation was accepted. The case was allocated to a different social worker.

3.52. On the 20th May 1986 L was seen by the health visitor with a small bruise on his forehead compatible with a fall. [redacted] was cheerful but needed nursery. The mother had a [illegible] with the health

rehousing and a place at a different nursery. On the 23rd May the allocated social worker wrote to the mother offering her an appointment.

3.53. On the 28th May 1986, the mother went to the clinic. Her own health visitor was on leave but she told another health visitor that she wished to discuss foster care as she was finding it hard to cope with the children. The health visitor contacted the and discovered that a social worker had been allocated and referred the mother to them. The mother told the social worker that she had difficulty in coping, that S and L were out of control. They were "wrecking the place". She was afraid she would injure them. She said she smacked them on the legs and bottom but they had injuries which she could not account for. L had "a thing" on his face. It was swollen and bruised and his mouth was cut inside. She thought it must have been her. [On the 3rd June her friend told the health visitor that L had had a large bite mark on his cheek, there was bruising and swelling and teeth marks. It may have been this injury.] The mother said that there had been a big change in her in the last 2 months which she could not account for. She did not think the father was the caus[redacted] worker tried to [redacted] dealing with her problems other than by receiving the children into care, but the mother was unwilling to consider such alternatives and spoke in a very rejecting way about the children even talking of adoption.

3.54. The social worker discussed the case with her senior. She was concerned that if the children were received into care the mother would disappear and not see them again. They agreed that it was premature to agree to a reception into care without having seen the children and with so little background information. The social worker told the mother that they would not receive the children into care but that she would come and see her at

the time which had already been agreed on the following day. The mother said that was okay. The social worker took her home, and noted that the children were in the bedroom with the babysitter, and were very quiet. The rest of the flat was clean and very tidy. [redacted] and L seemed pleased to see the mother and L in particular was clinging to her. L was seeking his mother's attention. [redacted] was smiling and playing one moment then suddenly crying for no apparent reason. L had a small graze on his chin and two small round marks, one on either side of his mouth. The mother said she didn't know what those marks were. The children had not had lunch. It was late afternoon and they were hungry and irritable. On her return the social worker discussed the case again with her senior and they agreed to offer a childminder for L for 5 half days a week.

3.55. The social worker visited the mother again the following morning. She was pleased about the offer of day care. The boys were in the bath laughing and playing with the bubbles. The mother said she felt better. She was pleased about the offer of a childminder for L and had agreed that after all she would take [redacted] back to the nursery. The social worker saw both boys undressed. L had bump marks and scratches on the back of the neck. He had a bump and bruise on his centre forehead which was said to have been from a bang on the window ledge. Both boys wanted their mother's attention. They were very jealous of each other. L had a tantrum. [redacted] was very upset about a broken video tape and blamed L. The social worker agreed to make a Section 1 payment as the mother said she had no money. She arranged to visit the following day. A social worker also inspected the hospital social worker's file.

3.57. The mother's behaviour came as a shock to the health visitor, who at that time was the professional who probably knew her best. Nothing in the mother's previous care of the children suggested that she was likely physically to abuse them. Both were bonded well with her. The health visitor was obviously alert to the risks to the children from the mother's lifestyle, such as the frequent moves, the fact that the mother was under stress and that she may have been leaving them in the care of other people, but abuse did seem to be out of character.

3.63. On the 5th June 1986 a case conference was held in the mother's absence. It is clear that this was being held under the standard procedure when a child was received into care, rather than being especially convened as a child abuse case conference. Both the health visitor and the social worker recounted in detail their dealings with the mother. The health visitor also passed on information from her contact with the neighbours. According to the minutes, which unfortunately had to be taken by the senior social worker chairing the meeting

(an aspect to which we shall return, see paras 8.28-30 below), the conclusion was that there was little real evidence to prevent the mother removing the children from care. It was decided that if the children did return home the social worker and health visitor would remain involved and that both children should have a full skeletal survey.

3.64. We have necessarily had to examine that decision in some detail. It is one of the points in the case at which a different decision by the agencies might significantly have affected the eventual outcome. The thinking behind it was that it was two years since the mother had removed [redacted] from the [redacted] from whom there was risk of abuse. Although it is not spelled out in the minutes, the mother was caring quite well for the children. They had developed well and achieved their milestones. The conference assessment of the mother was of a woman who was depressed and distressed and seeking help. They did not see it as a child abuse case. The conference saw the future in terms of the children being returned to the mother's care and working with the local authority in partnership. The case was not dissimilar from many others in the area. They would have hoped to work out conditions upon which the children would be returned to their mother. Their judgment was that there was insufficient reliable evidence for a Care Order and not sufficient urgency for a Place of Safety Order. Some doubt was expressed to us about whether the statutory test for either order, namely that the child "is being" ill-treated could have been met if the mother sought the voluntary removal of the children. The law had not yet been clarified on this point. See now R (A minor) v. [illegible] [illegible] 1987 [illegible]

Wardship as an option does not seem to have been considered

3.65. The case has also to be seen against the general policy of Sheffield only to take a Place of Safety Order when it was strictly necessary and generally to allow children to remain with their families. Moreover, at the time of this case conference, the Sheffield agencies had no reason to suppose that the mother would do what she in fact did. Since February 1985, there had been very little contact between her or the children and the father.

3.66. The only real evidence which the local authority had was the social worker's own observations of the injuries to L, what the mother had said about other injuries and the fact that she could not account for them, and the mother's own expressed fear that she would injure the children. The injuries actually observed by the social worker were not particularly serious nor were they in themselves of a type clearly indicative of non-accidental injury. Because the case was not considered to involve child abuse, there was no medical examination which might have suggested a contrary view.

3.67. Most professionals working with children are aware of the danger of developing high levels of tolerance to unacceptably low standards of parenting. It is a particular problem for those who are working in areas of high deprivation. On the other hand, an important part of the skill of knowing when properly to intervene depends upon a realistic assessment of how this particular family is managing overall compared with other families in the area with similar problems. That is clearly not a dimension which we can bring to our analysis of this case. We have come to the conclusion that in all the circumstances it would be [illegible]

Pages 43 to 45 have been redacted fully.

MID-JUNE 1986 TO NOVEMBER 1986

3.77. On the 16th June 1986, the Sheffield health visitor learned that the mother had taken the children to London and they were now with the father. She informed Sheffield Social Services who asked Islington to visit to see if the boys were at the father's home. The duty social worker, who happened to be an experienced former child care officer, did so. The old file on the family was not available, but he knew that Sheffield were concerned about the risk of the father's violence. He was therefore expecting possible trouble, verbal aggression or truculence. He did not encounter any of these things. The father welcomed him and showed him in. He found the boys playing happily in the care of the father and A. He picked up no adverse "vibes". The children were behaving normally. They were neither over-active nor withdrawn. A impressed him as a capable, sensible woman, not feckless but responsible. The flat itself was well cared for. He telephoned Sheffield to report.

3.78. In the meantime, the Sheffield social worker interviewed the mother's sister and her father. The sister was very concerned about the boys, particularly the risk of them being beaten by the father, based on what she said the mother had told her about the father's behaviour while they were together. The mother and Sheffield social worker unsuccessfully tried to meet each other. On the 27th June, the mother's sister told the social worker that the mother was not concerned about the boys. She said the mother was frightened of the father. If the boys came back, she would look after them for part of the time and the mother would look after them the rest of the time. This led to further telephone conversations between Sheffield and Islington, when the latter were asked to inform the father that the mother's sister did

3.29. In the meantime, on the 23rd June 1986, Sheffield had sent a report on the family to Islington. Although it is stamped as having been received in the neighbourhood office on the 24th June 1986, no-one dealing with the case can recall seeing the report at that time. (There are filing problems in neighbourhood offices to which we refer in paras 10.16 - 10.19 below). Similarly, it is far from certain when the old file which was requested on the 5th June was actually found and forwarded to the neighbourhood office.

3.30. The report summarises the history of the case and says, "We are concerned about the welfare and safety of [redacted] and L while they are in the care of the father and felt you needed to know the background information and to consider the necessity of supervising this situation." At this time it was uncertain where the children were going to remain. There was no suggestion from Sheffield that the children should be on the WAI register or in care.

3.31. The same duty social worker visited in response to the telephone call from Sheffield. This time the father was out and he only saw [redacted] and the children. The atmosphere was relaxed. He gained the impression from [redacted] correctly that the father would not be happy about returning the children to Sheffield. He left a letter for the father about the sister's proposals and invited [redacted] to discuss day care for the children. The father went to the office on the 30th June in response to this. Again he admitted having been violent to the mother but maintained his denial of ever beating S although he admitted [illegible]

after the children and that he was not prepared to return them. The Sheffield social worker wrote telling the mother this and encouraging her to get legal advice. She also passed on the information to the health visitor.

3.82. On the 1st July 1986, Sheffield wrote again to the London Borough of Islington bringing matters up-to-date. That effectively ended their involvement in the case although it was not formally closed until November 1986. The Sheffield health visitor made one further attempt to see the mother without success on the 15th July. In parallel with the contact between the two Social Services departments, the health visitor contacted her London counterpart. Coincidentally this was the same health visitor who had been responsible for the mother and S in 1984 and who was present when the mother came to the clinic on the 30th March.

3.83. The Islington health visitor's response was to telephone the neighbourhood office on the 14th July. She spoke to a senior social worker. Based on her knowledge of the March 1984 events (the full details were not yet in the hands of the neighbourhood office) she was extremely concerned about the children remaining with the father. She told the social worker that the father was a drug addict. He had in fact visited the neighbourhood office again some 3 days earlier where he had been seen by a different social worker who discussed the situation with him. The father confirmed that he was seeking custody. The social worker raised the father's past violence with him. He again denied any violence to S. Following the health visitor's call, the social worker was asked whether he had seen any signs of drug abuse on the father, but he had not. It was agreed that the health visitor would liaise with the Sheffield Health Authority and would make a home visit, although she was reluctant to do so alone.

3.84. She did make such a visit on the 14th July. The father was not there but she saw [redacted] and L, together with [redacted]. The health visitor was concerned that [redacted] seemed rather withdrawn and queried whether he was in fact backward. His speech had regressed to a stage known as echolalia, where the child repeats what is said to him. L seemed more outgoing. The health visitor was not concerned about the physical care of the children but did wonder about their emotional care because she felt [redacted] was very unhappy. The health visitor reported on her visit to Islington. Social Services had agreed to discuss the case at their allocation meeting and would consider calling a case conference. The childrens' health records were sent back from Sheffield to London.

3.85. Three days later, the father completed an application for day care. [redacted] was due to start nursery in September. The father was worried about [redacted] education and keen to get him assessed. Arrangements were made to convene a case conference. The health visitor rang back with information and was told that Islington were unable to allocate the case.

3.86. On the 18th July 1986, [redacted] and L were seen at the clinic, apparently with the father and given development checks. L was fine, but it is clear that his speech was less advanced than it had been at the time of the previous check. The health visitor reported concern about [redacted] echolalia and that he seemed withdrawn. The doctor saw [redacted] and noted this and that his speech seemed immature, and agreed to refer him for speech therapy. The developmental check showed that [redacted] development was [illegible]. Both children were given measles immunisation. [illegible] mentioned that [redacted] had previously been seen by the [illegible]

3.87. At the Social Services allocation meeting on the 23rd July, [redacted] was decided that they would not convene a child abuse case conference but hold an informal information sharing meeting. The effect of this was to cancel the attendance of the Juvenile Bureau, who indicated that they had no recent information to give. There may have been some confusion about this, because the note of the telephone conversation says that the father had not come to the police's attention, which was not true. The attendance of the GP was also cancelled. L's GP record from the early part of his life has gone missing. It is unclear whether it was ever transferred from Sheffield to London or if it was, what has happened to it since. [redacted] record shows that the GP was consulted about childhood ailments and colds and such like but that there were no material matters which might have affected the case conference decision.

3.88. [redacted] is important to note at this point that such informal meetings were reasonably common. Had such a meeting concluded that the children were at risk and their names ought to be on the register, a formal child abuse case conference would have been convened. Again, however, it is important to note that at that time only the names of children who were at actual rather than potential risk of abuse could be included in the register. The meeting took place on the 27th July 1986. It was chaired by a senior social worker and those present included representatives from Social Services, education and the health service. They decided:

(i) Not to put the childrens' names on the NAI register as the injuries were 2 years ago.

(ii) That [redacted] was to be monitored at school. (The Education Social Work Service confirming that he was due to start in September).

(iii) [redacted] to have speech therapy, which the health visitor was to follow-up.

(iv) The health visitor would encourage the family to register with a GP.

(v) The under-fives worker would encourage the father to put L's name on the list for playgroup.

(vi) The problem of monitoring the family in August was discussed. The health visitor was unable to guarantee a visit. It was hoped that the family would visit the clinic.

(vii) The Social Services would try to allocate the case.

(viii) The next meeting would be on the 4th November 1986.

3.89. Again we have looked in detail at this meeting and decision, firstly to see whether there should have been a formal child abuse case conference, as some people have subsequently suggested, and whether that would have made any difference to the decision. We doubt whether it would have made any difference. The principal effects of convening a child abuse case conference are that participants bring different expectations to such a case conference and make more effort to attend; there is a list of those who are required to be invited to a child abuse case conference; (as we have seen the effect of changing the title was that the police and the GP were not required to attend); there is a better chance of getting an independent minute-taker; and finally the discussion tends to be more structured because the forms which have to be completed require the participants to

direct their minds towards what decisions have been taken and how the child is to be protected.

3.90. We doubt whether any of these matters would have made any difference to the outcome of this case conference. In effect the decisions taken provided for a protection plan and who was to implement each part of it. By this stage Islington did have the old file so that this meeting had substantially all the information that there was available about the father. They did not know about his convictions, but these were not disclosed by the police until some considerable time after L's death in any event. We doubt whether they would have added much to the knowledge which the meeting had of the father's violence towards the mother. We have been assured, and accept that the police had no "background information" on the father to pass on. The father was not known as a pimp or a drug dealer in the area.

[redacted] violence of the father to [redacted] since she never told anyone about this until after she left him. The Islington agencies only learned the extent of it after L's death.

made some difference to th[redacted] professionals. (That is the visit to the Whittington Hospital. See para 3.147 below.) We think it unlikely, however, that if these childrens' names had been placed on the register in July 1986 they would still have been on the register by November 1987.

3.94. It is important to recognise that however well agencies co-operate, however good the procedures, however able and talented and well-trained the individuals working with a case, there is no way in which they can effectively monitor the situation so as to prevent a child dying in consequence of an incident of violent injury, except by removing that child from the home altogether.

3.95. Of the plans which were made at that meeting, some were put into effect and others were not. The Social Services department was unable to allocate the case. The effect of allocation is that one social worker then becomes responsible for dealing with the family and, where appropriate, co-ordinating the work of the other agencies. In this neighbourhood office, as in so many other Social Services departments, there are always more cases which need allocation than there are social workers to whom they may be given. It is always a question of deciding which cases should have the highest priority. Again on the basis of what was known about the family in July 1986, we do not think that it could be said to be a high priority case in Social Services terms. The crucial issue is whether or not any social worker who might have been allocated to the case would have succeeded in building the sort of relationship with the family which might have allowed problems to be discussed and dealt with. For reasons which we shall consider in more detail below, we think it unlikely that that would have been the case.

3.96. The under-fives worker did try to encourage the father to put L's name down for playgroup. She saw him on the 11th September but the father said that he thought L was too young for such a group and that in any event A was available to look after him. It is also right to point out that pressure for such places within Islington is enormous. There is a strong political commitment to the provision of care for the under-fives. In practice this has meant that the Social Services department have operated a quota system to try and ensure that a certain number of places are reserved for those children who have the greatest need for such provision. When a place becomes available, it is matter of deciding which of the pressing claimants is in the greatest need. Again this family was not in that category. As we understand it, for those who are not in the highest priority groups to stand any chance of securing a place in one of the nurseries at the age of 2½ to 3 years of age, it is necessary to put their name down at birth, if not actually during pregnancy, rather in the manner of some of the better known public schools!

3.97. At this meeting on 11th September 1986 the father indicated that he was unwilling to accept social work support. The health visitor therefore agreed to visit. She did so on the 17th September and saw the father as well as [redacted] and L together with [redacted]. There were no problems with L although he was a bit chesty. The father seemed caring and concerned and said that the school that [redacted] was attending was the same. The health visitor herself was reassured by this visit and recorded that there were no contra-indications to the children remaining at home.

3.100. According to [redacted] account given in the criminal trial, on about the 17th or 18th October 1986 she attended a neighbour's birthday party leaving the father in charge of the boys. On her return she saw that L had a swollen and bruised face, bruising on one [redacted] and on the bridge of his nose. He was very listless. He had a spongy bump on his head and seemed dazed. The father said that he had fallen downstairs. She suggested to the father that L should be seen by a doctor. According to her the father said that he would arrange to take L to the doctor but did not do so. She said that she did not believe the father's account of the injury but said nothing.

3.108. There is no doubt that the father did want the boys to be "tough". He criticised [redacted] for being too lenient and turning them into cissies. L was quite a tough character but everyone seems to agree that [redacted] was not. He was more sensitive and less athletic than either L or his [redacted] Having had the closest relationship with his father of any of the three boys, we consider that [redacted] was probably the most distressed by his father's anger or displeasure.

3.109. We think [redacted] probably was as genuinely concerned about the boys as he appeared to be. If it was an act, he certainly had the intelligence and linguistic skill to assume the role of caring father and to play it to perfection. We do not think that there were warning signs which were missed and which ought to have been picked up. We think this probably was a genuinely happy period in which the father, A and the children got to know each other.

3.110. It is not clear why [redacted] changed as it appears to have begun to do so in the Autumn of 1986. Whether the change was [redacted]

NOVEMBER 1986 TO AUGUST 1987

3.112. The father's temper became more uncertain and he would lash out at [redacted] and the children. Whilst she was still on crutches following an operation on her foot, there was an incident one Sunday morning. The children were drying themselves by the fire. The father came in in one of his moods. [redacted] went to get the breakfast. The father started on the children. She remonstrated with him whereupon he dragged her into the kitchen and threw the food everywhere. He then smacked L and [redacted]. [redacted] intervened. He threw her against the kitchen door. She fell because she had no balance. The father than threw her out of the home still in her pyjamas. She returned later. The father would not believe that he had hurt them. He always said he did not mean to and was contrite.

3.147. On the 22nd November 1987 L sustained an injury. He was taken to the Accident and Emergency (A & E) Department at the Whittington Hospital on the following morning. The father's account was that he fell on the stairs on top of L. The visible injury was that L's right thigh had swollen up overnight. It was very swollen but there was no bruising and no other injuries. He was examined by two doctors. X-rays were taken of his hips and legs. There was no bony injury. In the context of the medical evidence we consider this incident and what may have occurred subsequently in more detail below.

3.148. On the 25th November, the adjourned custody hearing took place. The mother did not attend. There was no Court welfare report. The Probation Officer had not appreciated the return date and had not completed his inquiries. An application for an adjournment was refused. The Magistrates heard the evidence of the father and granted custody to him. We examine the Court proceedings further at paras 6.30-31 below.

3.149. S was still not at school. On the 2nd December the father telephoned to say that he was absent because he had had to attend Court. On the 3rd December the ESW

made an unsuccessful visit. On the 9th the health visitor telephoned but received no reply. She visited the home which was apparently unoccupied. The kitchen curtains were drawn. On the 10th and 11th December 1987 there were unsuccessful attempts to visit made by the ESW. On the 11th the health visitor telephoned the father. He said his own commitments prevented him from bringing [redacted] to school. He was urged to take him. She passed this on to the ESW who arranged to contact the father the following week. S was not brought to school. There is no record of any attempted contact thereafter.

3.150. On Christmas Day at about 8 p.m., L was taken to the Whittington Hospital following a call to the Emergency Services. He was dead, emaciated, and had sustained severe and unusual injuries.

MEDICAL EVIDENCE

3.151. The most serious injuries were to the 3rd and 4th thoracic vertebrae. There were two injuries. The first was a flexion (bending forward) injury which in effect broke the back of the spine and damaged the spinous processes on these and adjoining vertebrae. Because of the degree of calcification of the bones, this injury was at least 3 weeks old but might have been as much as 6 weeks old. On the basis of the post mortem or radiological findings alone, the medical witnesses could not rule out the possibility of this injury having been caused before L was seen at the Whittington Hospital on the 23rd November, nearly 5 weeks earlier. He also had fractured ribs of similar age.

3.152. The second spinal injury was caused shortly before death. It was an extension injury (bending backwards). All the witnesses are agreed that a less serious fall, or shaking or a forceful putting of the child across the knee could have caused the damaged spine

to open in this way. All are agreed that by the time of this injury L was already dying from the previous injury.

3.153. There were a number of bruises and marks on L's body. There remains a dispute whether some of these were caused by blows with a studded belt as the Prosecution alleged at the trial. The witnesses agree however that the bruises and abrasions to the body show at the very least rough handling of a very sick child, and of pushing and shoving. L's left foot was very bruised and swollen. The father's contention that this injury was caused on a separate occasion is not accepted by the experts. They say that the effect of the spinal injury would have been to damage the spinal cord, leading to a gradual loss of sensation in and wasting of the lower leg muscles. Gradually L would have become unable to walk. They paint a vivid picture of him crawling around, dragging the left leg, unaware that he was banging it and of the bruising being caused by repeated bumps.

