

**Joint inspection of services to protect children and
young people in the Dundee City Council area**

June 2009

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Introduction

The *Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006*, together with the associated regulations and Code of Practice, provide the legislative framework for the conduct of joint inspections of the provision of services to children. Inspections are conducted within a published framework of quality indicators, *'How well are children and young people protected and their needs met?'¹*.

Inspection teams include Associate Assessors who are members of staff from services and agencies providing services to children and young people in other Scottish local authority areas.

¹ *'How well are children and young people protected and their needs met?'*. Self-evaluation using quality indicators, HM Inspectorate of Education 2005.

1. Background

The inspection of services to protect children² in the Dundee City Council area took place in February and March 2009. It covered the range of services and staff working in the area who had a role in protecting children. These included services provided by health, the police, the local authority and the Scottish Children's Reporter Administration (SCRA), as well as those provided by voluntary and independent organisations.

As part of the inspection process, inspectors reviewed practice through reading a sample of files held by services who work to protect children living in the area. Some of the children and families in the sample met and talked to inspectors about the services they had received.

Inspectors visited services that provided help to children and families, and met users of these services. They talked to staff with responsibilities for protecting children across all the key services. This included staff with leadership and operational management responsibilities as well as those working directly with children and families. Inspectors also sampled work that was being done in the area to protect children, by attending meetings and reviews.

At the same time as the inspection of services to protect children two other reviews relating to child protection issues were taking place. Dundee Children and Young Persons Protection Committee (CYPPC) had commissioned a significant case review into the circumstances around the death of Brandon Muir. The Chief Officers Group of Dundee City Council, Tayside Police and NHS Tayside had commissioned an independent review of matters relating to the death of Brandon Muir. The HMIE inspection did not consider this case.

As the findings in this report are based on a sample of children and families, inspectors cannot assure the quality of service received by every single child in the area who might need help.

Dundee City is situated to the north of the River Tay and borders with Angus and Perth and Kinross Councils. The local authority area covers 60 square kilometres. The area is compact and mainly urban.

Dundee City has a population of 142,150 of whom 16.6% are under the age of 16 years. There is a high rate of unemployment and a third of local wards have more than twice the national average unemployment claimant rate. The number of people seeking help for drug misuse for the first time is significantly higher than in comparator authorities³. There is a considerably higher percentage of families headed by a single parent in Dundee than for Scotland as a whole.

² Throughout this document 'children' refers to persons under the age of 18 years as defined in the *Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006*, Section 7(1).

³ Comparator authorities include Aberdeen City Council, Renfrewshire Council, Dumfries and Galloway Council, Inverclyde Council and South Ayrshire Council.

The number of incidents of domestic abuse in Dundee City in the year ending March 2007 was 1403, almost 50% higher than the figure for Scotland as a whole. Dundee City has a larger percentage of children looked after away from home than any of its comparator authorities.

2. Key strengths

Inspectors found the following key strengths in how well children were protected and their needs met in the Dundee City Council area.

- Support provided by statutory and voluntary services working to improve the wellbeing of vulnerable children and families.
- Approaches to promote children's understanding about keeping themselves safe.
- Early identification of pregnant women with problem substance misuse and the support provided by health and social work staff to keep newborn babies safe.
- The work of the Children's Rights Officer and *Who Cares?* in promoting the rights of looked after children in residential placements.

3. How effective is the help children get when they need it?

Staff across services had positive relationships with children and their families. Children knew how to keep themselves safe and were familiar with national helplines. A range of services provided effective help and support to vulnerable families. Most staff recognised when children were at risk of abuse or neglect and shared their concerns. Not all of these children were reported quickly to social workers or police. Immediate action was sometimes delayed and some children were left in high risk situations without adequate protection or support. The needs of vulnerable children and those recovering from abuse were not always met well.

Being listened to and respected

Overall, communication between staff, children and families was satisfactory. Most children and families were listened to and had positive relationships with staff. Children had regular contact with family support workers, health visitors and teachers. Family support workers were effective at maintaining helpful relationships and were persistent in involving parents who did not want to cooperate. Parents and children developed trusting relationships with staff from voluntary services. Staff used a range of approaches to communicate with children and parents. Staff working with very young children paid close attention to changes in behaviour to understand their feelings. Helpful translation services were available to assist communication with families whose first language was not English. Children and families found it difficult to establish trusting relationships with social workers when there were changes of staff. Children on the Child Protection Register (CPR) did not always see their key worker on their own.

At children's hearings, panel members encouraged parents and children to express their views and paid close attention to what they said. Children did not always get the support they needed to complete *Having Your Say* forms to report their views to hearings. Some children had benefited from the appointment of a Safeguarder to present their interests to panel members. The Children's Rights Officer and *Who Cares?* worker provided very effective support and helped children living in residential placements to express their views at important meetings. Staff were not consistent in their approaches to seeking children's views before decision-making meetings and some children did not have their views represented. Some children were not given enough time to develop trusting relationships with a person to help report their views before important decisions were made. Some children attended children's hearings with social workers who did not know them well.

Being helped to keep safe

Overall, the approaches to keep children safe and support vulnerable families were good. Staff across services, including those in voluntary organisations, tailored support to take account of the individual circumstances of vulnerable children and families. Family Support Teams worked well to improve the lives of vulnerable children. They successfully promoted children's development and helped parents to improve their parenting and adopt healthy lifestyles. The Community Family Support Project provided valuable support to families. Project staff worked well to improve

parental mental wellbeing and employability. The suitability of housing for homeless families had been improved. Recently developed multi-agency joint action teams (JATs), provided additional support for children to help them in school and nursery. The School Community Support Service (SCSS) helped to improve children's school attendance and encouraged positive relationships between families and school staff. Health visitors provided effective support to parents to help them attend to their children's health and development. Although there was an effective range of family support services, these were not well coordinated and there were some gaps in the support for vulnerable families with very young or older children. Services to assist children who were experiencing the effects of domestic abuse, parental substance misuse and mental ill-health were limited.

Children and young people were well aware of how to keep themselves safe. They had confidence in adults who worked with them and had someone they trusted to talk to about any worries or concerns. Relevant services contributed well to approaches to raise children's awareness of personal safety. Primary and secondary school programmes promoted children's physical and mental health. Programmes such as *Charterman* and *Cyberspyder* helped children to keep themselves safe and to use the internet and chat rooms safely. Community police officers, school nurses and voluntary agencies provided interesting and relevant experiences that helped children and young people know how to stay