3.154. L's stomach was empty. That and the degree of wasting, demonstrate that L's injuries, particularly the callousing around the oesophagus made eating difficult and that he was probably only able to drink for some time before his death.

3.155. All the experts are agreed that, contrary to the father's contention that he sought help promptly on the day of L's death, the child had been dead for at least 6 and possibly as much as 12 hours before he was brought to the hospital.

3.156. The injury which they all find difficult to account for in a domestic setting is the first spinal injury. The 3rd to 7th vertebrae are in the "immobile" part of the spine. [illegible]

only really described in road traffic or aircraft victims where the rapid deceleration before a crash causes the spine to fracture in this way.

3.157. The original suggestion of the Prosecution pathologist that the injuries were caused by severe shaking was a hypothesis based on the belief that both spinal injuries were caused at the same time. This assumption was challenged by one of the doctors consulted by the Defence and it is now accepted that there were two separate injuries. Any explanation which depends upon the child's own body weight causing the injury, such as flinging him forcefully against a wall or a fall, is regarded as untenable because his weight would not have created sufficient energy to cause these severe injuries.

3.158. They therefore examined the father's account of the accident on the 22nd November given at the trial to see whether this could account for the injuries. The doctors' understanding was that L was sitting at the bottom of the flight of stairs. The staircase is steep but quite narrow. There are 9 regular stairs and 3 angled stairs at the bottom of the flight as the stairs turn into the hall. As one comes down the stairs at the bottom, where the bend is, there is a toughened glass panel set into the wall. Looking down from the top there is a handrail in the wall on the right-hand side. On the left-hand side is an enclosed stairwell. The bannister on the left-hand side does not start until about 5 stairs down from the top. There was some evidence at the trial and to us about how steep and dangerous these stairs were. If it were being alleged that L might have fallen from the top of the staircase because of this it would be relevant. In view of the nature of the injuries, however, in our view this is a red herring.

3.159. The father went in for body-building and weight training. His account, as the doctors understood it, was that L was sitting at the bottom of the stairs. He went to vault past him using the handrail and stairwell for support and landed on top of the boy. They thought that if L was sitting towards the bottom of the stairs and the father landed on this part of his back from a vaulted leap from a height, his weight and the motion combined might be sufficient to cause the injury. Our understanding is that this explanation depends on L being seated and "fixed", perhaps ducking out of the way.

3.160. The difficulty about this is that the father's explanation to us was quite explicit. He said he came to the top of the stairs. L was about halfway down i.e. 4 or 5 stairs from the top, on the right-hand side (i.e. by the handrail). He saw his father and began scampering down "with his little feet - trying to beat me." He explained that this was something they often did and was a game L enjoyed, racing his father to see who was the first down. The father, as was usual on these occasions, went to vault past him. As he did so either L darted into his path or he misjudged it. They collided, the father striking him with his right hip. Both lost their balance and fell. The father tried to prevent his fall on L from being a heavy one but instead he landed on top of him. L was distressed, moaning and in pain. He said all different parts of him were hurting. The father said that there didn't seem to be too much wrong with him, but the following morning his leg was swollen and he could not walk on it. He took him to hospital that morning.

3.161. The father has consistently alleged that the spinal injury was caused by that fall and was missed by [illegible]

the sort of trauma described to us as required to cause the injury. If L had been knocked by his father in this way, one would have expected him to have been pushed towards the wall. He would either have lost his footing and slithered down 3 or 4 stairs on his back or been knocked forward and fallen onto his knees and hands. If his father fell with L, we can understand how such a fall might have produced the soft tissue injury to the leg, if the father landed on him in a way which caused the leg to be crushed. It is almost impossible, however, to envisage any way in which the father could have landed on L from the fall he describes in the way or with the force to have snapped his spine.

3.162. Although the doctors could not rule out the possibility that the spinal injury was missed they agreed that it is difficult to believe that the child was not in considerable pain. Because injuries of this type and severity are so rare, they could not rule out the possibility that it was asymptomatic at the time of the examination on the 23rd November. Because of the lack of natural movement in that part of the spine, the body in effect forms its own splint. In the medical literature there are instances described of asymptomatic injuries to the spinous processes, although it is right to say that these are all in cases of very young babies, who have been injured by severe shaking. None involved actual fracture of the spine as well so far as we can tell.

3.163. We therefore propose to examine the evidence of the injury and what happened subsequently on two alternative hypotheses. The first is that it was done by the fall on the 22nd November and was missed. The second is that it was not done on that occasion but by some subsequent traumatic event not long afterwards.

WAS THE SPINAL INJURY MISSED ON THE 23RD NOVEMBER 1987?

3.164. According to the hospital records, L was examined first by an older doctor and then by a younger one. This is confirmed by the doctors themselves, but disputed by the father who says it was the other way around. The evidence before us and in the criminal trial depends crucially on the evidence of the older doctor. It is right to say that her contemporaneous notes do not give details of how she carried out the examination. She was not asked for details until interviewed by the police on the 7th December 1988, over a year later, when they were clearly seeking to anticipate and if possible block the father's line of defence. The doctor said at the trial and confirmed that she in fact did have a clear recollection of examining L and graphically described her examination of the upper part of his body and testing his grip. She is certain that she did not miss a serious injury to the child's spine. The father denies this account. He says that she did not examine the upper part of L's body. He thinks he might have put her off doing so by talking about the injury to his leg. She sent him for x-ray of the hips and lower limbs.

3.165. The younger doctor examined the x-rays which showed that there was no bony injury to the lower part of the body and indeed no-one has ever suggested otherwise. She says that she did not examine L herself because the first doctor had already done so. Her diagnosis was of a soft tissue injury and she sent the father home with advice to contact his GP if L was no better. We examine other aspects of this visit at paras 6.23 - 6.28 below. If the older doctor is right about the way in which she carried out the examination it seems to us very improbable that she would have caused no pain to the child. She was a very experienced casualty officer who had a lot of clinical experience with children as well as with

possible injury had L shown pain or discomfort in the upper part of his body and would probably have ordered an x-ray of the upper part of the body as a precaution. (There is a complication in that these injuries might not have been revealed by such an x-ray, but that does not concern us at the present time.) The leg injury was itself slightly unusual. We have been told that there would have been about 2 or 3 pints of blood in the soft tissue to account for the degree of swelling.

3.166. Accordingly this hypothesis depends upon the rejection of that part of the doctors' evidence and the acceptance of the father's account that no such examination occurred. There are other discrepancies in their accounts apart from the order in which they examined the children. The older doctor recalls that S was there. The father says he was not but was cared for by a friend. This hypothesis also depends on the assumption that either the father's account of the way in which the injury was caused did cause it in spite of the medical evidence or his account of the way in which the injury occurred is not true.

3.167. If the spinal injury was missed and was caused by the accident on the 22nd November, it is difficult to account for the father's subsequent conduct in relation to the symptoms which all the experts agree L must have suffered in the following weeks. Although the swelling in his leg subsided, L's mobility would have been affected as he gradually lost strength and sensation in his lower limbs. He was weak, crawling or dragging himself about. He was unable to eat. Yet at no time did the father consult a doctor, despite advice that he should do so, when anyone of normal intelligence and mental health would have realised that the child was seriously ill. It is the more inexplicable because as we have shown above, the father was neither inadequate nor a person who was not prepared to obtain medical advice when

necessary. As we have seen, a month earlier, S had been taken to the GP with a runny nose and a month before that with a cold.

3.168. Similarly, he did not mention to the health visitor when she telephoned on the 11th December that L was unwell. The father has denied that he and the boys were away at all during this period. It is difficult to believe, in view of L's injury that they were all out when the health visitor and the ESW called on four occasions during December. The inference is irresistible that he did not answer the door.

3.169. We have obviously been handicapped in our consideration of the events of the last few weeks of L's life by the fact that a large number of friends and neighbours of the father who gave statements to the police, have not been willing to give evidence to us. We have tried to reconcile their written accounts with the evidence of the medical witnesses. It is not always possible to do so. Sometimes the witnesses may be mistaken as to the time when they saw the child. It seems to us, for example that the evidence of a neighbour at the trial who says that she saw L walking normally on the balcony at about the end of November is unlikely to be right on any view.

3.170. The friend of the father's who helped the father to care for the children saw L shortly after the injury to his leg. She said that he was unable to walk properly for about a week. On one occasion at her flat L urinated on her settee. He said he didn't want to get up and felt tired and wanted to sleep. She put a nappy on him and let him sleep. She said to the father that his leg looked worse. The father said that he would take L back to the hospital. She also described an incident with S at about that time when he came to her flat and spent the day with her. He [illegible] to go home, he was rubbing

and said that he wanted to live with her. Her relationship with the father became strained at about this point and she did not look after the boys again prior to the death.

3.171. She did say that she saw the boys when she delivered Christmas presents for them on the 23rd December. She says that L was sitting on the floor playing with his toys. He appeared to be cheerful and his normal self. She did not see him walking. Again we find this difficult to accept. The children often played behind the settee in a corner of the living room. How closely she actually observed L on this occasion we cannot judge.

3.172. Other witnesses say that L was walking with his injured leg following the accident and that he would emphasise his limp when one of the father's friends was there. Again this may have occurred in the period immediately following the accident, but we doubt whether it was true during the later period. On about the 18th December a neighbour says she saw L being pushed by a white woman in a pram (it is not clear whether this means a pushchair). This would obviously accord with the evidence that the child was too weak to walk by that stage.

3.173. The father himself alleged that on the 11th December he smacked the boys because they were climbing on the window. Again we doubt whether this is so in relation to L. He says that L also fell down the stairs on 20th December 1987. There is no other evidence of this. The medical view is that the injury to L's left foot was not caused on this occasion.

3.174. On the 21st December 1986 a neighbour babysat for the children. She did not see them because they were upstairs asleep in bed. On the following day A tele-

phoned. She had telephoned on several occasions after she left. On this occasion the father said that L was down in the dumps as he had had an accident sliding downstairs and wanted to stay in bed. He said that he had been seen at the hospital. A's purpose in telephoning on this occasion was to try to persuade the father to let the boys come to her after Christmas. He made some excuse. On Christmas Eve the same neighbour called with presents for the children but she did not see them.

3.175. On Christmas Day, the boys were apparently coming downstairs when L fell. [redacted] told his father L had fallen down the stairs and he picked him up and laid him on the settee. According to the father he ate a meal in the early afternoon, vomited and then laid down for a bit. The father eventually realised that the boy was dead and attempted to revive him. He then called the Emergency Services.

3.176. A friend of the father's said that the father telephoned him at about 12.20 p.m. on Christmas Day. He arranged to call round. The father said to him not to come before 1.30 p.m. because he was going out. This seems extraordinary, if true. This friend arrived at about 2.20 and left about half an hour later. This is at the extreme limit for the latest probable time of death. He says he saw L sitting at the kitchen table eating his dinner. He was sad, not his usual happy self. The medical evidence is that it is possible that a fall on Christmas Day would have accounted for the second spinal injury but that L would not then have sat up and eaten his dinner. We conclude that the father's friend was trying to help the father, and his evidence cannot be relied on.

[redacted]

that the child was dead. But the father continues to deny that there was any delay, a matter about which the doctors are unanimous.

THE SPINAL INJURY WAS NOT CAUSED BEFORE THE 23RD NOVEMBER, BUT AFTERWARDS

3.178. If the older doctor and not the father is correct, and the spinal injury suffered by L was not caused by the accident on the 22nd, it means that some other severe trauma must have caused it. This is obviously hypothetical. It could be the explanation that on another occasion L, who was not yet fully mobile after the earlier accident was coming downstairs on his bottom. The father then attempted to vault over him, misjudged it and landed on the boy in the manner described in paragraph 3.159. Alternatively there would have had to be some other similar trauma involving a combination of heavy force and motion.

3.179. On this hypothesis, of course, the father's failure to get medical help or to answer the door to the ESW or health visitor during the period become more sinister. The father realised that L had suffered a serious injury for which he was directly responsible. Vaulting over L after the accident so shortly before would have been regarded by anyone as culpably stupid. For the child to have suffered two serious accidents in a short space of time would inevitably have raised questions. He probably hoped that L would get better. His own nerves may have been frayed by the anxiety of the situation. It might have been this which caused the rough handling or pushing and shoving of L, especially if the father wanted to believe that the boy could still do the things which he usually did and that his symptoms were just play-acting. The failure to call the Emergency Services when he realised that L was dead and the attempt

to involve others in a false account of L being alive earlier in the day could then be seen as an attempt to play for time.

3.180. It has been strongly put to us that the father's account has been consistent and should be accepted as truthful. He has always said that there were two falls accounting for the injuries, long before he knew that the medical evidence would eventually support that contention. It has been suggested that it would be extraordinary if the father, lacking medical knowledge, happened to think up the one explanation which accounts for these unusual injuries. Unfortunately, on the evidence we have, his account does not do so. If there were two similar incidents, it would be a partial account.

3.181. We regret that we have not been able to form a firm conclusion on the medical evidence. The older doctor's evidence, as we understand it, was crucial at the trial, and it seems probable that the jury accepted it. The evidence does not point consistently and cogently either towards the conclusion that the injury must have been caused before that visit to the hospital, or that it must have happened afterwards. As we have demonstrated, either hypothesis poses considerable difficulties. We are aware that by failing to reach a definite conclusion we are letting down those who have been hoping that we will be able to tell them "what happened" to L.

3.182. We suspect that ultimately which of the two hypotheses is accepted depends upon the reader's view of the father. Those who are sympathetic towards him will accept his account and explanation. For them he will be a genuinely caring father indulging in a piece of horseplay with a small boy which went tragically wrong. They will regard his refusal to obtain medical help as a mistake which he himself acknowledged and with which he

will have to live. Those who are unsympathetic or hostile towards the father will question why he was encouraging this sort of play at all on a steep flight of stairs with a glass panel at the bottom. It was an obvious hazard. The possibility of a tragic accident with the child falling through the panel ought to have occurred to any responsible parent. They will also see his failure to obtain medical help, and his failure to admit anyone from the agencies into the home during the last weeks of L's life as sinister, even evil.

AFTER THE DEATH

3.183. The police obtained a Place of Safety Order in respect of [redacted] on the evening of the death. He was removed to the Whittington Hospital where he remained on the childrens' ward until the beginning of January. Initially his father stayed there as well. Both of them were interviewed by the police. During this period the post mortem was carried out. The police obtained statements from neighbours and friends of the father, the doctors at the hospital, A and the mother.

3.184. On the 31st December a child abuse case conference was convened and Islington obtained an interim Care Order from the Juvenile Court. [redacted] was moved to foster parents on the following day. Initially he saw his father five times per week. There was a further conference on the 11th January. [redacted] was made a Ward of Court on the 13th and access was then reduced to three times per week. It was supervised and took place either at the neighbourhood office or the childrens' home.

3.185. On the 4th February 1988 a skeletal survey was carried out on [redacted]. The x-rays subsequently showed injuries to him. He had a broken left clavicle and healed fractures of the 9th, 10th and 11th ribs. The father denies causing any of these injuries. There is

dispute about how old the clavicle injury is. It was said by the Prosecution Pathologist to be at least 6 months old. An expert on behalf of the father says that it is much older than that. He says that the clavicle is obviously deformed in a photograph taken in July 1986 which suggests that the bone was broken then. If so, the clear inference would be that it was caused while S was still in his mother's care. Unfortunately the doctor who was consulted by the father, who had hoped to be able to attend to give evidence was unable to do so at the last moment. If his theory is correct, it does mean that not only the social workers who saw S stripped in May 1986 when they were looking for injuries on him but also the doctor who examined him for his developmental check on the 18th July 1986 and following the injury on the 12th May 1987 also failed to see the injury. S was apparently stripped on both occasions. Although the father was charged with cruelty to S in respect of these injuries, the charge was not proceeded with following his conviction in respect of L. We do not think it would be right for us to draw any conclusions about this aspect of the matter based upon the evidence before us.

3.186. It was not until the 4th May 1988 that the father was charged with any offence. The committal began on the 4th August 1988 but was adjourned and not completed until the 6th October. He was not brought to trial until June of the following year, when he was convicted of manslaughter. On a second charge, of assault occasioning actual bodily harm to L the father was acquitted.

3.187. On the same day, however, he was convicted of firearms offences. The allegation was that he was seen in a basement and found to be carrying a gun. He threatened the officers who went to arrest him. He was sentenced to 5 years' imprisonment. We have only limited information about this offence which had no direct bearing on our enquiries, since it happened after S was

in care. We have read some of the Press reports of what the father is alleged to have said about it. No-one that we have interviewed ever saw him in possession of a gun or knew that he had access to guns. We do not think that we can take this aspect of the matter any further.

3.188. On the 26th and 27th July 1989 the Wardship proceedings were concluded. [redacted] remains in the care of the local authority.

3.189. The ACPC instituted its own review into the case on the 16th August 1988, following the guidelines laid out in the Government pamphlet "Working Together". This was completed by the end of September 1988 and made interim findings. It had been intended to follow this up once the father's trial was over with a full review but this was overtaken by the institution of this inquiry. The DHSS Inspectorate also reviewed the case in April or May of 1989 and concluded that there was no question of anyone being to blame.

3.190. We examine the events following the death in more detail in later paragraphs.

4.12. One aspect which has been suggested to us is that it might have made it easier for [redacted] to talk about the injuries to the children had she known about the previous allegations of violence to [redacted]. As it was she knew nothing either about those allegations or about what had happened to the mother. We are not persuaded that it would have actually encouraged her to report the father's behaviour to the authorities, but it does raise an important issue of principle as to whether and in what circumstances the Social Services ought to divulge to a new co-habitee information about violence towards a previous partner or the children of a previous relationship.

4.13. We have tried to consider whether it is possible to make a recommendation about this as a practice. We have concluded, however, that at the end of the day it must be a matter for the discretion of those in possession of the information.

4.14. We would offer the following guidance:-

(i) The workers should have clear in their minds the child protection issues which arise from the particular conduct. It is these which need to be addressed.

(ii) The violent conduct should be raised first with the person against whom the allegations are made. He or she should [redacted] be invited to tell the new partner themselves, failing which the Social Services will do so, especially where this is the reason for concern about the current family situation.

(iii) It is obviously easier to disclose allegations which are admitted to be true. Where the allegations are disputed, disclosure of

> the information is potentially defamatory. Care should be taken to assert as fact, only that which in the last analysis can be proved to be true. In many cases it will be sufficient to assert that allegations have been made to the local authority that the person has been violent, and that these cause the professionals concern for the children's safety. The social workers should take advice from the legal department if necessary. We do not think that fear of proceedings ought to inhibit the social workers from taking necessary steps to protect the child.

4.15. We think that there should perhaps be more of a bias towards disclosure than there is at present. Whilst the Social Services' ability to dissuade women from believing that their partner has "changed" may well be limited, we think there are many cases where such partners do need to be warned about the consequences for themselves or any children in their care of continuing in a relationship with a violent partner. It is easy for social workers to assume that a visit from the Social Services will make such a partner aware that there must be some concern. This is not necessarily so. A thought that the Social Services always checked up when the children moved from a home in one part of the country to live with someone else.

4.16. In [redacted] case, however, the question of why she did not disclose the risk to the children after she left the father has also to be addressed. We think there were a number of factors. First, as we have indicated, the father had apparently heeded her warning a few months earlier and had not behaved aggressively towards the children. It is also true that by the time she left, [redacted] was mentally and physically completely drained and

profoundly depressed. She described herself as having no energy and finding it almost impossible to get going. It took a long time for her to recover a measure of self-confidence.

4.17. She was also hoping that the father would allow the children to come and live with her. That was why she kept in touch with him by telephone. Since she had no legal prospect of getting care of them, her hopes rested entirely upon the father's co-operation. Clearly a disclosure to the authorities would not have assisted her in that objective.

4.18. Most importantly, however, we do not think that it ever occurred to her to do so.

IMPLICATIONS FOR FUTURE CASE WORK

4.19. We have explored the main participants' attitudes towards the agencies, and particularly Social Services in some detail. It is important to understand whether the fact that so much was not disclosed to the agencies was due to the choice of the individuals concerned or some agency failure. There is no suggestion here, as is sometimes the case, that either the mother or A ever wanted to talk to a social worker but could not get hold of one, or that they thought that all social workers were "useless".

4.20. None of these adults was inadequate or feckless. The agencies spend a lot of time dealing with people who are both. It is very difficult for the services to work effectively with those who have a high level of social skills, reasonable confidence in parenting, who keep appointments and take their children to the clinic regularly or when asked. Such families are extremely unlikely to confide in any agency professional. Apart from their own reticence about doing so, the agency

professionals simply do not spend as much time with such families as they do for example when they are trying to train an inadequate, unsupported mother in basic parenting skills.

4.21. The children were actually seen by professionals on a large number of occasions. Most of the unsuccessful attempts to visit were either because the mother had moved without telling the agencies, or were during in the last weeks of L's life. There were only two other occasions in 1987 when the health visitor tried unsuccessfully to see the family. On the first of those the children were actually seen two days later at home. On the second she saw L at home with his father two weeks later.

4.22. The only area in which the father and [redacted] fell short was in relation to [redacted]. During his first year, of course, he was not of compulsory school age. He did have a lot of absences but there was nothing very effective that could be done about it. After he reached the school age, there were of course procedures for compelling him to attend. We examine these more closely below (paras 13.2 to 13.5).

4.23. It is of course a characteristic of many of the cases in which a child dies at the hands of a parent that it emerges that no-one from any of the agencies actually saw the child during the last weeks of his life. That pattern is repeated here although to a lesser degree than in many other cases. After the death this becomes significant. Pre-death the workers may not even have realised that it was happening. In a case such as this, prolonged absence from school, though worrying, does not in itself ring alarm bells. Workers who visit, who have not been denied access before, such as the health visitor, assume that the family are out when they call.

4.24. It was said to us before we started hearing evidence that if we could suggest ways in which families like this, who in no way stand out from hundreds of others with whom the agencies are dealing, could somehow be identified before the tragedy occurs it would be an enormous help. It will be clear from the pages that follow that although we suggest ways in which practice might be improved, we have been unable to suggest an infallible method of spotting potential child killers.

CHAPTER 5

OVERVIEW

5.1. As we have already indicated, it is easy with hindsight to blame the professionals involved for their failure to spot what was going on. For the reasons that we have already set out in some detail in Chapters 2 to 4 above, we are not convinced that this was a case where they failed to spot what was going on but rather one in which there was not anything to spot. We have already indicated that throughout the period that the children were with A and the father there were many more positive than negative observations about the way that the children were being cared for and their relationships with the father and with [redacted].

5.2. We have already observed that there was nothing that made this case stand out from hundreds of others. Sadly there is still a lot of domestic violence going on. A's thinness and tension which the health visitor clearly sensed during her visit on the 5th March 1987 appears to be the only indication which suggested that all might not be as well as it appeared on the surface. Even then it is clear that the health visitor's first assumption, understandably, was that [redacted]'s thinness might have some medical cause.

5.3. The other complicating factor about the management of this case is that on each occasion when the children were known to be the victims of some assault, i.e. in March 1984 and May or June 1986, the children moved to a different part of the country and to a completely different domestic situation. Thus Sheffield and the other Yorkshire agencies were dealing with the situation of a mother who had separated herself and her child from an allegedly violent partner. The abuser was off the scene so long as the mother remained apart from

him. To her credit for a long time despite the strong physical attraction she still felt for the father, the mother did indeed remain apart from him.

5.4. Similarly, when it was the mother who was expressing concern about her own potential for violence towards the children she took them to the father and left them there. Had she remained, the earlier concerns in London about the father and the recent concerns in Sheffield about the mother would have come together, and there is no doubt that the level of anxiety within the agencies would have been very much higher. The child protection machinery would almost certainly have swung into operation. Instead, the effect of the move was once more to remove the children from the person from whom they were at the most immediate risk. They were placed with the father who was in a new relationship. No Court action had been taken or full investigation into the earlier allegations against the father had been carried out because at that time it was not necessary. Similarly, further work with the mother about why she was lashing out at the children was not done in 1986, for the same reason.

5.5. The most remarkable thing, as we have said above (paragraph 3.105) is that the children were not more disturbed and damaged in 1986 than they appeared to be. As we have seen, their placement with ● and the father, contrary to expectations, seems to have been extremely successful in the early months. On each occasion it is impossible to say that the decision to see how the new situation developed was the wrong one. On the contrary on each occasion in the childrens' interests it was probably right.

CHAPTER 6

INTER-AGENCY CO-OPERATION AND WORK TOGETHER PRIOR TO THE DEATH

6.1. We think that overall the co-operation and liaison between the agencies in this case was very good. In both Islington and Sheffield, there seems to be particularly close co-operation between the local health visitor and the local authority. We found no reluctance to share information or to seek the advice and help of the other when required. In Islington, this extended to the local doctors and the ESW Service and the Probation Service.

6.2. Similarly, when any of the individuals agreed to carry out some task in relation to a plan for monitoring the children, they seem to have done so. Occasionally things do not get followed up but by and large, at a local level, if a worker from one of the agencies agreed that they would do something, their colleagues from the other agencies could feel confident that that part of the plan would be carried out.

6.3. Again, when one looks at the occasions when the case was transferred between London and Sheffield, there was good liaison between the two. All the main information available was passed onto the receiving agency, albeit in summary form. We think that the way in which information is transferred between Social Service departments might be improved. We have considered the wisdom of transferring whole case files, and whether the records should follow the family within social work in the way that they do within the health service. We have come to the conclusion that to do so in all cases would be unwieldy and unworkable. This means that it is essential that there should be a good summary of the known informa-

tion when the case is transferred. We have tried to think about ways in which this could be done without imposing yet another burden on already over-stretched Social Services teams.

6.4. We are quite clear that the responsibility of sending a proper summary is with the agency transferring the case. They may wish to make suggestions about how the future management of the case might be dealt with by the receiving agency or at the very least what they were planning to do had the case remained with them. It is, however for the receiving agency to make its own assessment of what action is required and to consider for example whether a child abuse case conference should be called. At the end of this chapter, we include a draft form, which we thought might be helpful. It is not the definitive version and might well be adapted and improved. We hope it will encourage discussion.

6.5. The system operated within the health service whereby the complete record is transferred when the child moves seems to have worked reasonably well in the present case. There are bound to be difficulties when the parent and children are moving as frequently as the mother did during 1984 and 1986. This was not a case, however, where the family was moving in order to avoid the watchful eye of the agencies. Similarly, at no time were the community health services having to deal with a child where their lack of background knowledge was crucial. We are quite satisfied from what we have seen that had that been the situation the health visitors would have telephoned and made contact with their counterparts in order to alert them to any cause for anxiety.

6.6. We have highlighted at paragraph 3.23(b) above the problems which arose over the central filing of the medical reports on abused children within the health service. The effect of this, for example was that a

doctor called to a school to treat an injured child for which an accidental explanation was given, would have had no way of knowing that the same child or his sister had suffered a similar injury a year earlier and given a similar explanation. It seems to us obvious that such reports should form part of the medical file on the child.

6.7. There is an obvious hiatus when a child starts school, and the question clearly does arise how much information obtained during the pre-school years should be passed on. We think it must depend upon whether or not the child is still regarded as vulnerable by the time he starts school. Where that is the case, one would expect suspected NAI to be recorded. More difficult is the child who has a number of "accidents" where the explanation is accepted each time - just. We think it is probably possible to summarise those sort of concerns in a report to the school.

6.8. Concern is sometimes expressed about labelling children in this way. One answer would be for there to be periodic reviews of such school health records. Another is that there should be a fresh record when the child transfers to secondary school, with only matters of continuing concern entered on it.

LACK OF CENTRAL INDEX IN SOCIAL SERVICES DEPARTMENTS

6.9. Neither Sheffield nor Islington any longer operates a system whereby an index is maintained of all families and individuals who are known to the Social Services department. In Islington, each neighbourhood office keeps its own index of those known to the office. Sheffield has a similar system, compounded in their case by the fact that the file is known only by the name of the person who first makes contact. Thus, in Sheffield,

there was no way within the system that the social workers dealing with [redacted] and L could have found out about the substantial file held in respect of the other child, G. It was only the coincidence of [redacted] social worker realising that this was the same family that allowed the exchange of information about the father.

6.10. We do not consider that the only centralised index, which does exist, namely the Child Protection Register, is sufficient. People do move within the borough, and do not always disclose previous involvement with the Social Services. There is no way that a neighbourhood office dealing with a request for Section 1 money can discover that there is a substantial file on the family held in another office, except by chance. If an injured child is treated at the Whittington Hospital, there is no way they can find out whether the family is known to Social Services except by ringing up to 24 neighbourhood offices to find out. We emphasise that we do not think that it made any difference in the present case. It might have helped to locate the old file more quickly in 1986, but that is all. We consider it to be a valuable tool, however, and probably essential when operating a decentralised system based on a local office.

CASE CONFERENCES

6.11. We have considered these in some detail already in relation to the individual meetings which were held (paragraphs 3.89). The evidence which we have received gives rise to some general concerns.

6.12. The first is the importance attached to the label rather than the contents. The present system seems to mean that the Social Services decide in advance of the conference whether the case involves "child abuse" or not in order to decide whether to hold a "child abuse case conference" or some other form of meeting or conference.

It does seem to us that we have moved away rather from the concept of the professionals from the agencies involved meeting together to share information in order to decide whether there has been child abuse or not. In this case it made no difference, because of a lot of the information had already been exchanged in advance of the conference. In other cases it might. At the very least it means that people are going to a meeting which is not designated as a CACC with rather different expectations from those when they attend a conference which is so designated. Where there is any doubt, we think that they should err on the side of holding a child abuse case conference.

6.13. We are also concerned that in some quarters, having a case conference is regarded as the solution to a difficult problem rather than a forum for discussion and analysis. We think it may also be used as a substitute by other agencies for taking action which properly belongs to them.

6.14. Another aspect which we found of some concern is that the case conference becomes the focal point of the work rather than the assessment. We were struck by the fact that in both London and Sheffield, the social workers made assessments of the family and then collected the background information for the conference. We appreciate that in an emergency it will not be possible for the information to be shared in advance of the assessment. For example, if the duty social worker who visited the father and A on the 17th June 1986 had known a bit more, not so much even about the allegations of violence in 1984 but about the disruptions and disturbances which the children had been through in the months leading up to their move to the father (see list at the end of Chapter 3), his assessment of the children being happy in that home would have carried even greater weight, because it would have brought together the known

information. Under the prevailing system, the assessment is made that the children are all right and the question then is whether anything in the background information is sufficiently compelling to undermine that assessment of the current situation. It is difficult for the individual worker or the case conference to answer with hindsight the question "whether if the background information had been available it would have made any difference to the assessment.

6.15. It seems to us that case conferences are still used far too much for discussion and not enough for analysis. It is very difficult to collate information which is given orally in these circumstances, so as to build up an accurate picture of what is happening. It is not helped by the fact that the information often seems to be given in a generalised way and is particularly vague as to the dates when incidents happened. We think that if the practice developed of agencies submitting written summaries, including the dates of any contacts with the family prior to the conference to the person chairing it, this could be collated into a chronology which would form an accurate and sensible basis for analysis and discussion. We appreciate that lack of adequate administrative support is a big consideration here. At the same time we would envisage that the length of time spent by the professionals at case conferences, and indeed at times even the need for such a conference at all, could be significantly reduced by the introduction of this sort of system.

6.16. Another aspect which has emerged during our discussions is the extent to which those who attend case conferences often have unrealistic expectations of the other agencies' powers and what they are able to achieve. For example, it is commonly assumed that if a person has convictions, the police will "know". They do not appreciate that in order to carry out the necessary

checks the police need not only the name but also the date of birth of the individual concerned. It is far from routine practice amongst the other agencies to establish the date of birth of the adults that they are dealing with.

6.17. Similarly, there is a common belief that however impotent the other agencies may be when it comes to dealing with the family, Social Services ought to "do something". This is particularly so in those cases where there is a lot of non-specific "concern" but very little hard evidence.

6.18. These sort of expectations can create a false sense of confidence not only that all the information is being given but also that although no formal action is to be taken some other agency will be "keeping an eye on things". For example, the health visitors have responsibility for infants in their first year of life, involving regular checks and visits. For pre-school age children over a year, their responsibility is essentially to ensure that they have their developmental checks. In the present case it is clear that the health visitors were doing much more than that. The problem is that their resources are very stretched. In this sort of situation they cannot visit as regularly as would be needed for them to have an effective monitoring role in high risk cases but their occasional contact with the family encourages the belief that all is well.

6.19. It is easy to say of course that they should not carry out such informal monitoring. It is much more difficult in practice where there is concern that the children might be at risk. What we wish to emphasise is the limitations of this sort of system. We discuss in more detail the question of informal monitoring systems at para 8.24. The urgency which seems to us to have the

biggest problems in establishing the limits of its own role is the ESW Service.

6.20. The ESWs former role as "truant officers" has clearly been expanded but there are uneasy grey areas around the edges. We do not find that these caused any practical difficulties in the present case between them and the Social Services. The main problem arose in relation to the Press publicity of the trial since the expression "social worker" was used to describe the ESW for whom the Social Services department were not responsible.

6.21. We think that the question of each agency's powers, procedures and what they can or cannot do is a matter for urgent inter-agency training and information. See also paragraphs 8.8 & 8.14 below.

ACCIDENT AND EMERGENCY DEPARTMENT

6.22. Apart from the aspects which we have considered in detail in Chapter 3, we have had to look at other aspects of L's visit to the Whittington Hospital on the 23rd November 1987. It seems to be generally agreed among the doctors that the injury suffered by L on this occasion was an unusual one, and was not obviously explained by the history given by the father. What is striking is the absence of the sort of bumps and bruises one might expect to find on a child who had fallen on the stairs. As we have previously stated, the doctor who examined L had a lot of experience of examining children. She was not suspicious that it might have been non-accidental. She was clearly impressed by the father and by the happy relationship that there appeared to be between him and L. She had no sense that there might be something wrong. Working in a busy accident department there are frequently times when people suffer serious accidents and sustain unexpectedly minor injuries or

injuries which are different from those which might be expected.

6.23. In her notes, however, she records "Not v. helpful answers to questions." This suggests that attempts to probe the father's explanation were not very helpful.

6.24. There was no procedure at the Whittington Hospital at the time for routinely involving a paediatrician in the work of the A and E department. Many of those working in both departments are junior doctors doing a six month training stint. We accept that it was probably not always easy to get hold of a paediatrician when required. Had the Registrar or Consultant Paediatrician been called, we think this injury which was evidence of considerable internal bleeding, might well have raised questions in their minds, coupled as it was with the slender history given.

6.25. Related to this is the question of whether or not the injury should have led to L's admission. It is impossible to say whether if he had been admitted it would have been discovered that he was suffering from a spinal injury, if indeed he was. It obviously increases the possibility of that happening.

6.26. Again we appreciate that in the A and E department in this hospital, as in many others, it is easy for a suspicious injury to be missed. We consider in Chapter 11, the need to improve the training of doctors in the A and E department in relation to child abuse and also the question of referring injured children to the paediatrician.

6.27. It is only if the doctor's suspicions were aroused in the first instance that any check would have been made to see whether the child's name was on the NAI

register. There was no health visitor liaison post covering the A and E department. There was no system for notifying the health visitor that the child had been seen at the hospital. Given that frequent accidental injury can be an indicator of child abuse, we think that it is essential for some system of notification to be implemented, and explore that further in Chapter 11. The traditional system of notifying the GP is inadequate. We have been unable to establish when, if at all, the GP was notified that L had been treated. But where, as in Islington, the medical care of the under-fives is largely done by health visitors and community medical officers in clinics, it seems to us essential that they are notified as well. In the present case, we think that the health visitor, had she received notification of this incident would have visited the home. Whether she would have succeeded in seeing L is more difficult to gauge. We think that she would have needed to see him on more than one occasion, and to have seen that he was getting worse and not better, for it to have made any practical difference to the outcome of this case.

GENERAL PRACTITIONERS

6.28. They appear to have paid little part in the lives of [redacted] and L. For a long time no-one was able to establish who was treating the boys. They changed GP within Islington as well as on moves from other parts of the country. We do not consider that this is a case in which the attendance of the GP would have made any significant difference to the assessment of the case at any stage. On the other hand it is a matter of concern, particularly as it is still the GPs who are notified of hospital attendances and admissions, that they routinely play so little part in case conferences.

THE PROBATION OFFICER

6.29. The preparation of Court Welfare Reports by the Probation Service represents only a very small part of their work. We explore this further in Chapter 14. The Probation Officer assigned to the custody case in 1987 was relatively inexperienced and did not prepare a report in time, nor make any worthwhile inquiries into the case. He clearly should have done so. Missing the date was an oversight on his part and it is fair to say that he was on leave for part of this period. Had he prepared a report, a part of the preparation would have been to see the father and children together. Whether he would actually have done so, whether that would have been in the home or at his office, and whether he would have formed any different assessment of the relationship between them, is impossible to say. He would probably have seen them before the injury to L. All these are matters of speculation.

6.30. It seems to us to be important to look realistically at the factual situation which would have confronted the Magistrates on the adjourned hearing if there had been a report. The mother had abandoned her cross-application. The children had been cared for successfully by the father for 18 months. Inquiries from other agencies would have revealed that they were happy with the standard and quality of the childrens' care, despite earlier misgivings. It is difficult to see how the Magistrates would have arrived at any conclusion other than the one they did, namely that the children should remain with the father. It seems to us that the most that would have happened is that there would have been a supervision order. We think it highly unlikely that the Magistrates, on the basis of anything which might have been in a probation report produced in the middle of November, would have considered removing the children from their father. Had they made a supervision order, it

is extremely unlikely that anyone would have been allocated in the ensuing month, or been able to visit the father prior to the death. Again we think there are unrealistic expectations about the protection that can be afforded to children in unopposed Court proceedings.

FILTERING OF INFORMATION

6.31. It is clear from our investigations that at every stage the information which reaches the Social Services is filtered in some way. In most agencies the whole system depends upon the least experienced people being alerted to the risk of abuse. This applies to junior doctors in A and E and paediatric departments, to new health visitors, and to teachers in their first job. It is clearly valuable if the junior person can discuss it with a more experienced colleague to decide whether or not the child protection procedures should be implemented or not. This sort of filter may be necessary and helpful. On the other hand the more that information gets passed from individual to individual before reaching those who have to act on it, the greater the risk of distortion and, in some cases lack of immediacy.

6.32. The two agencies who have the greatest problems with this are the education service and the police. In the education service, as we have seen, the teacher reports injuries to the head teacher. If she thinks they are trivial or accepts the parents' explanation, she would not usually pass them on to the ESW Service. When they are passed on, it is the head teacher who reports what the teacher has said to the ESW who then contacts the Social Services. Similarly, in the police service, cases involving suspected injury to children were at that time reported to the Juvenile Bureau. That aspect appears to have worked quite well. More difficult are the problems which arise when the police investigate a crime involving the parents which indicates a lifestyle

which might be detrimental for the children, for example drug abuse or prostitution, or where they may be caught in the crossfire of domestic violence between their parents. Such incidents may or may not get reported to the police officers with responsibility for protecting children from abuse. Again there is a filtering mechanism at work which means that all these incidents do not necessarily get passed on to the Social Services.

6.33. Related to this is the question of selective disclosure of information by agencies to one another. There is no problem about this in the obvious and serious cases. No-one fails to disclose having seen serious injuries to a child but there are as we explore in detail in Chapter 7, very real tensions between the functions of the agencies in relation to child protection and their more usual roles.

6.34. We think that such filtering is inevitable. What is important is to recognise that it is happening and not to assume that everything which there is to be disclosed has been made known.

RECOMMENDATIONS

1. That consideration be given to improving the system of transferring information about children who are at risk from abuse to their school records.

2. That wherever possible, Social Services should obtain information from other agencies before making an assessment of the children's situation rather than afterwards.

3. That, wherever possible, a summary of each agency's contact with the family should be submitted in writing to the person chairing the case conference in advance of the conference taking place.

NAME OF TRANSFERRING AGENCY

CASE TRANSFER FORM

Name of Client:

Last address here:

Reason for transfer:

Recent care status			
S.2 S.3 Care Order		S.O. P.S.O. Other None	

Names & Addresses of significant family members:

Name	Address	Relationship	Care status, if any

History of contact with this Department:

Date	Nature of contact	Worker involved

(Continue on a separate sheet if required. List the contacts which have given rise to recent concern and background information as relevant. Attach any case conference notes or reports which give details of contact)

Summary of information received from other agencies:

Date	Nature of contact	Worker involved

Current concerns of agencies/impressions/comments.

Names, addresses and telephone numbers of workers known to be holding information on the family

Suggested future work

CHAPTER 7

INTER-AGENCY CO-OPERATION FOLLOWING THE DEATH

7.1. Islington has a good record of inter-agency co-operation both at the field service level and at the management level. We think that objectively there was a good level of co-operation between them following this child's death, but that this case highlights the problems which can still arise even when conscientious authorities are genuinely trying to work together. The level of real co-operation is high so long as there is no conflict between the need to protect the child and the needs of the agencies. These conflicts and tensions do exist and it is in our view unhelpful that both the Government's "Working Together" document (which we consider further in Chapter 8) and the local procedures provide little if any help in resolving these issues and tend to gloss over them.

7.2. A fundamental issue which has not been resolved is whether the role of other agencies is to supply the Social Services department with the relevant information in their possession to enable the department to carry out its statutory function of protecting children, or whether they are all genuinely co-operating fully and equally in the child's interests regardless of the legitimate need of their own agencies. All the difficulties which we outline in the following paragraphs stem from this fundamental, unresolved issue.

THE PROSECUTION PROCESS AND THE NEEDS OF THE SURVIVING CHILD

7.3. There are two related aspects to this. The first is the delay which the criminal proceedings involved before the child's future could be resolved and the

second is the tensions arising between the police and the Social Services in relation to the investigation.

DELAY

7.4. As we have seen, there was a delay of about 18 months between the death of L and the father's conviction. This was not the result of a deliberate intention on the part of either the Prosecution or the father and his legal representatives to delay the matter. A number of factors contributed towards it:

(i) The serious and unusual nature of the child's injuries. This meant that the pathologist who carried out the post-mortem wished to consult with colleagues and carry out further investigations into the injuries. The history of this aspect of the matter is as follows:-

26/12/87 Post-mortem. Oral report from the pathologist to the investigating officer about the spinal injuries and other fractures and his assessment that they had been deliberately inflicted.

These findings were incorporated into a report by the pathologist dated the same day. It is not clear when this was actually prepared or put in the hands of the police.

17/2/88 Pathologist's police statement exhibiting his report.

11/3/88 Radiologist's report on x-rays to S.

14/3/88 Pathologist's report on x-rays on S, confirming NAI.

18/7/88 Pathologist's report of the histological findings of the post-mortem.

7.5. The investigating officers sent the file to the Crown Prosecution Service (CPS) about the middle of February 1988 following the receipt of the pathologist's written report. They had already completed other aspects of their investigation. At the end of March the information in relation to S was also available. The CPS delay seems to have been in deciding whether there was in fact sufficient evidence against the father to warrant a prosecution. The CPS did not decide there was until the beginning of May 1988 when the father was charged with manslaughter and the related offences. We have not investigated the reasons for this aspect of the delay fully, and do not know what problems the CPS may have had in reaching their decision. On the face of it, however, the delay of 2½ months here seems excessive.

7.6. The criminal proceedings began with the father's appearance in the Magistrates' Court. He was granted bail subject to a number of conditions and released shortly afterwards. The next stage of the process was for the CPS to collate the witness statements and serve them on the Defence in order to commit the Defendant for trial. The father was remanded to the 1st June 1988 to allow this to be done. It is not clear whether the statements were available, but it is clear that the father decided, as he was entitled to do, to challenge the written evidence at the committal stage, in order to try and establish that there was in fact no case for him to answer. The case was adjourned for that purpose. This is common practice in busy Magistrates' Courts.

7.7. The committal was due to take place on the 4th August. As we understand it the CPS estimated that the committal would last half a day, and that was the amount of time allowed to deal with it. In fact that time was only sufficient to allow the pathologist's evidence to be given. The earliest date when a full day's hearing could be given was the 5th October when the committal was

completed. He did not succeed in having the prosecution case rejected. He was committed for trial at the Central Criminal Court, still on bail.

7.8. Inevitably that meant that in terms of listing the case for trial the case would have a lower priority than those in which the accused was in custody. It was clearly a case where a date needed to be fixed in order to ensure the attendance of the expert witnesses. Regrettably, a delay of 8 months between committal and trial at the Central Criminal Court is not uncommon. The social worker did try to get the matter dealt with promptly. An Assistant Director of Social Services wrote to the CPS about this on the 2nd December 1988.

7.9. Because of the delay in the criminal proceedings, the did try to get the wardship proceedings dealt with in advance of the criminal trial. Their view was that whilst the conviction of the father would make [redacted] return to live with him out of the question, [redacted] should not actually return to him even if he were acquitted. The original estimate for the hearing of the wardship proceedings was 2 weeks. Again pressures on Court time in the Family Division of the High Court seemed to have caused similar problems. Although delay in such cases is acknowledged on all sides to be undesirable this case illustrates the unreality of trying to impose short fixed time limits for the disposal of care cases. In the present case, it is also right to point out that the delay actually operated in favour of the Social Services' long term plans for [redacted].

7.10. The other aspect was that the delay in relation to the post-mortem and the criminal proceedings seem also to have delayed the release of L's body by the Coroner, at least in the initial months after the death. On about [redacted] the father's lawyers indicated that they did not need a post mortem examination by [redacted]

expert. Thereafter the delay was due to the fact that the Coroner was unable to make contact with the mother. It was assumed that she would be making the funeral arrangements. It was not until 27th September that her Solicitors notified the Coroner that she was not after all proposing to do so. The father then made the arrangements for the funeral on 10th October 1988. This obviously delayed the grieving process for the family, including [redacted].

CONFLICT BETWEEN THE NEEDS OF S AND THE NEEDS OF THE POLICE IN PROSECUTING

7.11. It is clear from our inquiries that this case has caused some damage to the previous good relationship between the police and the Social Services. In the following paragraphs we examine some of the concerns, what caused them, and whether or not they were justified.

[redacted]

Changes in the Police Structure

7.12. During the period covered by this Inquiry, the police structure for the investigation of child abuse changed. As we have noted, child abuse was previously investigated in the same way as other criminal offences and matters of note were passed to the Juvenile Bureau which was responsible for liaison locally. At the beginning of 1989 the police established specialist child protection teams of about 10 or 11 officers who are responsible for investigating the vast majority of child abuse cases. They operate under guidelines in which it is quite clear that the question of whether or not there should be a prosecution of an alleged offender is usually but not always to be determined by whether or not this is in the best interests of the child.

7.13. There are two main exceptions to this. The first is cases involving the suspected homicide of a child, or cases involving very serious injuries to a child, which are dealt with Divisionally by the Murder Squad or other appropriate team. The second exception is when the abuse alleged is part of a wider spectrum of criminality, for example a child pornography ring. These too are investigated divisionally. Accordingly, although the present case was investigated under the old system rather than the new, we think that the same problems could still arise in fatality cases.

Disclosure by the Police of Information Obtained During the Criminal Investigation

7.14. It has been put to us that the police had a lot more information about the father and what had happened than they were prepared to disclose to the Social Services or at case conferences. As will be clear from what follows, so far as the social workers who were actually dealing with the case were concerned, there were some specific areas of concern about the police disclosure, but they were not generally under the impression at the time that the police were in possession of a lot of information which was not being passed on. It was at a much later stage, in about April 1989, that a senior police officer conveyed to the Social Services management the impression that the case was far more serious, in terms of the social work management of it, than had previously been thought. Concern about the police's conduct really stemmed from that meeting. From there it filtered through to the social workers dealing with the case.

7.15. We have looked in considerable detail at the various files to see when information came into the possession of the police, and when it in turn was

disclosed to . In relation to the police investigations, and the evidence which they uncovered, we are quite satisfied that all their material findings together with the weight which the investigating officers actually attached to them was disclosed to the subsequent case conferences or Social Services without undue delay. We think that at the time the evidence was submitted to the CPS, there was genuine uncertainty as to whether or not the evidence did disclose a sufficient case against the father.

7.16. As was the common practice, an investigating officer as well as the officer from the Juvenile Bureau attended the earlier case conference. There clearly was some discussion between them prior to the earlier case conferences about what they could say. We think it is important for the representatives of other agencies to appreciate that when a police investigation is in its early stages harm may be done by disclosing all the details of the progress of the investigation, particularly about areas of possible weakness in the case. Within that constraint, which we regard as legitimate, we think that there was full and proper oral disclosure of the police's information at these meetings and in other discussions between the investigating officer and social worker.

7.17. The first area of difficulty which arose was because of fears on the part of the police that , who was one of the main Prosecution witnesses would come under pressure from friends of the father not to give evidence. was also concerned about this. She was advised by the police not to discuss the case with anyone. This was interpreted as including the Social Services. This is a very real problem. was a significant adult in the childrens' lives, and the social workers clearly needed to find out what she had to say, and what her future role was likely to be.

7.18. The other major problem was that there were considerable difficulties in the Social Services obtaining copies of the pathologist's reports, and the written statements of both medical and other witnesses, especially the mother and [redacted] The police state that once the matter has been referred to the CPS, it is a matter for them whether these statements are disclosed or not. The situation is also complicated by the fact that the police solicitors have traditionally taken the view that the written statements of witnesses other than police officers can only be disclosed with those witnesses' consent. We explore this proposition in more detail later.

7.19. Whilst we can see that there is a legitimate area of concern about these statements being produced to the Social Services in advance of the committal proceedings, when they are given to the accused, we can see no reason why they should not be produced to the Social Services department to the extent that they wish to see them once that has occurred. It is absurd that the only people who do not know the details of the evidence are those who have a statutory responsibility to protect the surviving child.

7.20. There is another side to the coin. The alternative to the Social Services being supplied with details of the police evidence is that they have to carry out their own investigations in parallel with those of the police. Apart from being a needless duplication between agencies who are supposed to be working together, it does mean that statements given by witnesses to the Social Services may be inconsistent with the statements given to the police. If such statements are then made available to the accused, as they would have been here in the wardship proceedings, they will provide evidence for the cross-examination and possible undermining of the prosecution witnesses. Accordingly we think that it is

very much in the police's own interests to reconsider the attitude towards the disclosure of written evidence which they currently take.

7.21. The main difficulty is that the police have traditionally regarded and still regard the information in their hands as more confidential than the confidential information possessed by the other agencies. It seems to us that "Working Together" is about the exchange of <u>confidential</u> information. No agency has any difficulty about exchanging non-confidential information. The problems have always centred around issues for example of confidentiality between doctor and patient, the Probation Service and its clients and breaking the confidences of the children themselves. In paragraphs 5.4 and 5.5 of "Working Together" the issue of medical confidentiality is addressed. In relation to doctors, their professional guidance concludes:-

> **".... if a doctor has reason for believing that a child is being physically or sexually abused, not only is it permissible for the doctor to disclose information it is his duty to do so."**

Similar guidance is given to health visitors and other nurses, emphasising that they must be able to justify any failure to disclose. We see no reason why this principle should not apply to the police. If there is to be a genuine sharing of information the whole issue of confidentiality has got to be addressed by the police. It seems to us that the other agencies have now resolved their difficulties about this by giving priority to the need to protect the child.

7.22. Essentially the question of how much is disclosed depends in the last analysis on the degree of trust which those attending a case conference have that the other individuals will keep the information given to them

confidential. It is of course true that the more individuals who are given a piece of information the greater the risk of some disclosure. The police have concerns that disclosing information to the social workers means that they might pass it on, whether deliberately or inadvertently to the accused person. Their other concern relates to the disclosure of previous convictions. The father's convictions were not actually given to the department until the 5th May 1989. The convictions are sometimes given to the person chairing the case conference, which the police guidance recommends, but are not necessarily the subject of discussion or general disclosure. The alternative, and for some officers the preferred course is to disclose this information to the local authority's legal department, who can apparently be trusted with it.

7.23. It would be wrong to give the impression that this lack of trust is only on the police's side. Social workers are often similarly reluctant to share information which comes to them about criminal activity within the family with the police. This is again tied up with the question of whether or not there is a genuine co-operation in partnership, or whether the are the recipients of information from other agencies rather than the providers of it. It is always easier to recognise the failure of other agencies to disclose than it is to recognise one's own inhibitions about doing so.

7.24. There was one other aspect which caused in our view quite legitimate concern on the part of the department. Although as we have seen was kept in hospital under the terms of the Place of Safety Order, no arrangements were made for him to be x-rayed. It was only at the second case conference on the 11th January that the suggested that this should be carried out. The father consented. The social worker made the arrangements but attended the appointment with [illegible]. Although [illegible]

social worker was informed orally of the result of the x-ray, the report was not only obtained by the police, and as we have seen submitted to the pathologist, but thereafter they refused to give a copy of it to the social workers. The Social Services did not in fact receive it until the doctor herself sent them a copy on the 9th May 1988. They were not sent to them by the police until the beginning of July, when they were accompanied by the pathologist's findings.

7.25. We consider that there is no justification for this at all. The Social Services had statutory responsibility for [redacted], who was in their care. It is quite intolerable that the details should have been withheld from them for 5 months.

7.26. We think that the bias from the police should be towards giving as much disclosure as they properly can. Where they are unwilling to do so they should make it clear to the conference that they are temporarily withholding some information for good reason.

How the Misunderstanding Arose

7.27. In April 1989, after the date for the trial had been fixed, a senior local police officer in the station carrying out the investigation looked at the file. He then contacted senior Social Services management and arranged a meeting with them. His purpose was friendly. He wanted to alert them to the risk of a possible outcry about the Social Services handling of the case. He presented the case to them in a way which suggested that the case was not only more serious than they had been led to suppose but that the social workers had been naive in their dealings with the father. In particular, he gave them the impression:-

7.29. Similarly, the police file contains no evidence from anyone in Sheffield to substantiate what management were being told. We refer to paras 3.47 to 3.58 above.

7.30. Neither the mother nor [redacted] did sell their story to the Press. So far as we can tell this was never more than a suggestion by the police themselves that it was a possibility. It caused a lot of trouble and concern.

7.31. We think that the officer probably did intend to be helpful by presenting events in the most damaging way that they could be interpreted. We think that he believed that the Social Services department had been hoodwinked by a manipulative and violent man. We are quite satisfied that he did think that the social workers had been naive. There is no evidence to substantiate this view.

7.32. The police officer then had a meeting with the Assistant Commissioner and the Press Officer at which they clearly decided to try and distance themselves from Press criticism of the Social Services. They agreed to refer any Press inquiries on to the Social Services and leave them to deal with it.

7.33. As we have already made clear we consider that this intervention, though intended to be helpful, was in fact extremely damaging to the relationship between the Social Services and the police both at the managerial and local level.

PRESS COVERAGE OF THE TRIAL

7.34. The question of whether or not the Judge dealing with the criminal case should make an Order restricting publicity about S was raised at the beginning of the father's trial. Following the decision to sever the Indictment related to S from the Indictment relating to

L, the Judge ruled, rightly as a matter of law, that the statutory provision allowing him to prohibit publicity which would identify the child did not apply because the provision is limited to the situation where the child is either the Defendant or the victim of the proceedings or a witness in them. had no such role in relation to the charge against the father of the manslaughter of L. Such an Order clearly could have been made had the charge against S been proceeded with.

7.35. was of course a ward of court. The Social Services department believed that this would automatically prevent there being any publicity about him in the criminal proceedings. In fact that is not the case. His status as a ward prevents any publication of evidence given in the wardship proceedings, but does not constitute a blanket ban on all Press publicity.

7.36. It is of course possible to seek such an Order in the wardship proceedings. No Order was sought in advance of the criminal trial, because as we have indicated, no-one seems to have appreciated that there might be publicity in relation to .

7.37. As frequently happens in such cases, there was in fact a lot of Press coverage of the Prosecution opening speech. There was some further publicity surrounding the pathologist's evidence and that of . s name was mentioned in what was otherwise accurate factual reporting of the criminal proceedings.

7.38. The Social Services were concerned and sought legal advice about whether or not they could prevent further publicity in relation to when the case came to an end. They were advised that it was probably too late, since his name had already been mentioned.

7.39. Predictably there was a lot of sensational Press coverage surrounding the conviction. It included photographs of [redacted] the mother, [redacted] and in one case, [redacted].

7.40. The photographs of the children given to the Press were in fact those which had been relied on by the Prosecution to provide a contrast between L's appearance during the holiday in Ireland in August 1987 and his death. They had been given to the police by [redacted]. It was the officer who was in charge of the investigation who released the photographs.

7.41. It has been interesting to compare the social workers' perceptions of this publicity with the reality. We were told that [redacted]'s photograph was "all over the tabloids." In fact, from the evidence that we have seen, there was only one newspaper, The Guardian, which published the photo of [redacted]. Several of the others published the photographs of L, but we do not consider that their publication can properly be a matter of criticism. We think the disclosure of [redacted] photograph was insensitive and its publication by the newspaper regrettable. The actual information given about [redacted] however was limited, factual, and accurate.

7.42. We feel bound to say that we think that some of the social workers have over-reacted on this issue, probably because of the other matters to which we refer below. There are lots of children who get caught up in a variety of tragedies. Their names and photographs flit across the newspaper pages in a brief burst of publicity. [redacted] was one of them. We think it is unrealistic to think that he can be completely shielded from the Press interest in his brother's fate.

7.43. In fact, [redacted] seems to have been far less affected by the publicity than the adults, whose privacy was intruded. The mother and her family came under press

pressure to make statements. She and [redacted] were besieged by photographers as they left the Court.

7.44. The investigating officer made the following attributed comment which was reported only in one of the local papers. He was reported to have said that in no way did he criticise the actions of any agency involved. "It was a very difficult situation. [The father] was not a helpful character. He lied to the Courts to get custody of the children and it was impossible for the welfare agencies to know that. They can't just go crashing through peoples' doors and the neighbours always gave him a glowing report and said he was a good father," he said.

7.45. More widely reported was the comment of "a police spokesman" who gave a comment more in keeping with the approach of the senior officer to whose meeting with Social Services management we have referred above. Since he himself had left the area by the time of the trial, and did not attend it, our conclusion about this comment is that it probably originated within the Police Press office with whom he had discussed his view of the case.

7.46. Linked with this inflammatory comment were a number of inaccurate statements relating to the Social Services involvement in the case. These caused considerable and understandable concern to the social workers involved who sought a meeting with management and attempted to persuade them to publish a retraction. They took the view that to do so some time afterwards would simply stir the matter up again, assuming that the Press published it at all. The Director, in his capacity as chair of the ACPC, published a joint publicity statement on behalf of the agencies. Management's failure to support the social workers on this issue has left a residual anger. It is our view that, it would have been an appropriate and helpful support for the staff had

management agreed to issue such a statement, even if the Press had not in fact published it.

OTHER ASPECTS

7.47. It would be wrong to leave the impression that inter-agency problems arise only between the police and Social Services. In this case, for example, there was a problem because a health service representative agreed at one of the case conferences to obtain information from other health authorities about the childrens' attendance at casualty departments. Subsequently, her superior told her not to do so because she thought it was better for Social Services to approach them directly. The representative therefore told Social Services that she was not after all able to do this, although she tried to be as helpful as possible in supplying the information that was already available to the health service.

7.48. Again, although not very significant in itself, this does pose issues for inter-agency co-operation. This aspect was raised by the senior social worker with the child abuse co-ordinator. Although she said that she would raise the matter on the ACPC, she did not in fact do so. Accordingly there was no follow-up so far as the neighbourhood office was concerned.

7.49. Again this seems to us to relate back to the central issue identified at paragraph 7.2 above. If the agencies are genuinely co-operating together, this should involve a proper sharing of the workload. If the philosophy is that other agencies are assisting Social Services by supplying information, it would not necessarily be appropriate for them to make such inquiries.

7.50. For most of the period between L's death and the father's trial, the father was having supervised access to S 3 times per week. As we shall see below, this

imposed a considerable burden on the resources of the neighbourhood office. It was complicated, however, by the fact that the discretionary power to supervise the access, imposed by the wardship court, was turned into an obligation to do so by one of the father's bail conditions. This provided that the father was not to see [redacted] except in the presence of a social worker. That slight modification to the wording made a considerable difference to the burden which was imposed on the Social Services department.

7.51. This aspect, together with the failure to protect [redacted] from publicity has obviously given rise to the criticism that the left hand of the court system does not know what the right is doing. Regrettably, this is frequently true. The court system is not a cohesive whole. Neither the Magistrates' Court nor the Crown Courts have much experience of the refinements of wardship. Understanding really depends upon whether the practitioners or the Judge happen to have experience of the wardship jurisdiction. It is probably true that the only two people in Court at the father's trial who really appreciated the indications of [redacted] being a ward were the Solicitor from the local authority and the father's Solicitor.

7.52. We find it difficult to see any way in which other Courts could be notified of the child's status as a ward routinely by the High Court itself. Although they loom large in child protection terms, criminal proceedings involving wards of court form only a minute part of the criminal cases determined nationally, or even in London alone. To circulate all the courts regularly with the names of all the children who are wards of court (which would include thousands of names) seems to us likely to produce a lot of paper, but no protection of any real value.

7.53. It is obviously helpful if those appearing before the criminal court know and are able to make effective use of the fact that the child is a ward. Even here, however, there are some practical difficulties. Publication of confidential information about a ward of court is a contempt. The precise limits of this are still very blurred. The giving of factual information about the details of Court Orders in respect of a ward to those who have a need to know in order to assist in safeguarding his welfare is probably not contempt but what was said by the parties, or witnesses to support the making of such an Order, would be.

7.54. It seems to us that this is in fact part of a much wider criticism of the criminal process, namely that witnesses and others who may be affected by the criminal court's decision are not parties to the proceedings, and have no right to argue about what is either said or done. Unfortunately reform of the criminal process so as to give them a greater voice is beyond the scope of this inquiry.

MANAGEMENT SUPPORT FOR WORKERS DEALING WITH THE CASE

7.55. The circumstances in which individuals learned of the tragedy of L's death have been very varied. Some have had a lot of support from their superiors and colleagues, others have not. As we explore further in Chapter 18, many still have unresolved feelings of guilt and anxiety about the case which they have not felt able to discuss. The approach to these problems will vary from agency to agency, and will obviously depend upon the degree of involvement. We think, however, that management should make sure that all staff who are concerned are told of the death at the earliest opportunity and do not simply find out later. In a case such as this, the workers were not themselves bereaved, and we are not discussing bereavement counselling so much as an oppor-

tunity to discuss, if they choose, professional and personal issues arising out of the case.

7.56. The recommendations which arise out of the issues addressed in this chapter are dealt with below in relation to the ACPC or specific agencies.

CHAPTER 8

"WORKING TOGETHER" : THE THEORY AND THE PRACTICE

8.1. In this chapter we consider the guidance given by the Government to agencies trying to work together and consider, in the light of what happened in this case, where the guidance needs further clarification or the practice needs to be improved to comply with it. References are to paragraph numbers within the booklet.

8.2. As we indicated in Chapter 7, we think that the underlying philosophy of this pamphlet needs to be clarified. In some passages, for example in paragraph 1.3 it speaks of other agencies, "... advising and assisting the local authority in the discharge of its child protection and child care duties." At others, for example paragraph 2.2 "the primary responsibility of the Social Services department does not diminish the role of other agencies or the need for inter-agency co-operation in the planning and providing of services for a child or family." In many cases there is no obvious inconsistency between the two. This case has highlighted the problems that can arise when there is.

8.3. Paragraphs 2.17 and 2.18 deal with the responsibilities of other agencies when the child is in the care of the local authority. Under an ordinary care order, the local authority have parental rights over the child. That is not the case where a care order is made in the wardship proceedings, where parental responsibility remains in the Court. It seems to us, in principle, that this guidance was intended to and should apply where the local authority have a care order in whatever proceedings it is granted.

8.4. Paragraph 2.18 provides "The staff of other agencies providing services to the child ... must recognise their responsibilities to see that the local authority in its parental role is kept fully and immediately informed of all matters relevant to the welfare of the child." In relation to the x-rays obtained on S (see paragraph 7.24 above, adherence to these guidelines (which were not of course in force until July 1988, after the x-rays on ● were taken,) ought to discourage something of the same kind happening again.

8.5. Paragraph 3.4 emphasises the need for the staff in A and E departments to be alert to the possibility of child abuse, and that they should seek specialist advice from a consultant paediatrician or radiologist in the assessment. We have already considered the application of this to the present case at paragraphs 6.25 to 6.27 above.

8.6. Paragraphs 5.2, 8.3 and 8.7 emphasise the importance of training, both on a single discipline and multi-discipline basis. The ACPC has produced its own child protection manual, which it is in the early stages of revising. All the other agencies have their own procedures manuals as well, which include aspects of identifying and dealing with child abuse. The agencies vary in their approach. For some their own manual is the first point of reference, to be checked with the ACPC manual, copies of which may or may not be available easily. For others, and particularly Social Services, the ACPC manual is the first point of reference.

8.7. Similarly, they vary in the extent to which they give their staff assistance in identifying symptoms or situations which may be indicative of child abuse. Usually they are geared to the situations which staff in their own agency are likely to encounter. Some go beyond this. The Probation Service, for example, has a section

on the medical symptoms of child abuse which would be an extremely useful reference work for the junior doctors (see further below) but the chances of the average probation officer seeing children stripped and examining them for equivocal injuries seem to us rather remote. Their involvement is far more likely to arise either because they are given accounts of abuse by the adults whom they see or because of obvious visible marks on the children.

8.8. These manuals have very little inter-agency dimension. They do not for example usually give staff an indication of what procedures will be followed by those in other agencies. We think that this might be helpful. For the reasons given at paragraphs 6.17 to 6.22 above, we think it would also be helpful for such manuals to include information about what other agencies can and cannot do.

8.9. There has so far been very little inter-agency training in child abuse. The ACPC produced a video on child sexual abuse which appears to have been widely shown and to have been appreciated. Where inter-disciplinary training takes place, it usually consists of someone from another discipline coming to explain his or her work to the staff. There is hardly any joint training with people from the different agencies and disciplines coming together to be trained together. We think that this is the direction in which future training should go, alongside skills training within each agency.

8.10. One problem with training, whether it is done within the agency or outside is that whilst almost everyone agrees that it is "a good thing", in practice training budgets are often inadequate to do the job properly and are vulnerable to cuts in public expenditure. It is important to recognise that good training is not necessarily to be equated with "going on courses."

One difficulty is that as the work gets more locally based, which is the trend within the agencies, the number and variety of child abuse cases which one team will encounter may be quite small. The opportunities for "on the job" learning, are therefore more limited than was the case when teams operated within a larger geographical area. Accordingly, the need for more formalised training is greater than was previously the case.

8.11. As we have already made clear we do not think that there was any training which those who had dealings with this family might have had which would have alerted them to the risk to L from his father.

8.12. The one area, where we think training needs to be considered as a matter of urgency is within the hospital. So far as we can tell from our inquiries, junior doctors coming into the department have no training other than that which is included in their basic training in symptoms which should cause concern. The Paediatrician did from time to time give a lecture outlining some of the main points, but this was not systematic. As the doctors change every 6 months, it is essential that they have some induction training in the recognition of child abuse.

8.13. It also seems to us essential that this is done on a multi-agency basis. The hospital is not isolated from the community, and if anything the doctors there need more information about the role and procedures of the other agencies than is the case for those who are working in the community services.

8.14. In order to deal with the problem which we have identified, ideally we think there should be at least 1 full-time post for both a health visitor and a social worker in the [illegible] Department whose roles would include [illegible] liaison. [illegible]

induction training we think that the permanent staff should also be trained about the work of other agencies.

8.15. We think that they would also be helped by a good easy to use quick reference guide, which they were encouraged to use. Most of the manuals which we have seen seem to be rather cumbersome.

8.16. The identification of child abuse is often a matter of asking the right questions, for example whether the account of the injury is consistent with it. Again we have considered the question of whether some sort of form might be a useful starting point. We have already commented on the usefulness of the form developed by the ESW service, which we have modified and attach as an appendix to this chapter. We think that something of this sort might be useful for inexperienced hospital staff.

WORKING TOGETHER IN INDIVIDUAL CASES

8.17. This is dealt with in Chapter 5 of "Working Together". Paragraph 5.3 deals with the obligation of those attending case conferences to deal with the information given in confidence. As we have seen at paragraphs 7.21 to 7.23, this bland statement does not address, still less help to resolve, some of the very real problems which can arise between the agencies. Similarly, although the question of medical confidentiality is addressed (because this has always been a recognised area of medical ethics about which guidance needed to be given), we have highlighted other areas in which confidentiality has been claimed for information, and about which this document is silent (see, for example paras 7.14 to 7.26 above).

8.18. Similarly, we think that the guidance in paragraph 5.6 about the transfer of agency records is of very

little help, particularly as it affects the . We have tried to give some practical assistance about this in paras 6.3 to 6.4 above.

8.19. Paragraph 5.11 deals with the need for close co-operation between the police and in the investigation of abuse. As we have seen, this sort of co-operation will continue to have little direct application to cases involving a fatality. We have, however, had a good deal of evidence about the recent setting up of the child protection team within the police service, and how this is working in practice so far as the other agencies are concerned.

8.20. The police have their own training programmes. These have included input from the Social Services child abuse co-ordinator, and the use of the jointly produced video. The main obstacle to a more systematic programme of joint training leading to joint investigation is the structure of the Social Services department, which we consider in detail in Chapter 10 below. The large number of neighbourhood offices, with their commitment to generic social work, means that there is no comparable specialist child abuse team within the Social Services department, members of which could undertake training together.

8.21. It is clear from what we have heard that there are reservations about what is happening. The police appear to have embraced the idea of a specialist team with the requisite training and expertise with enthusiasm. They have made considerable strides in a short space of time. It does not, however, render the police "the experts" in the investigation of child abuse. The police's role in the protection of children will continue to be ancillary to the work of the Social Services department where the statutory responsibility remains, and not [illegible] for it. In particular, they

planning for surviving children, or dealing with other disrupted family situations, it is important that the police recognise the limitations of their expertise as well as its strengths.

Child Protection Registers

8.22. In Islington, the child protection register is kept and maintained by the child abuse co-ordinator. In Sheffield, it was formerly kept within the health service, but has recently been transferred to the Social Services department.

8.23. Paragraph 5.31 lists the categories of children whose names can be put on the register. The ACPC guidelines in Islington are broadly similar. Sheffield, as we have seen, did not have and still does not have a category for those who are at significant potential risk.

8.24. It is of some interest that both the health and education service operate their own systems for monitoring children about whom they are concerned, but whose names are not on the child protection register. In each case the system includes other children about whom there is concern, but in respect of whom no issue of suspected child abuse arises. Whilst we think such systems are useful tools, it is essential that they do not become "mini child protection registers."

8.25. Paragraph 5.33 gives advice about who should manage the register, and making it available to the other agencies. As we have said, this is currently done by the child abuse co-ordinator in Islington. A copy of it is kept at the Whittington Hospital. We were extremely concerned to learn that there was a period a few months ago when the register was unable to be kept up-to-date because of the lack of adequate administrative support. The accurate maintenance of the register is essential

an administrative task. It does not need to be done by the child abuse co-ordinator herself, although we understand it frequently is. A register which is not accurate and up-to-date, in our view is worse than useless. If the child's name should be on it and is not, it is likely to give a false sense of security to someone from another agency. It also seems to us to be a misuse of the expensive specialised skills of the child abuse co-ordinator for her to be involved in maintaining the register.

8.26. The registration of a child's name inevitably brings into effect a number of other conference and review procedures which are time consuming and expensive in terms of the time of the professionals involved. In the present case for example [redacted] name was placed on the register at the time that he moved to foster parents. We think that this does raise the question of whether where a child has been removed from the care of the alleged abuser it is always necessary for his or her name to go on the register. We recognise, of course, that it is a very dangerous assumption to make that children, once removed from their homes are necessarily "safe". This is particularly so in the case of sexually abused children where it is recognised that they are more vulnerable than non-abused children to the risk of further abuse.

8.27. The guidance about entering the child's name on the register at paragraph 5.32 seems to suggest that in every case where the child comes into one of the categories, and the agencies agree to work together to protect him, his name should be included on the register together with a record of the plan and the services to be provided. Where the essential protection for the child is that he is no longer living in the home in which he was abused, the fact that there is still some element of inter-agency work does not, in our view, render

necessary in all cases for the child's name to be on the register.

Case Conferences

8.28. As we have already stated at para 6.14 above, we think that despite the urging of paragraph 5.38, case conferences can be seen not only as an end in themselves but also in themselves the solution to an intractable problem "If you can't think what else to do, have a case conference."

8.29. So far as the specific recommendations of the guide about the conduct of case conferences, again, the neighbourhood system within Islington causes practical difficulties in terms of having a person independent of the management of the case chairing the conference. There are only two or three senior staff in any of the offices. Because the offices are small, and there is a high priority given to duty work, these officers tend to be involved in a lot of the work done by the office, even if they are not directly supervising the worker in the particular case. For a senior social worker from another neighbourhood office to chair the meeting can cause severe problems for that office, as we examine in more detail in Chapter 10.

8.30. Similarly, the desirability of having a specialist minute-taker is universally acknowledged. There are in fact 3 such minute-takers employed within the Borough. They cannot begin to cope with the 600 or so case conferences a year which are held within the Borough. They try to ensure that all the initial case conferences have a specialist minute-taker, but apart from that it is usually the person chairing the meeting who also has to take the minutes.

8.31. Within Islington, the procedures provide that although case conferences will normally be called by the Social Services, if necessary at the request of another agency (as per paragraph 5.42) another agency may itself convene a case conference if it is appropriate to do so. In practice, this seems hardly ever to happen, although occasionally the health services have been responsible for convening a conference.

8.32. Paragraph 5.43 deals with the importance of those who are unable to attend making written contributions. We would like to go further than this, as outlined in para 6.16 above.

8.33. Paragraph 5.45 addresses the question of the involvement of parents at case conferences. The parents in the present case did not attend any of the case conferences. Whilst we do not dissent at all from what is said about this in a general way, the problems which we have highlighted at paragraph 7.14 to 7.26 above, for example, would be greatly exacerbated if the alleged abuser were present. There are obvious difficulties when the alleged abuser is present at a case conference at an early stage of the police investigation, where the question of a criminal charge is still being considered. Again this very real difficulty is not touched on by the guidance but it is a matter of very real difficulty and should be.

Supervision

8.34. Good supervision comprises two elements. Firstly it is a tool of good management, allowing managers to ensure that the agency's statutory responsibilities are being carried out and that the work is being done satisfactorily. Secondly it is to give professional support to the staff. It should consider and monitor the

child protection plans and ensure that they are being complied with.

8.35. It is the clear expectation of paragraph 5.50, that all agencies will provide supervision. Predictably, there is more resistance to it within the Probation Service than within most other agencies. It is not entirely clear how it operates within the schools. Recent managerial changes within the health authority have meant that arrangements have had to be made for "professional" supervision to be given in appropriate cases by a person who is not the health visitor's line manager, where the line manager comes from a background other than health visiting.

8.36. As this is not a case in which any failings of supervision contributed in any way to the tragedy, it would be wrong for us to question the value of a system in which the professionals themselves have such faith. There is an obvious value in being able to share the problems and stresses of some of the very difficult case loads which professionals in deprived inner city areas have to bear.

8.37. What seems to us to be lacking, and what in our view is urgently needed within supervision in many instances is positive praise for good work. The point has been made to us more than once during this inquiry that particularly for social workers, no-one praises you for good pieces of work, they only blame you when things go wrong. It seems to us that management too have a role in this.

JOINT POLICIES AND PROCEDURES

8.38. This is dealt with in Part 7 of the guidance. It replaces the old Area Review Committees with a new animal, the Area Child Protection Committee (ACPC). It

provides for them to be representatives, to be jointly funded and defines their responsibilities.

8.39. Within Islington, the ACPC is chaired by the Director of Social Services. It operates mainly through the ACPC Sub-Committee which is chaired by one of the Assistant Directors. All the local agencies send senior people to these meetings most of whom are now at some distance from practice. In paragraph 7.9, the guidance sets out the main areas of work and activity for such ACPC. We deal in paragraph 9 with the way in which the ACPC operates in practice.

CASE REVIEWS

8.40. Part 9 sets out in detail the procedure to be followed in reviewing a case where a child dies. The ACPC attempted to follow this guidance when the document was published in July 1988. As we shall see in Chapter 17, their interpretation of the guidance produced a review which was wholly inadequate. To that extent this case illustrates a number of practical difficulties about the advice offered and the need for it to be reconsidered. This chapter should be read in conjunction with Chapter 17.

8.41. To begin with, this case highlights that the advice given in paragraph 9.6 that case reviews should be completed within 2 or 3 weeks of the death can be completely unrealistic. Within 2 or 3 weeks of L's death, the pathologist was still carrying out investigations to establish the likely cause of death and whether there was any criminal responsibility by the father. As we have seen there was very real doubt about whether criminal liability could be established (see paragraphs 7.5 and 7.16 above) and he was not in fact charged until over 4 months later.

8.42. In addition, this was a case where a worthwhile review needed to look at not only the action of the agencies in the light of what they did know, but whether in the light of information which subsequently came to light, there were warning signs which had been missed, or other information which they ought to have known. Again to suggest that full details of the information which the police had obtained from interviewing witnesses should be published within a month of the death, whilst the police inquiries were still going on and it was unclear whether there would be a prosecution or not seems to us to be totally unreal. We agree that speed is desirable but not if a speedy resolution results in an inadequate or incomplete case review.

8.43. Again, some of the agencies, notably the Probation Service, have carried out their own review of the case to see what lessons can be learned for their own agency. Because of the timing of this review, they in fact carried out their own review only after submitting their evidence to the ACPC. This meant that the lessons which they considered the service needed to learn from the present case were not fed into the ACPC review. Instead, the ACPC representative was having to give an individual rather than an agency view of the case. It has been forcefully argued to us that this is the wrong way round, and that the ACPC review might be more worthwhile if it included the considered views of the participating agencies themselves.

8.44. Whilst there is clearly a need to respond to public anxiety and media pressure, we do not think that these should be the dominating considerations about when the report should be done.

8.45. It is also important to bear in mind, that although this was not such a case, there have been a number of instances in recent years when it has been the

agency staff who have been dissatisfied with the procedure and conclusions of the internal review and have pressed for a more public form of inquiry. In paragraph 9.8, the guide sets out the objectives of the review as being

(a) to establish facts;

(b) to assess whether decisions and actions taken in the case were reasonable and responsible;

(c) to check whether established procedures were followed;

(d) to consider whether the services provided matched the needs of the case bearing in mind the resources available;

(e) to recommend any appropriate action in the light of the review's findings.

That is exactly what the ACPC in the present case sought but failed to do.

3.46. One aspect which caused the ACPC considerable difficulty, and which is not addressed at all in "Working Together" was the issue of "sub judice" or Contempt of Court. There were two aspects to this. Firstly, whether the police could properly disclose evidence which would be used in the criminal trial to the ACPC. Secondly, what could properly be included in a review report published before the trial. We consider this further in detail in Chapter 17.

PUBLIC AND MEDIA INTEREST

8.47. We have dealt with aspects of this in some detail at paragraphs 7.34 to 7.46 above. The ACPC did prepare a joint press statement, which was issued by the Director as chairman of the ACPC. It is not clear to what extent the police adopted that statement, bearing in mind what we have set out at paragraph 7.32 above. Essentially this statement referred to the setting up of this inquiry.

8.48. The difficulty which arose in the present case, was over the inaccurate press statements in relation to the involvement of the Social Services department (see paras 7.45 to 7.46 above). This produces a conflict of roles for the Director. He clearly felt that he was committed to joint publicity through the ACPC, rather than an independent statement on behalf of the Social Services department. We recognise, however that there may well be cases, particularly when an internal review has already been carried out, where the staff need to feel that they are publicly supported by the Director in statements which are made to the Press. This will be particularly the case when the review has not disclosed any negligence or lack of proper judgment. From the point of view of the staff there is a big difference between a public statement that "There is to be an inquiry to establish what went wrong" and a statement which emphasises that the case has already been investigated, that no negligence has been found, but "there is nevertheless to be an inquiry."

THE POLICE

8.49. For the reasons which we have already given at paragraphs 7.14 to 7.16 above, we think that the guidance in paragraph 8.11 ought to address the problems which

arise when there is a conflict between the needs of the prosecution and the needs of the child.

RECOMMENDATIONS

The Government should consider further the "Working Together" guidance and in particular the following aspects

1. The fundamental philosophy underlying the guidance (see paras 7.2 and 8.2).

2. The conflict between the legitimate needs of the police prosecution and the needs of the child.

3. The proper approach to confidentiality by the police. (Para 8.7).

4. The implications of parents attending case conferences where there is a pending prosecution.

5. The transfer of records between agencies, especially local authorities. (paras 6.3-4

6. The timing of case reviews (Paras 8.40-8.44).

7. The issue of contempt of court in relation to the publication of the review (8.46 and Chapter 17).

8. The role of the ACPC (Paras 9.6 - 9.9). We deal with the Recommendations for particular agencies arising out of this chapter in subsequent Chapters.

REPORT OF POSSIBLE NON-ACCIDENTAL INJURY/CHILD ABUSE
(see Paragraph 8.16)

Name of Child:

Address:

Date of Birth:

Name of parent/s or guardian:

Name of person accompanying child
(if not parent/guardian)

Home telephone or emergency contact number:

Siblings in the family?

Time and date of report:

When was the injury noticed and by whom?

When is the injury reported to have occurred?

What is the nature of the injury? Please describe, e.g. marks, bruises, colour, size and location.

What does the child say about the injury? Has the explanation given by the child remained unaltered?

Does the injury appear to be consistent with the child's account? If not, why not?

What does the accompanying adult say about the injury?

Does the injury appear to be consistent with that account? If not, why not?

Have you had an opportunity to examine the rest of the child's body? If so, any observations?

Have you had any previous concerns about the child, or a member of the family with reference to suspected Child Abuse/Neglect/Non-Accidental Injury?

; the child been examined by a paediatrician. If so, whom?

:s the injury require medical treatment/admission?

s Social Services (or any other "outside" agency) involved with the
nily?

y other information? e.g. Language spoken by the parent/s if not
uent in English

AGNOSIS

CHAPTER 9

THE AREA CHILD PROTECTION COMMITTEE

9.1. The agency representatives on the ACPC, as we have noted in paragraph 8. above, all hold relatively senior posts, often a specialist child abuse post, within their agency. They are well intentioned, conscientious, and convinced of the worthwhile role that they are carrying out.

9.2. The difficulty is that more than a year after "Working Together" the ACPC has no budget, no delegated responsibilities, no secretariat and what it is actually able to achieve is extremely limited.

9.3. It is not unique in this, so far as we are aware there is no ACPC in the country which has established a joint budget, to which all the other agencies contribute, although in some areas there is joint funding between the Social Services department and the health department. There has been some joint funding of particular projects both in Islington and elsewhere.

9.4. It has been difficult for us to establish precisely what the ACPC has done other than hold reviews and produce the joint video because there are no records kept of its meetings, since there is no-one available to take the minutes. We are left with an overwhelming impression of a talking shop in which there is a good level of rapport and co-operation between the individuals who comprise the ACPC and its sub-committees, but the agencies whom they represent continue largely to perform their work in ignorance of its deliberations and achievements. There is, in parallel with the ACPC, good local co-operation between the agencies. But so far as we can tell there is little correlation between these two phenomena, and little input in either direction.

9.5. We have already identified a number of issues which need to be addressed by the ACPC. These include:

(i) the essential nature of inter-agency co-operation (paragraph 7.2 above);

(ii) joint training (8.6 to 8.13 above);

(iii) the extent to which the administrative support for the child protection register and the management of case conferences fall short of the recommended guidance. (Paragraphs 8.22 to 8.43 above).

The ACPC is also supposed to monitor practice in individual cases, but appears to have no real plan for doing so, nor the means to bring about effective monitoring.

9.6. Another aspect which concerns us is the inter-relation between the ACPC and the elected members of the local authority or the lay members of the health authority. The latter appear to have no input into the ACPC. So long as the ACPC remains an organisation without money or power, we suspect that this does not cause either conflict or practical difficulty. Some of the issues which we have raised, and which we see as essentially matters for inter-agency decision within the ACPC do have implications, as we have indicated (for example in paragraphs 8.20 and 8.21 above) for the delivery of services within the present structure of 24 neighbourhood offices.

9.7. We think that if the ACPC is ever going to be effective, there needs to be a clear agreement with the individual agencies about which matters are properly the concern of the ACPC and over which it should have control.

service must be provided", and which must remain within the control of the agencies.

9.8. If the ACPC is not going to have either an effective budget or any real input into the sort of areas which we think are properly within the ambit of an effective child protection committee, then it seems to us that the ACPC needs to become a much smaller group, which is concerned with reviewing and up-dating the procedures and remains as a channel through which inter-agency communication, over issues of joint training can take place.

9.9. If, as we believe, the pattern that we have found here is not dissimilar from that in other parts of the country, then we think the Government too should reconsider the role which it gives to the ACPC in its guidance.

9.10. The extent to which individuals on the ACPC are empowered to bind the agency varies. Again this seems to us to be an area which requires clarification. It is important that everybody on the ACPC should be aware of the limit of the role of the other members and what authority they possess. For example, it has been a matter of concern in relation to the establishment of this inquiry first that the police were unwilling to agree to be involved, and second that the representative of the police on the ACPC who was thought to have responsibility for child protection issues turned out not to have when it came to making decisions on this issue. It seems to us that that sort of confusion and withdrawal of committment at will again makes any effective work by the ACPC impossible.

9.11. Our recommendations for the ACPC are really to be found throughout this entire chapter.

CHAPTER 10

ISSUES FOR AGENCIES: (1) ISLINGTON SOCIAL SERVICES DEPARTMENT

10.1. Before 1985, Social Services operated in 10 area teams within the borough. They were larger than the present teams and had their own administrative staff, usually a team clerk, receptionist and typist. They were large enough to provide a good range of professional support, not only to the basic grade social workers but also to the senior social workers who were also able to share problems with their colleagues. They were able to initiate community projects. The system seems to have produced a remarkably stable workforce compared with many other departments. During the late 70s and early 80s the pressures were towards more centralization.

10.2. In 1982/3, the policy changed and since then there has been an unwavering commitment towards decentralization. Prior to 1985, the Social Services department was the only one which operated in the way which we have described. Housing, environmental health and many other services were all centralized. In 1985 Social Services, housing, including repairs, and environmental health were all decentralized to 24 neighbourhood offices. There is a commitment to generic working within both the Social Services department and, since 1988, with the introduction of a career grade system for administrative staff, generic working for much of the administrative work as well.

10.3. We have inevitably heard a lot about the effects of decentralization during the course of this inquiry. No-one who has spoken to us is opposed to the idea of the neighbourhood office system and all seem genuinely committed to the idea of trying to make it work.

10.8. The particular neighbourhood office with which we have been concerned has been a useful one to look at for this purpose. On any of the indicators which are used, it is nearly always in the middle. It is not the busiest, or the least busy; it is not in either the most deprived or the least deprived parts of the borough; it has an average number of demands on its services.

10.9. It is also housed in one of the purpose-built neighbourhood offices produced by the Architects' Department. The design is open plan. In concept, and in the publicity photographs, it provides a pleasant, uncluttered environment in which local people can discuss their problems, while their toddlers sit beside them in their pushchairs. (See Fig 1 on next page). The reality as shown in the remaining photographs is very different. There is enormous pressure on space. The storage facilities are wholly inadequate, so that most of the floor space not occupied by office furniture is used for the storage of stationery. The waiting area is public. The interview rooms have glass windows and adjoin the waiting area. The room which was intended to be the focal point for community activities is too small for many of them to be held there and is in any event the only available space for conferences, supervising access (as in S's case), staff supervision and almost any activity which cannot be carried out at a desk.

10.10. It is impossible to underestimate the difficulties of trying to provide a proper social work service in this atmosphere. Although recently additional telephones have been supplied, there are insufficient outlets for them. Until then the senior social worker was sharing a telephone with 6 other people. The duty service is conducted by two people from a desk within feet of reception. The home helps organiser is, on certain days of the week, giving instructions to and receiving reports from her staff [illegible] of the unit. [illegible]

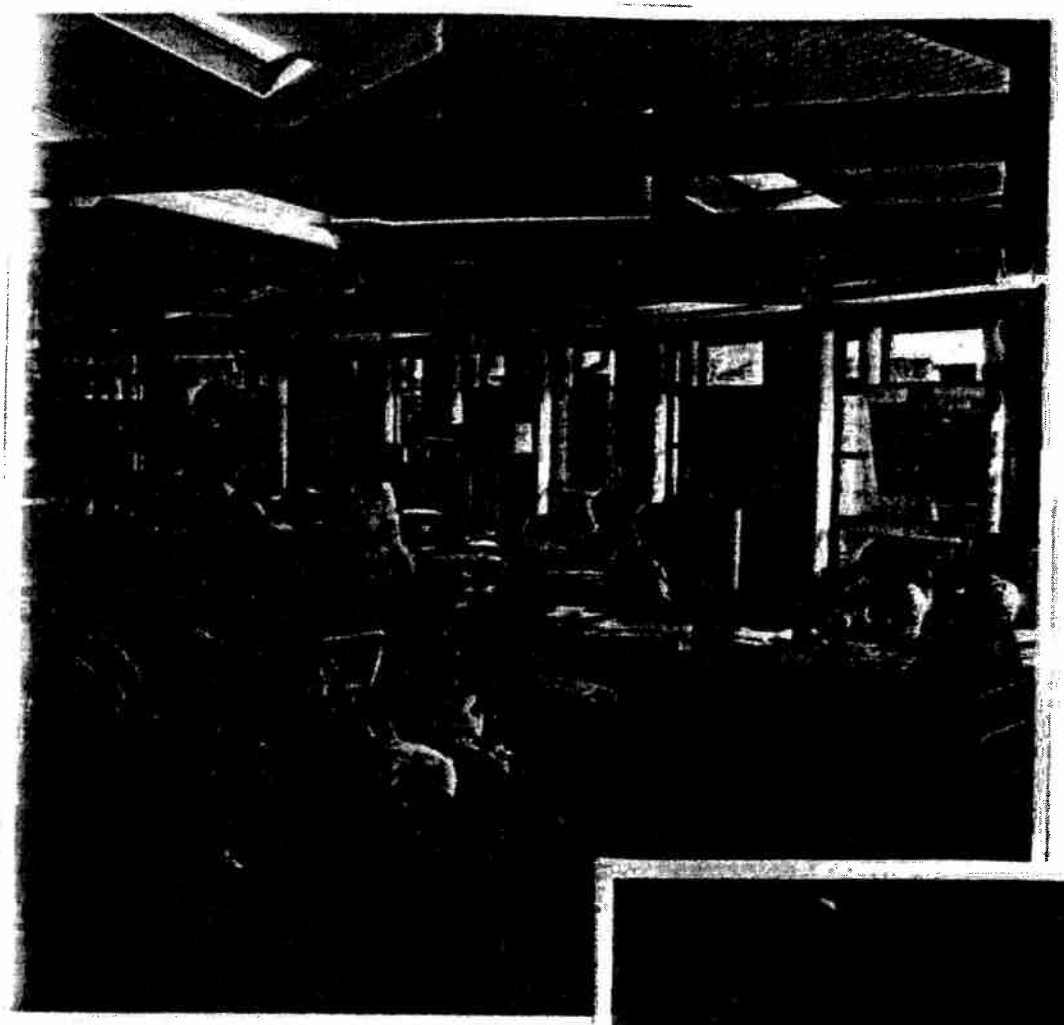

Fig 1. The Neighbourhood Office (Photo on the front of "Going Local")

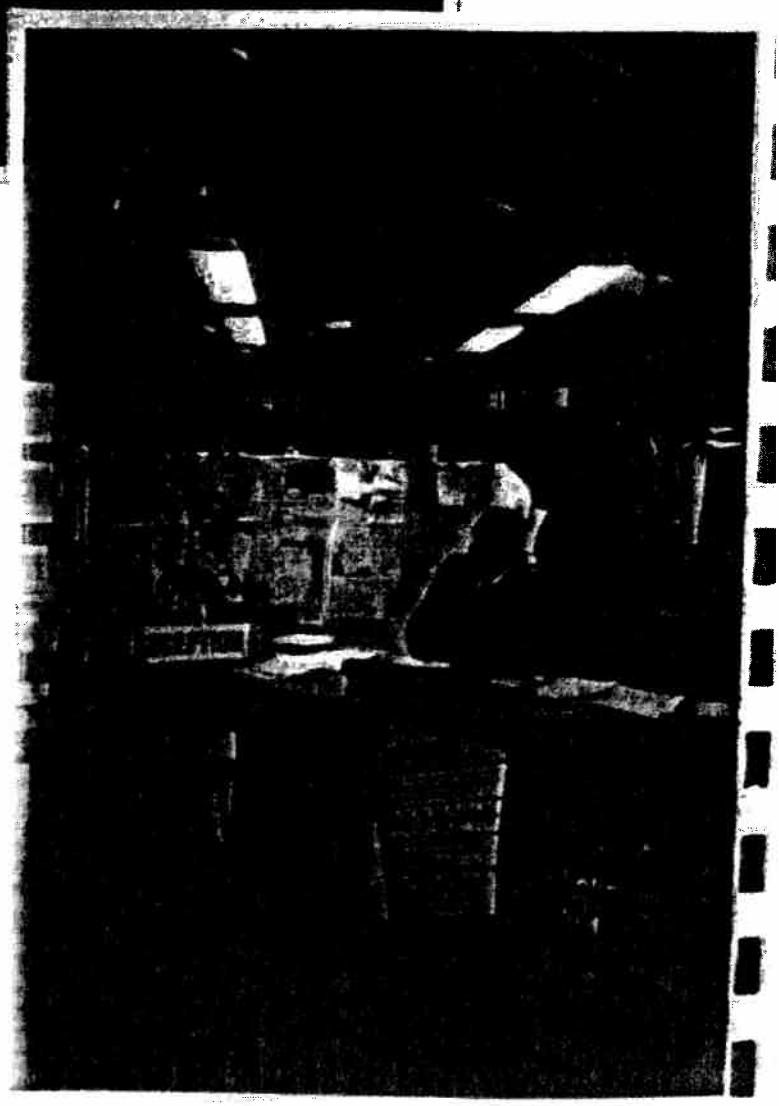

Fig 2. Reception area in the Neighbourhood Office November 1989

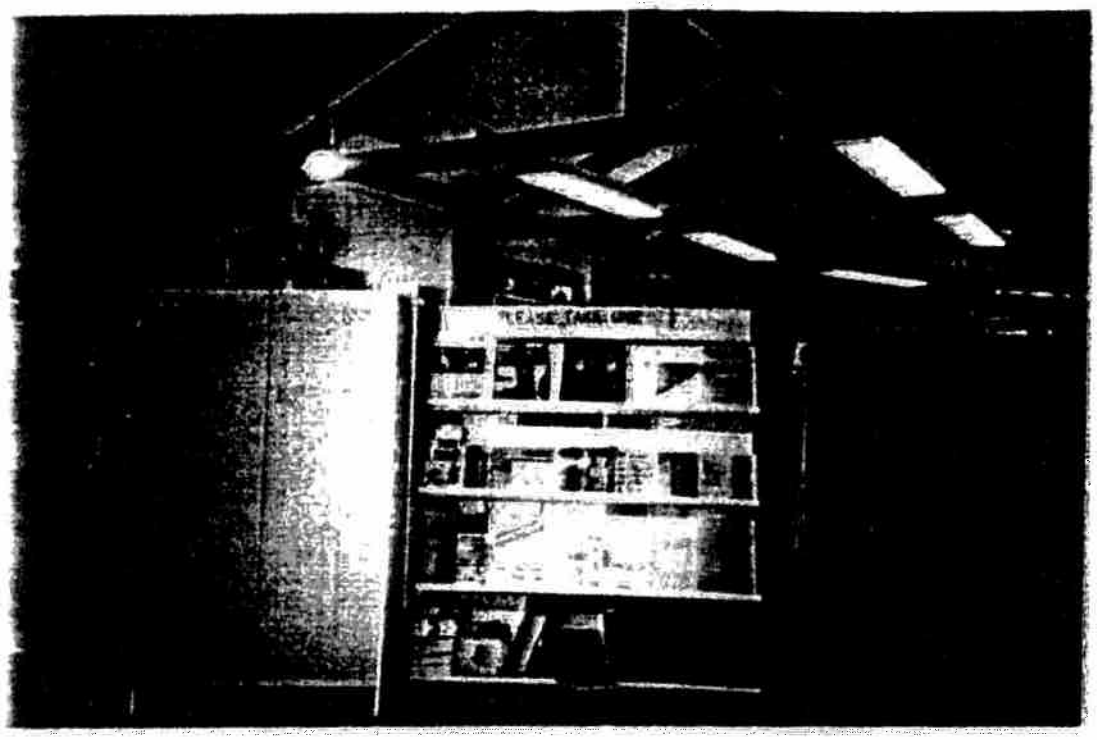

Fig 3. View for person seated in reception

Fig 4. General view of Social Services Department

no privacy for telephone calls and it is very easy for those who are on duty to get sucked into whatever is going on in the office. The presence of the cash office increases the risk of assaults on staff by robbers. One senior social worker described having a shot gun pointed at his head during a robbery, while he was trying to deal with a social work emergency.

10.11. These are the practical problems simply arising out of the design of the office. They are compounded if one or more of the social work staff is out of the office. There is no leeway within the system to provide adequate cover for absences due to sickness, leave or people being away on training. A peripatetic team was established to provide cover for absences, but only where the absence is for 3 weeks or more. In practice this team can cover only half the requests for assistance it receives. The main reason that the system has not already collapsed is the high level of dedication which there has been amongst the staff.

10.12. The pressures bear heaviest upon the senior staff who have the responsibility for maintaining the service. They are doing so in our view at considerable cost in personal terms and in many instances are stretching themselves beyond what is reasonable. The pressures are made worse by their isolation and the lack of other colleagues with whom to discuss difficult problems. They receive little, if any, personal supervision. Within this office, for example, both the full-time seniors come from different social work backgrounds and have different interests. One has a background in residential care, while the other has always worked in local offices. The latter has undergone some training in child protection work, particularly in relation to sexual abuse, not because it is an area in which he is particularly interested, but in order to provide some expertise on these matters within the team. For both of

them, it means that in the areas of work in which they are regarded as having the expertise, there is little the other can offer them in terms of professional support in difficult cases.

10.13. The Council policy is that priority has to be given to providing a duty service to those who come in with problems requiring social work help. When the office first opened, people were seen whenever possible as and when they came in. This proved so unworkable, that the office now operate an appointment system for seeing people. Even so this means that the social workers' priorities are determined by the public who come in, rather than the social workers themselves. Whilst in some cases it will be the person who comes in who has the urgent problem, in others it will be a family with whom there is a long term piece of work who experience a sudden crisis and need the attention of the social worker dealing with their case.

10.14. Obviously, there are aspects of the social work task which fit happily into the neighbourhood concept. These are the issues that local people are understandably concerned about. They want proper nursery facilities, home help services, luncheon clubs and residential care for the elderly. They are usually far less concerned about for example the provision for adequate care facilities for the mentally ill in the neighbourhood and have no real role in the decision to remove children from their families.

10.15. The real objection to the present system is that the pressures of maintaining the service are so great that there is no proper time for reflection or planning. This means that the task becomes almost entirely a matter of reacting to crises rather than undertaking effective preventative work. It is the latter which is the professional task from which most social workers derive

their job satisfaction. A present emphasis on provision of demand-led services to the public is analogous to seeing the role of the general practitioner as being to sit in his surgery and write prescriptions. It may be that that is what he spends a lot of his time doing, but it is unlikely to be the reason why he went into medicine.

ADMINISTRATION

10.16. The pressures on the administrative side are just as great. The Council's priorities are to staff the reception desk and the cash office. Priority is also given to the computerized recording of housing repairs. The level of absenteeism amongst administrative staff is very high. This means that there is often no-one available to carry out routine tasks such as filing or typing.

10.17. Included within the administrative staff are some who were specialist staff within for example the Social Services or housing department before decentralization. They have been allowed to remain as specialists. Typing is regarded as a specialised skill. None of the other administrative tasks, including reception or manning the cash office are. Since 1988, there has been a career grade system for administrative staff who may be required to deal with any of the administrative tasks in the office. We are told that many enjoy the opportunities for promotion and advancement which this system allows, and which the former did not. In terms of the overall service, it seems to us that the practical effect is patchy. The system also undervalues the specialist skills needed to do some of these tasks. Having the cash office staffed by the innumerate, filing done by the dyslexic and disorganised, and reception by the surly or the charmless seems to us a recipe for administrative chaos. It creates enormous pressures within the neigh-

bourhood office, not least on the administrative staff themselves. Every further decentralization, and there are a number of other projects in the pipeline, creates additional administrative burdens in the neighbourhood office, where even finding space to put the extra forms is a problem.

10.18. The level of administrative support provided for each office is determined centrally. It is based upon analysis of the number of specific tasks performed by each office during the period. In our view the indicators used give a totally inadequate measure of the real level of administrative support required by Social Services. The same may be true for the other departments but they are beyond the scope of this Inquiry. For the administration, as for Social Services, there are no economies of scale within such a small office.

10.19. The fundamental problem is that whenever there are financial constraints administrative staff tend to be regarded as expendable. What actually happens, as we have discovered, is that the more highly paid and skilled staff end up spending a lot of their time doing their own administration which could be done more cost-effectively by someone else. We have already identified the problems in relation to the maintenance of the child protection register (see para 8.25 above). Social workers are having to spend time telephoning to arrange case conferences and writing up reports and their notes for themselves. This is inefficient and wasteful. It seems to us that at the very least the system whereby each social work team had a clerk who knew the work and was able to deal with the routine tasks ought to be reinstated as soon as possible.

10.20. A good receptionist, too, can take a lot of the burden from the specialist staff by being able to filter some of the non-urgent cases without always having to

refer to a social worker. In this particular neighbourhood office, the typist was formerly employed in Social Services, and so has some understanding of which pieces of typing are urgent and which less so. This is not so in other offices. It again makes a big difference.

10.21. Computerisation is sometimes considered to be the answer to many administrative problems. Progress in this area has been slow within the Social Services department. There are now plans to introduce computers within the next two years. Where they will be put, and how staff will be trained to use them are issues which will need to be resolved.

THE PREMISES

10.22. We have tried to discover the original specification for the neighbourhood offices, for example how many staff they were designed for, what facilities were thought necessary and what storage space would be required. We wanted to see whether the offices were originally adequate, but the volume of work has increased to such an extent that they no longer are, or whether, indeed, they were too small and the design was flawed from the beginning. To our surprise, we have been quite unable to obtain this piece of information.

10.23. Some of the neighbourhood offices, like this one, were specially designed. Others are adaptations of older buildings. Some of the sites, including this one, do have additional land which would permit the size of the buildings to be increased somewhat. The basic design of the newer offices, however, does not, for example permit the building of additional storeys on top of the existing structure.

10.24. This poses an intractable problem. The neighbourhood office system is, as we have seen, an expensive

way of delivering the service. The answer to some of the problems which we have raised above would be to close some of the outlets and create larger teams in the remaining offices. This would go a long way towards solving some of the problems. The difficulty is that in many of the offices there is simply no physical space in which to put them, and no space into which the offices can be expanded. Financial constraints have meant that the proposed development of some sites has had to be postponed. It may be that the answer is to look for alternative sites which already have purpose-built accommodation.

10.25. It is almost impossible for Social Services to carry out their work without sufficient space for holding case conferences or specialised treatment or interviewing. During the period in which the access to S by his father was being supervised, there were lots of problems arising out of the use of the community room for this purpose. Sometimes it would be double booked. At other times it would have to be shared with those who required it for other purposes. In any event it was not private and far from being an ideal environment in which to supervise access at all.

10.26. Similarly, we have tried to think about the possible effect of this environment on someone in the position of [redacted] had she ever reached a point at which she decided to tell the Social Services what was going on. Having steeled herself to go to the office, she might or might not have been seen on that day. Assuming that she then returned, she would have sat in the waiting area along with all the other people who have business in either Social Services or one of the other departments. The risk of her being seen there by a neighbour or someone who knows the father [illegible] for example, waiting to [illegible] benefit query is high. She would then be interviewed in a small room with [illegible]

afford privacy from those who are waiting. It seems to us that this environment certainly does not encourage a nervous woman, or perhaps the neighbour of an abused child, to unburden themselves.

10.27. None of those who have spoken to us seek to suggest that any of these problems made any difference to the way in which the present case was handled. We think that actually that was probably true. Paradoxically although one area of concern has been the fact that no social worker was in fact allocated to the case as they had hoped, it may well be that this family received a better service through being dealt with on the duty system than would have been the case had they been a "low priority" allocated case.

10.28. We have nevertheless felt compelled to outline some of the problems which face those seeking to work in the neighbourhood office environment. At times we have wondered how if the system had been intended to make the lives of those seeking to operate it as difficult as possible, things would have been done differently. As we have said, there is a genuine widespread commitment to the delivery of services through the neighbourhood system. The effective delivery of those services, however, depends upon them being properly resourced and upon there being adequate and efficient administrative staff.

10.29. No one has sought to suggest that the problems of the neighbourhood office or its administration actually made any difference in the present case. That is no reason for complacency. The problems which we highlight in paragraphs 10.11 to 10.15 mean that proper prevention work and considered planning for children at risk are not able to be carried out. The situation is worse now than it was in 1986/87. The deficiencies inherent in the system have to some extent been masked by the stable and

experienced social work force. The staff are beginning to leave, mostly for better paid jobs elsewhere. Once these small social work teams consist of unexperienced staff working under the stresses we have identified, the risk of a preventable tragedy occurring is high. We think the present neighbourhood office structure is a time bomb waiting to go off.

MANAGEMENT WITHIN THE SOCIAL SERVICES

10.30. The theory underpinning the neighbourhood office system is that there is a strong local base and a strong centre which provides the expertise and back-up, for example in child abuse, which the small local team might not be able to provide for itself. The reality is very different. There are now a Deputy Director and four Assistant Directors responsible for a group of neighbourhood offices, who also have borough-wide responsibility for some of the Social Services functions. The main link between the Assistant Directors and the neighbourhood officers who are accountable to them is the weekly meeting of these officers. There are also meetings of senior social workers.

10.31. So far as the problems within the neighbourhood offices are concerned, we think that these were raised repeatedly in the period following decentralization. Management were aware of the problems, particularly in relation to administration, but were seen as powerless to do anything about them.

10.32. There were two main reasons for this. The first was that, because there was a lot of opposition to the whole scheme from within the Social Services department and the decision was in effect taken to impose the scheme anyway, any subsequent criticisms were seen as a hankering after the old system. "Departmentalism" became the unpardonable sin. Any attempt by management to raise the

legitimate professional concerns which we have set out were dismissed in this way.

10.33. The second reason was that a lot of management's time in the intervening years has been taken up with trying to cut the budget in order to meet financial targets and constraints. This has been time and energy consuming.

10.34. Management's own problems have been compounded by their own lack of adequate administrative staff. Paradoxically, this has meant that when the Chief Executive's Department recently undertook a survey of the administrative needs of the neighbourhood offices, and invited Social Services to support their argument for the need for specialised administrative staff, they had no-one who could do the work involved in gathering the requisite statistical information! Once again, an opportunity for the department to fight its corner was lost.

10.35. We gained a distinct impression during this inquiry that we were raising as current concerns within the neighbourhood offices, issues which management generally (and not just within Social Services) thought had gone away. So far as the elected members are concerned, the view appears to be that these are residual skirmishes in a struggle for power which the decentralized departments have already lost.

10.36. As we have set out, we are concerned about the lack of any real appreciation of the problems, or of the fact that they are getting worse and not better. (See Paragraph 10.29). The social work force is now less stable. Experienced social workers, and senior social workers are now leaving. Islington's rates of pay are now lower than many of the neighbouring boroughs. Some staff are being attracted away for that reason. They are

not being replaced by staff of comparable experience. There is no longer any post qualification training for basic grade social workers to supplement the CQSW. Apart from the approved social worker training under the Mental Health Act, (which requires attendance on a 60 day training course) newly qualified social workers are expected to have the skill to tackle any social work problem which the office encounters. What they are permitted to do is the responsibility of their supervisor. We consider the question of training in more detail below.

10.37. It has been forcefully argued to us that what is required is a review of the neighbourhood office system from a Social Services perspective. This would be carried out by a small working party which would include within its membership a high proportion of neighbourhood officers and senior social workers from such offices. This is obviously one possible way forward. Unless it is accompanied by a willingness to listen to and tackle the legitimate concerns of those who are trying to deliver a service in these circumstances, we can see no point at all in embarking upon such a review.

10.38. We suspect that senior managers and elected members could probably learn just as much about the real problems by attending some of the regular meetings of neighbourhood officers and senior social workers and asking them. However it is tackled, we are quite sure that this issue must be looked at as a matter of urgency and must be tackled in a co-operative partnership between the Social Services department and the elected members.

STRENGTHENING THE CENTRE

10.39. As we have seen, the aim of achieving devolved power to the neighbourhood offices and at the same time maintaining a central pool of professional expertise upon

which they can draw is not working in practice. This is not the fault of any of the individuals involved, but rather a combination of factors.

10.40. To begin with, there is the problem that once a post which is labelled "co-ordinator" or "advisor" is created, that person comes to be regarded as "the Council's expert" on this particular issue. This applies in particular to the post of Child Abuse Co-Ordinator but also, to a lesser extent to the Race Policy and Practice Officer (children and families) and the other similar policy posts in relation to mental health and the disabled. The assumption seems to be that by the creation of such a post the authority has "tackled" the problem.

10.41. In practice it means that such individuals spend a lot of time representing the Council at meetings where these issues are raised.

10.42. They can easily get sucked into attending case conferences, or as we have seen, into administrative tasks associated with their role, and have less and less time to be a real resource for the neighbourhood offices in terms of expertise and advice. In addition to the Child Abuse Co-ordinator, we think that there is a need for a number (about 10) of specialist Child Abuse practitioners (not a Team) based in neighbourhood offices. They would be able to engage in joint training with the police and share in the investigation of suspected child abuse. They would also increase the level of expertise available in the neighbourhood offices.

10.43. Coupled with this is the lack of supervision and real managerial support for the senior staff in the neighbourhood offices. They receive minimal personal supervision or professional support, although this is

recommended by Government. The meetings of neighbourhood officers and senior social workers to which we have referred are clearly valued but in our view are not a substitute. They appear to be essentially an opportunity for senior management to impart information. As we have indicated we think there is a real need for management to listen to what some of these senior staff may have to say to them.

10.44. The third limb relates to training. We have outlined some of the problems already. The funding problems in relation to child abuse have been mitigated by Government money made available to Social Services departments for this purpose following the Cleveland report. The main problem about the staff in the neighbourhood offices being adequately trained, however, is the difficulty about releasing them for such training where that represents a cut of 20%-25% in the staff available to deal with the rest of the work.

10.45. Related to that is the fact that the same constraints prevent senior social workers who have gained experience in particular fields of work communicating that experience to other workers as part of a total training programme. Similarly, there is no planned obligatory programme for the progressive training of social workers in areas where it is recognised that additional training is necessary.

10.46. Legislative changes, including the coming into force of the new Children Act and the changes in relation to the community care of the mentally ill will have massive training implications for the department. At present the policy is that hardly anyone can be sent on externally organised courses. We understand that the policy in relation to this changes almost from year to year, which does not allow for any forward planning.

Again we see this as a problem which unless it is tackled soon will become completely unmanageable.

10.47. Again, the obstacle does seem to be in part at least an unwillingness to accept the importance of those who deal with this area of work having the requisite professional skills. In terms of inter-agency working, it is essential that social workers' expertise and skill is recognised by the other professionals with whom they have to deal. The Cleveland report highlighted the problems that can arise when the judgment of social workers is overborne by that of the medical profession. Again there is no evidence that this happened in the present case. We highlight it because part of our role is to make recommendations which might prevent a similar tragedy happening again.

RECOMMENDATIONS

1. The whole issue of the delivery of from the existing neighbourhood office structure needs to be examined as a matter of urgency.

2. The administrative support for the Social Services department at all levels needs to be examined. The very minimum requirement appears to us to be that each neighbourhood office (and the peripatetic team) should have its own team clerk who would release the social workers from a lot of unnecessary administrative pressures.

3. The elected members need to recognise the legitimate professional concerns of the department in order to ensure that its statutory responsibilities are carried out.

4. The training needs of the department need to be carefully examined and the problems addressed.

5. The question of proper professional support for neighbourhood officers and senior social workers needs to be addressed.

6. The role of specialist advisory posts within the Social Services department needs to be looked at. So far as possible, they should be freed from all the tasks which they currently undertake which prevent them carrying out their proper advisory and training roles.

7. There should be a central index of all the files (see paragraphs 6.9-10 above).

8. The authority also needs to address its role in relation to the ACPC (see Chapter 9 above), including support for the Child Protection Register (see paras 8.22 to 8.25 above) and proper administrative support for case conferences (paras 8.28 to 8.30 above).

9. The creation of a number of specialist child abuse practitioners (not a team) in the Neighbourhood Offices to participate in joint investigation with the police, and increase the level of expertise available to the neighbourhood teams.

10. The interrelation between Departmental and ACPC publicity following a tragedy (see para 7.46 above).

CHAPTER 11

ISSUES FOR AGENCIES: (2) THE HEALTH SERVICE

11.1. Although as we have seen, there are problems and frustrations for staff in Social Services departments, their management structures and procedures seem essentially designed and intended to facilitate the exchange of information rather than the reverse. We have not found this to be so within the health service. What we have found is excellent local liaison, particularly by the health visitors and community doctors, which is operating despite traditional information systems which restrict rather than encourage the exchange of information.

11.2. We have highlighted already the most serious of these restrictions as they affected this case. In summary they are:

(i) The failure to provide copies of the doctor's report to other agencies in March 1984 (see paragraph 3.23(b) above).

(ii) The lack of any liaison between the hospital A and E department and the community health services. (See para 6.25 above).

(iii) The lack of any effective exchange of information between the GPs and the health centres.

11.3. We have already dealt in detail with the issues arising out of the failure to circulate the medical report and the problems which can still face doctors dealing with suspected child abuse within the family (see paragraphs 6.6 - 6.8 above).

11.4. Similarly, we have highlighted the clear need for better liaison between the paediatric and A and E departments at the hospital (see paras 6.22-24 above).

11.5. We also consider that there should be a proper system of liaison between the A and E department and the health centres. (See para 6.25). Ideally we think that this should be done by a health visitor post within the hospital. This is a common model which works extremely well in other parts of the country, notably in terms of our investigation, in Scarborough. Such a person would be responsible for notifying the health centres of all admissions to the A and E department of children under 5. They would also have a training role within the hospital.

11.6. Obviously this needs to be done promptly, as does the notification by the hospital to the GP (see para 6.25). It is important to emphasise that this is just as important in the case of accidental injury to children as in suspected NAI cases.

11.7. At the very least, even if such a post as we have envisaged cannot be created, there should be a system of written notification to the health centres, at least as reliable.

11.8. If the paediatric input into the A and E department is to be strengthened in the manner which we envisage, consideration will obviously have to be given to who is accountable for ensuring that such liaison takes place and that a senior paediatrician is consulted in such cases. It is the responsibility of the district health authority to make sure that this is being done.

11.9. In many parts of the country, health visitors are based in GP surgeries. As we have seen, that is not the case in Islington. This means that there is an important gap between the information provided to the general

practitioner and information available to the health visitor. It is unlikely that this was particularly significant here, but in many cases it will be. This involves health visitors having access not only to the childrens' health records but also those of the adults involved. We suspect that it is the latter which in many cases will be of more significance.

11.10. We therefore recommend that health visitors as involved health professionals should have access to the general practitioner's information, and vice versa, where there is a risk to the safety of the child.

11.11. We have also highlighted our concern about the lack of professional support for the community medical officers, who seem to us to be very isolated professionally, and who are carrying a heavy responsibility. Attention needs to be given to this.

11.12. We have dealt at para 8.34 with the consequences of some of the changes within the structure for the management of health visitors within the service. This seems to have removed the nursing managers from their traditional head nursing role into a much more specialised managerial role. This has been in operation for such a short time that it is impossible for us to say whether it is a change for the better or for the worse. What is obvious is that the training which such managers are receiving for their changed role is really very limited. Again if they are to carry it out effectively, this needs to be looked at.

11.13. Overall we are extremely concerned by the fact that the Area Health Authority (AHA) has really only addressed Child Protection in the context of the community services. This means that the quality of the service in the hospitals is variable and in relation to

some of the issues highlighted, very poor. The AHA must consider these matters as a matter of urgency.

RECOMMENDATIONS

1. That medical reports prepared on children where abuse is suspected, if not actually proved, be made available to the other agencies concerned with child protection.

2. That there be a proper system for ensuring that the records of school age children and the under fives within the same family are accessible to the medical and nursing staff dealing with suspected NAI in relation to other family members.

3. That a health visitor liaison post be established at the A and E department of the Whittington Hospital with a liaison and training role.

4. That health visitors have access to general practitioners' information and vice versa where there is a risk to the safety of the child.

5. That the A and E department notifies general practitioners as a matter of urgency when a child is treated for injury whether or not NAI is suspected.

6. That the district health authority addresses the training needs of staff within the A and E department both on a single and multi-disciplinary basis.

7. That a proper system of consultation with the paediatric department is established within the A and E department in cases of injury to children

and that responsibility for ensuring such consultation takes place is clearly defined.

8. That a proper system of professional support for community medical officers is established.

9. That there is a proper training programme for nursing managers.

10. That the results of x-rays or other medical procedures on a child in care are not withheld from Social Services, even if they are also passed to other agencies (paras 7.24-7.25).

CHAPTER 12

ISSUES FOR AGENCIES: (3) THE POLICE

12.1. As set out at paras 7.12 to 7.13 above, the police have recently changed the basis upon which they investigate child abuse cases. This is linked to changes in approach to the investigation and to the question of prosecution. It is envisaged that officers will be transferred to the child protection team for a minimum period of 2 years with 3 or 4 being the norm. It is not envisaged that for most officers this will become a full-time career post.

12.2. In many ways this development is to be welcomed. It is a conscious attempt to deal with an area of work where the traditional police role is not always appropriate. On the other hand, there do seem to us to be a number of potential problems for such a team.

12.3. The first is that such a team will become marginalised within the force. Under the previous system, the juvenile liaison officers were based in local police stations, worked in the same basic way, and were able to pick up on that important network of suspicion and concern about particular individuals which did not lead to prosecution.

12.4. The child protection team recruits officers who are trained in the traditional police investigation methods and transplants them into a very different ethos, in which not only is a successful prosecution not always the desirable outcome but in which they are expected to share sensitive information with other agencies. We think that there is a much greater risk that the child protection team will become marginalised within the force than was the case with the old juvenile bureau liaison officers. We do not think they will be as well placed to

pick up on information as was formerly the case, and we think that their ethos may mean that in time information is withheld from them by other parts of the force who are suspicious of this method of working. We have been confidently assured that none of these concerns are justified. We remain unconvinced.

12.5. We have already highlighted a number of problems which the police have in terms of any real inter-agency co-operation in a case such as the present. These embrace a number of issues. The first is the disclosure of previous convictions to the case conference. The policy in relation to this is now that these should be given to the person chairing the case conference for him or her to decide what use to make of them. Some officers prefer to disclose them to the legal department. We agree that the previous convictions should be made available to the person chairing the case conference for them to decide what use to make of them. If a person does have convictions which do not appear to be relevant to the consideration of the case conference, we see no reason why this cannot be stated. We do not accept that previous convictions are any more sensitive than a lot of other information which is given to the case conference, and do at least have the merit of being able to be confirmed with a reasonable degree of accuracy. As we have already made clear, we do not think that the disclosure of the father's convictions in the present case would actually have made any real difference to the deliberations, but the fact that they were not disclosed until such a long time after the death is a matter for very real concern in terms of inter-agency co-operation.

12.6. We have already dealt in some detail with the thorny issue of the disclosure of the police witness statements to the Social Services department. The same issues arise in relation to the disclosure of the statements to this Inquiry. Again this raises real

questions about the police's commitment to the "Working Together" approach.

12.7. The thinking behind it is that because there is no general obligation on the public to assist the police by providing evidence for a prosecution, the witness should feel confident that he or she is providing information only for that purpose, and that it will not be used for any other purpose without their consent. In effect it is allowing the witness to claim privilege in respect of information given to the police.

12.8. This is different from the general legal principle which is that the privilege which attaches to documents prepared for the purpose of litigation is that of the party to the litigation, rather than the witness. Whether or not a party can or cannot be compelled to disclose a particular piece of information is a matter for the Court itself. In relation to a criminal prosecution, the prosecution is required to disclose the statements taken from witnesses upon which it does not intend to rely, usually those favourable to the defence. They are not permitted to refuse to give this information because a particular witness says they do not want it disclosed.

12.9. Historically there has been a limited protection surrounding the identity of police informers. This has been extended to the contents of their information where that has been given in confidence. It is right to say that none of the leading authorities on this topic (Alfred Crompton Amusement Machines Ltd v Customs & Excise Commissioners (No.2) (1974) A.C. 405, Rogers v. Home Secretary (1973) A.C. 388 and Neilson v. Laugharne (1981) 2 WLR 537) actually deal with the circumstances in which witness statements taken for the purpose of a criminal prosecution where the evidence will almost invariably be given in public would be disclosed. They

all concern information which was gathered for purposes other than a public trial.

12.10. Accordingly, we are very doubtful whether the rationale contended for by the police is actually soundly based in law. Even if it is in relation to the general disclosure of witness statements to those who wish to bring civil proceedings against the police force arising out of criminal prosecutions, it seems to us that the issue has not really been considered in the context of child protection. We think that it should be as a matter of urgency. If necessary the matter can be dealt with by explaining to witnesses that the material may be made available to other agencies concerned with child protection. A comparable privilege already exists where agencies dealing with child protection need to protect the identity of those who give them information (see D v. NSPCC (1978) A.C. 171). Accordingly, where there is very real concern that a witness does not wish to be identified, we see no difficulty about protecting that individual's privacy.

12.11. Related to this is the question of whether or not the police themselves, who are involved in direct liaison with the other agencies, can disclose the relevant statements, or whether, as they believe, the authority of the CPS is required. We think that this is an issue which the police and the CPS need to address together as a matter of urgency.

12.12. We think that the police and the CPS have a particular responsibility to try and ensure that the prosecution of offenders takes place as soon as possible. Although as we have highlighted (see paragraphs to above) there were particular difficulties here in prosecuting the matter speedily, there were also delays which are much more difficult to account for and which we think might have been avoided. There was a long delay in

taking the decision to prosecute. There was also an unnecessary delay to the committal proceedings because of an inaccurate estimate of the probable length of the hearing.

12.13. An aspect of the prosecution process which has also troubled us is the lack of human concern for the main prosecution witnesses in this case. Once they had given evidence, they seemed to have been left to run the gauntlet of the Press without any support. They were not kept informed of what was happening, despite promises that they would be, and appear to have learned the outcome of the criminal trial from the Press. This is clearly unsatisfactory, and we do think that the police should be more sensitive about this.

12.14. We have already dealt in detail with a number of other aspects of the police role which need attention. These include:-

(i) Liaison so that sufficient information is given to the Court dealing with bail to ensure that bail conditions are consistent with other Court Orders. (paras 7.50 to 7.53 above).

(ii) Police dealings with the Press (paras 7.40 to 7.46 above). The report on the x-rays (paras 7.24 to 7.25 above).

RECOMMENDATIONS

(a) That the relevant witness statements be made available to the Social Services department at the earliest possible opportunity and in any event by the time they are disclosed to the accused.

(b) Where the Social Services department initiate medical investigations on behalf of the child the reports should be submitted in the first instance to the Social Services department and not to the police. If they are given to the police, copies should be disclosed to the Social Services department immediately.

(c) The police and Crown Prosecution Service should consider who has authority to authorise the disclosure of witness statements.

(d) Officers dealing with bail applications should have sufficient information about any other Court Orders in relation to the child to enable them to place it before the Court to try and ensure that any bail conditions are not inconsistent with those Orders.

(e) Details of relevant criminal convictions should be given to the person chairing a child abuse case conference.

(f) The police service should consider whether and to what extent it is appropriate for them to deal with the Press separately from any ACPC joint statement in fatal child abuse cases.

CHAPTER 13

ISSUES FOR AGENCIES: (4) THE EDUCATION SERVICE

13.1. Again as is clear from the foregoing, no real criticism can be made of the performance of the individuals who were concerned in the present case. We have raised (para 6.30 above) the problems which arise from the system whereby referrals are made through the head teacher and the ESW to the Social Services department. It is not clear whether having a liaison teacher, as proposed in "Working Together" would improve things. The alternative to the present system is obviously to permit direct referral from the teacher or head teacher to the school. This would create a different set of problems. We would have felt it necessary to explore this in more detail, but for the fact that within a relatively short space of time education, and the equivalent of the ESW service is going to become controlled by the London boroughs, rather than the ILEA. Accordingly, if the service continues to exist it will have to be integrated within the local authority provision. There is an outstanding dispute as to whether it will remain within the education department or become part of the Social Services department. We would like the opportunity to be taken for a critical assessment of the role.

13.2. The period which clearly arouses the most concern in the present case is the period from half term onwards in October 1987 when [redacted] failed to attend school at all. We think that the ESW made considerable efforts to try and see the father. She was hampered by the limitations of her role. ESWs have no power to force entry. As with so many human situations, the easy one to deal with is where the child is absent and there is no contact and no explanation from the parents. The difficult ones are those where there are repeated periods of absence

followed by short periods of attendance, or where, as here, there are plausible explanations for the absence and promises to ensure attendance are not kept.

13.3. Again ESWs have very little power to deal with the situation where they are given an explanation which they know to be false. The father's explanation for the absence at the beginning of December, given to the head teacher, that he had to attend Court on that day, was as we have seen, plausible but untrue. Had she been aware of that, there was, nevertheless very little that the ESW could have done about it.

13.4. We have considered whether or not there should be some machinery which is automatically triggered when the child is absent for a fixed period. The obvious drawback to such a system is that it will fail to protect children who are absent for shorter periods. We do think that the education department's own machinery ought to be triggered rather more quickly than it appears to be, but we appreciate that there are drawbacks with fixed time limits. What we think is needed is rather more vigilance by schools and an acceptance by them of their responsibilities to ensure that children attend. We think that this responsibility has become rather blurred by the existence of the ESW service.

13.5. We have also considered whether or not it would be helpful for there to be meetings between the ESW service and the Social Services department in relation to cases of prolonged or repeated absence. There are obvious practical difficulties in relation to organising this with 24 neighbourhood offices. There is also the problem that we doubt whether this will be a speedy enough machinery to have helped in a case such as the present.

RECOMMENDATIONS

1. That the role of the education social worker be clarified and careful consideration given as to whether their future role is properly within the Social Services or the education department.

2. That the responsibility of the school for dealing with absences should be clearly stated and the machinery overhauled so that proceedings are initiated swiftly to deal with prolonged or persistent absence, particularly in cases where attempts to contact the family are unsuccessful.

CHAPTER 14

ISSUES FOR AGENCIES: (5) THE PROBATION SERVICE

14.1. The Probation Service, as we have noted, carried out its own internal review into this case, which appears to us to have been thorough. The failure of the Probation Officer to provide a report for the Court was a significant matter so far as they were concerned, in that his default was not justified and reflected badly on the Service. Considerable local negotiation had been involved to get a 3 month period for preparing a report in family cases, and it was a matter of concern when this deadline was not complied with.

14.2. We agree that he clearly should have provided a report by the due date, although as we have indicated, we do not think that this was likely to have led to a removal of the children from the father or that his investigations would have alerted the Probation Officer to concerns about the father's care of either of the children.

14.3. The Probation Service has also been involved in looking at the way in which the specialist task of producing court welfare reports might most effectively be done. As we have seen, these are not a priority within the Probation Service. They have developed specialist teams to deal with this work. They are not able to handle all of it and a limited amount will still be dealt with by the field services. This obviously makes training in child protection issues easier and recognises the different skills involved in this work. On balance we applaud this development, although it does mean that those within the field services are likely to be less well able to deal with these reports in future, than is currently the case.

14.4. We have dealt in para 8.34 above with the question of supervision within the Probation Service. This is a relatively recent development and has not always been appreciated. So far as the particular Probation Officer in this case was concerned, he was relatively inexperienced and welcomed and appreciated supervision. His supervisor received no training in supervision skills. She was relatively new in post and had a background in the specialised hostels. The preparation of this particular report does not appear to have been discussed in supervision. Had it been, the difficulty might have been picked up. Since the problem appears to have been that the officer was not aware of the date for which the report had to be ready, rather than that he was putting it off because he did not know how to tackle it, we do not really see this as a problem caused by the failure of supervision.

14.5. It seems to us that most of the problems which arise from this case for the Probation Service have already been tackled by them, and our recommendations are therefore limited to the joint ones arising out of Chapters 6, 8 and 9.

CHAPTER 15

ISSUES FOR AGENCIES: (6) SHEFFIELD SOCIAL SERVICES DEPARTMENT

15.1. Having been commissioned by the Islington agencies to enquire into this case, it did not seem to us appropriate to conduct our inquiries in Sheffield in the same detail. We have highlighted a number of particular aspects of organisation arising out of this case which we consider need to be addressed.

15.2. Sheffield still has no category for putting children who are potentially at risk on to its child protection register. Whilst we understand the reasons for this, we consider that they are not complying with the Government's guidelines. This is not a problem provided that no child dies in their area whose name was not on the register but who fell within such a potential category.

15.3. We are also extremely concerned about the lack of a central register for Social Services files. Cross-referencing, as we have seen (paragraphs 6.9 to 6.10 above) is made more difficult in Sheffield because files are identified by the name of the first person with whom the Social Services department come into contact. There is no system for cross-referencing the files with those held on other members of the household who may have different names. It seems to us to be a serious defect in terms of protecting other children within the family.

15.4. Very similar problems to those faced by Islington in relation to chairing and minute-taking at conferences apply also in Sheffield. They too are unable to provide independent minute-takers or chairs for case conferences. Of those we have seen, we do not think that this would

have made any difference to the present case, previous inquiries, as well as the Government guidance have highlighted the importance of this.

15.5. Recommendations 2, 7 and 8 which we have made in relation to Islington (see Chapter 10 above) apply equally to Sheffield.

CHAPTER 16

ISSUES FOR AGENCIES: (7) LEGAL DEPARTMENT

16.1. Despite the recommendations of previous Inquiries, it is clear that the legal department within Islington is not always able to attend case conferences even when they are invited to do so. The main reason for this is lack of staff to provide attendance at the 600 or so case conferences held annually. The difficulty is obviously compounded by the neighbourhood office structure. It may be that more frequent use should be made of seeking advice over the telephone or submitting the relevant documents to the legal department for advice.

16.2. Obviously, the legal department does not get invited to the sort of informal information sharing meetings that we have considered in this case. Again we do not think that this made any difference to the outcome.

16.3. It is, however, apparent, that there is widespread lack of knowledge about the legal framework within which the social workers have to act and of the related criminal process. Ideally it would be helpful if the legal department could be involved in training. The lack of numbers, however, realistically makes this unworkable.

16.4. It also appears, as we shall see below, that the ACPC did not apparently seek any advice from the legal department about the issues which concerned it in relation to carrying out the review. It seems to us to be just as necessary for the ACPC to have access to competent legal advice about legal issues affecting its deliberations as it is for the Social Services department.

16.5. Because we are concerned about the police practice of disclosing convictions to the legal department rather than to case conferences, we do not think that the legal department should be colluding in this practice.

CHAPTER 17

ACPC REVIEW

17.1. As we have seen in Chapters 9 and 10, the ACPC attempted to carry out a review of this case in accordance with the principles set out in "Working Together". We have already dealt with the general issues raised by that at paras 8.39 to 8.44 above.

17.2. One major issue which was of concern to the ACPC, and which is not addressed at all in "Working Together" is the issue of "sub judice" or contempt of court. By the time it instituted its own review there was a pending criminal prosecution against the father where it was anticipated that he would plead not guilty. This will be the case where many such reviews are instituted.

17.3. Under Section 1 of the Contempt of Court 1981, conduct may be treated as contempt of court as tending to interfere with the course of justice in particular legal proceedings, regardless of intent to do so. The mischief is the risk of prejudice to a fair trial. In Section 2(2), the rule applies only to a publication which creates a substantial risk that the course of justice in the proceedings in question will be seriously impeded or prejudiced. It seems to us that a report published which reaches conclusions about whether or not a carer was to blame for the death of a child prima facie creates such a substantial risk. Since those preparing the report would be well aware of the pending prosecution, they would have no defence under Section 3.

17.4. Whatever may be the legal position in relation to the publication of any such review, we do not see that the "sub judice" rule has any proper application to the confidential disclosure between agencies of information and evidence which may be used in the pending criminal

proceedings. (See Section 2(1) Contempt of Court Act 1981). Indeed if the review is to be effective, it will often be essential that evidence in possession of the police which discloses a state of affairs which was not known to the Social Services department at the time is made available to the review.

17.5. Whether or not it was as a result of slightly muddled thinking on this issue, the ACPC sub-committee decided that the review would initially consider only the information which was available to the agencies about the family up to the time of death. As we have seen, they intended that there should be a further review, to take place after the criminal trial, which would look at the issues in the light of information which subsequently became available. Each agency was accordingly asked to produce a factual statement of its involvement with the family prior to the death. All the agencies, including the police, did so.

17.6. None of the agencies was asked what inferences for practice they thought ought to be drawn from their involvement, bearing in mind the fact of the child's subsequent death or information which had come to light since the death. Instead, the ACPC sub-policy sub-committee considered the factual reports and made a number of recommendations arising out of them for consideration by the different agencies. So far as we can tell those recommendations have largely been accepted. Inevitably, however, they were superficial, and would not in any sense have allayed public anxiety arising out of the case, which is intended to be one of the principal objects of such a review.

17.7. Although, as we have seen, the factual issues in the criminal trial here were more complex than in many others, in many cases where the carers of the child plead not guilty, the defence will either be that the injuries

were caused accidentally, or that they were caused by a partner or someone else. The ACPC, therefore is almost invariably going to be carrying out a review in circumstances in which the death is either the result of criminal conduct or is accidental. It may be that any criticism of the agencies' conduct will have to be considered alternatively on the basis of criminality or accident.

17.8. We think that the only effective way of conducting a review is to examine the facts as fully as they are known at the time when the review is instituted, and take into account any material which subsequently comes to light. We think that there should be a more concerted effort to obtain information from other agencies, outside the ACPC, who are known to have it, than was the case here.

17.9. We think that there is a lot to be said for a properly conducted inter-agency review of the case which can obviate the need for a public inquiry. The difficulty then arises in relation to the publication of the report or action being taken arising out of it.

17.10. In fairness to the staff involved, it seems to us desirable that they should know as soon as possible whether their conduct has or has not been the subject of criticism. If there is evidence to justify disciplinary proceedings against any members of staff, it is our view that those should be instituted and dealt with using the normal procedures as soon as possible. This is not inconsistent with any question of contempt of court. Those who are alleged to have committed criminal offences which form breaches of disciplinary codes are frequently dealt with by their firm's disciplinary procedures while the criminal case against them is still pending. We see no reason in principle why disciplinary proceedings, if appropriate, against staff should not be carried on while

the criminal trial is pending. In many cases, such as the present, there will be no question of any disciplinary proceedings against members of staff, and for reasons of morale, it is clearly desirable that they should know this as soon as possible, and that they should, as we have argued in para 7.46 above, thereafter receive public managerial support for the fact that they are not considered to be to blame.

17.11. The problem as we see it is that if the findings of the report are published for this limited purpose, there is a strong risk of its contents being disclosed to the Press by those who seem incapable of refraining from so doing, with a consequent risk of prejudicing the criminal proceedings.

17.12. This is potentially an intractable problem. It clearly needs to be addressed both by Government and the ACPC. The answer may be that there will be cases where full publication is not prejudicial, and others where it clearly is and publication of the review therefore has to be postponed until the outcome of the criminal trial. There may be some cases where limited disclosure of the findings of the review can be made and clear warnings given to all the agencies and those who receive a copy of the report, that publication of any other part of the review at this stage could prejudice the criminal trial and render both the individual and the authority liable to contempt of court proceedings.

17.13. The disclosure by the police of witness statements to the review obviously raises for them the same questions which we have addressed in Chapter 12. Again it seems to us that this is an essential element of "Working Together".

17.14. Although considerable concern has been expressed to us that the police did not disclose all the informa-

tion they had to the review, we have concluded that such criticism was unfair. It was unfair because the police, like everyone else, were asked for and provided details of their involvement with the family prior to the death. It was also unfair, because as we have considered in detail in para 7.14 to 7.33 above, the suggestion that the police were not disclosing all the information which they had available was fallacious.

17.15. In preparing evidence for the review, we think that the investigation within each agency should obviously be carried out by a senior person within management who is unconnected with the case. In the case of Social Services, we think this should have been an Assistant Director.

17.16. As we have indicated, we think that the present case highlights serious deficiencies in the recommended guidance for the conduct of such reviews. We recommend that they are reconsidered by Government and the ACPC in the light of this case.

CHAPTER 18

THE INQUIRY

18.1. We set out at the beginning of this report our procedures and the level of co-operation which we received. From the point of view of the panel, this form of procedure has many advantages and few disadvantages. We are aware, however, that the balance is not quite the same for those who give evidence.

18.2. There are two separate but related aspects of our procedure which need to be considered. The first is whether or not the Inquiry should be held in public. If the Inquiry is held in public, then it is much more difficult to maintain the approach of a small panel making its own inquiries. The pressure for those whose conduct may be criticised in public to be represented and participate is very high. We know of no recent inquiry into child abuse which has sat in public but has not adopted traditional court room procedures for the conduct of its proceedings.

18.3. We think that the arguments against holding such inquiries in public which have been addressed in a number of previous reports are soundly based. The amount of genuine interest by the general public in the proceedings of such an inquiry, as opposed to its conclusions, is minimal. Few are attended by anyone other than interested parties. Particularly where the inquiry is a non-statutory one, so that there is no power to compel witnesses to attend or to produce documents, in our experience the reluctance to appear or to disclose confidential material is very high. In our view this seriously hampers such inquiries in their endeavours to find out the truth about what happened. It is also very difficult in such a forum for anyone to criticise their colleagues in the presence of [illegible]

desire to make such criticism has not characterised our inquiry, but it has at least permitted those who wish to do so to be frank about areas of difficulty.

18.4. It would of course be possible to hold the Inquiry in private but nevertheless adopt the procedure of having the interested parties represented and permitted to cross-examine witnesses. Such a procedure has the advantage of permitting cross-examination of the witnesses but the major disadvantage in our view that it makes confidentiality almost as impossible to preserve as it would be in a public hearing.

18.5. There is, in our view a further issue, namely whether proceedings should be confidential as well as private. As we have seen, the decision was eventually taken that these proceedings would be confidential. We took a decision at an early stage that if this was to be the case we would keep our own notes about the evidence, for our own purposes, and there would not be a formal transcript. This again has been a matter of concern to some participants who would have liked the opportunity to scrutinize what they said and then "clarify" it afterwards. This in itself has implications for confidentiality. Once transcripts start being circulated outside the control of the panel, it is very easy for confidentiality to be broken. Almost everyone believes that breaches of confidentiality are committed by other people. They themselves would never dream of doing so! Whilst for some individuals that is no less than the truth, there are others for whom keeping a confidence means to preface their disclosure with "Don't tell anyone else but ..."!

18.6. There are also problems because such transcripts are extremely costly to prepare. The destruction of our own notes once the inquiry process is complete is a sensible matter. The destruction of such a transcript is

not. Once it is known to exist, it is very difficult to prevent individuals from seeking to use it to conduct their own inquiry into who was really to blame for what happened. Even if that does not happen, the very existence of such a transcript is in our view prejudicial to the objective that people should feel free to speak in confidence.

18.7. We are obviously aware that the ability to speak in confidence is not in itself a guarantee of truthfulness. The major drawback of the procedure, as we have indicated, is that witnesses are not cross-examined or confronted by conflicting evidence in the same way in which they would be in a more adversarial procedure. We have tried to do so wherever possible, but it is not always easy, particularly when it is also necessary to avoid revealing the specific source of the information.

18.8. Another advantage of this procedure from the panel's point of view is that they are in control of the evidence which is put before them. They are not at the mercy of those whose purpose is to obscure issues or to keep the panel from finding out particular pieces of information. The drawback is that the inquiries are initially at least limited by the panel's own view of what is important and relevant and they do not necessarily have access to all the information which would be available were all the agencies and individuals concerned to be represented and participating. That may mean that lines of inquiry which might be suggested by such material may remain unknown to the panel. The other side of that is that many of those who have participated have been happy to discuss issues and have from time to time opened up fresh lines of inquiry and fresh ways of looking at the problems. We think that that willingness on the part of individuals has probably been more valuable to us than the possible losses.

THE VALUE OF SUCH INQUIRIES

18.9. There have been so many public inquiries in recent years into child abuse cases that some of those participating have queried the value of yet another one. Although there have been some aspects of inter-agency co-operation which have been raised for the first time by this inquiry, it is also true that much of what we have said has been said by previous inquiries.

18.10. Although we have been helped by hearing from the witnesses who have spoken to us, many of our conclusions about the facts and the work of the agencies could equally have been drawn by an intelligent reading of the available written material.

18.11. Although this form of inquiry is considerably cheaper than its full-scale public equivalent realistically it is still diverting scarce resources away from the solution of problems which are already known and identified.

18.12. It is also the case, obviously, that the existence of such an inquiry prolongs the agony for all those who have been involved. How much publicity attaches to the publication of the report varies, usually according to the sensational nature of its finding or the extent to which it finds scapegoats. Publication does, however, bring the tragedy once more into the public domain, which has consequences for the family itself and also prolongs the strain upon the workers in the case. By the time this report is published it will be nearly two years from L's death. The stress of this on the staff involved is considerable. The extent to which such inquiries in themselves inhibit other work being done is a significant consideration. At least, so far as we know, the staff did not have to close the neighbourhood office in order

that people could attend the inquiry! That has not always been the case with some recent public inquiries.

18.13. It has been clear to us during the course of this inquiry that a considerable number of those involved have been carrying burdens of unresolved guilt and anxiety about which some at least have found it difficult to speak before. Some, as we have indicated, have been offered little or no opportunity to do so. There may be advantages in being able to talk to those who are known to be quite independent of the managerial structures. Whilst we would not under-estimate the importance of this element in our work, it seems to us that it is an expensive way of providing therapeutic counselling.

18.14. We have also provided others, particularly the field workers themselves, with the opportunity to talk about the practical problems and benefits of inter-agency co-operation. We approached our work on the basis that everyone agrees in theory that inter-agency co-operation is a good thing. Almost every inquiry has highlighted instances where it has not happened, and we wanted to look at what the obstacles are to true co-operation in practice. We hope that this approach has been helpful.

18.15. We have also provided an opportunity for those who have participated to talk about the problems within their own agencies. Many have voiced their frustrations and difficulties in carrying out their work. In many instances they have made it clear that these are problems which are known about. They have told us about them with the flickering hope that our inquiry might succeed in effecting some improvement, but without much real expectation that that will be so.

18.16. To this limited extent, therefore, we consider that there may have been some positive benefit for those who have participated which may help to counterbalance

their understandable negative concerns about it. As we indicated in Chapter 2, we think there are very serious questionmarks about the value of such enquiries which are often demanded almost automatically and with very little appreciation of the impact of such an inquiry on those involved. The death of a child is not always preventable. Children do die, sometimes tragically, and sometimes at the hands of those who should care for them. Responsibility for these deaths lies overwhelmingly with those who kill them, not with those whose role has been to try to help the family.

18.17. The real value of this Inquiry lies in the extent to which its recommendations are actually implemented.

SUMMARY OF RECOMMENDATIONS

ALL AGENCIES

1. That wherever possible, Social Services should obtain information from other agencies before making an assessment of the children's situation rather than afterwards.

2. That, wherever possible, a summary of each agency's contact with the family should be submitted in writing to the person chairing the case conference in advance of the conference taking place.

3. The ACPC and the individual agencies need to clarify its role, power and to decide whether or not it is to be properly funded.

ISSUES FOR SOCIAL SERVICES

4. The whole issue of the delivery of from the existing neighbourhood office structure needs to be examined as a matter of urgency.

5. The administrative support for the Social Services department at all levels needs to be examined. The very minimum requirement appears to us to be that each neighbourhood office (and the peripatetic team) should have its own team clerk who would release the social workers from a lot of unnecessary administrative pressures.

6. The elected members need to recognise the legitimate professional concerns of the department in order to ensure that its statutory responsibilities are carried out.

7. The training needs of the department need to be carefully examined and the problems addressed.

8. The question of proper professional support for neighbourhood officers and senior social workers needs to be addressed.

9. The role of specialist advisory posts within the Social Services department needs to be looked at. So far as possible, they should be freed from all the tasks which they currently undertake which prevent them carrying out their proper advisory and training roles.

10. There should be a central index of all the files (see paragraphs 6.9-10 above).

11. The authority also needs to address its role in relation to the ACPC (see Chapter 9 above), including support for the Child Protection Register (see paras 8.22 to 8.25 above) and proper administrative support for case conferences (paras 8.28 to 8.30 above).

12. The creation of a number of specialist child abuse practitioners (not a team) in the Neighbourhood Offices to participate in joint investigation with the police, and increase the level of expertise available to the neighbourhood teams.

13. The interrelation between Departmental and ACPC publicity following a tragedy (see para 7.46 above).

ISSUES FOR HEALTH AUTHORITY

14. That consideration be given to improving the system of transferring information about children who are at risk from abuse to their school records.

15. That medical reports prepared on children where abuse is suspected, if not actually proved, be made available to the other agencies concerned with child protection.

16. That there be a proper system for ensuring that the records of school age children and the under fives within the same family are accessible to the medical and nursing staff dealing with suspected NAI in relation to other family members.

17. That a health visitor liaison post be established at the A and E department of the Whittington Hospital with a liaison and training role.

18. That health visitors have access to general practitioners' information and vice versa where there is a risk to the safety of the child.

19. That the A and E department notifies general practitioners as a matter of urgency when a child is treated for injury whether or not NAI is suspected.

20. That the district health authority addresses the training needs of staff within the A and E department both on a single and multi-disciplinary basis.

21. That a proper system of consultation with the paediatric department is established within the A and E department in cases of injury to children and that responsibility for ensuring such consultation takes place is clearly defined.

22. That a proper system of professional support for community medical officers is established.

23. That there is a proper training programme for nursing managers.

24. That the results of x-rays or other medical procedures on a child in care are not withheld from Social Services, even if they are also passed to other agencies (paras 7.24-7.25).

ISSUES FOR POLICE

25. That the relevant witness statements be made available to the Social Services department at the earliest possible opportunity and in any event by the time they are disclosed to the accused.

26. Where the Social Services department initiate medical investigations on behalf of the child the reports should be submitted in the first instance to the Social Services department and not to the police. If they are given to the police, copies should be disclosed to the Social Services department immediately.

27. The police and Crown Prosecution Service should consider who has authority to authorise the disclosure of witness statements.

28. Officers dealing with bail applications should have sufficient information about any other Court Orders in relation to the child to enable them to place it before the Court to try and ensure that any bail conditions are not inconsistent with those Orders.

29. Details of relevant criminal convictions should be given to the person chairing a child abuse case conference.

30. The police service should consider whether and to what extent it is appropriate for them to deal with the Press separately from any ACPC joint statement in fatal child abuse cases.

ISSUES FOR EDUCATION SERVICE

31. That the role of the education social worker be clarified and careful consideration given as to whether their future role is properly within the Social Services or the education department.

32. That the responsibility of the school for dealing with absences should be clearly stated and the machinery overhauled so that proceedings are initiated swiftly to deal with prolonged or persistent absence, particularly in cases where attempts to contact the family are unsuccessful.

ISSUES FOR GOVERNMENT

The Government should consider further the "Working Together" guidance and in particular the following aspects

33. The fundamental philosophy underlying the guidance (see paras 7.2 and 8.2).

34. The conflict between the legitimate needs of the police prosecution and the needs of the child.

35. The proper approach to confidentiality by the police. (Para 8.7).

36. The implications of parents attending case conferences where there is a pending prosecution.

37. The transfer of records between agencies, especially local authorities. (paras 6.3-4

38. The timing of case reviews (Paras 8.40-8.44).

39. The issue of contempt of court in relation to the publication of the review (8.46 and Chapter 17).

40. The role of the ACPC (Paras 9.6 - 9.9). We deal with the Recommendations for particular agencies arising out of this chapter in subsequent Chapters.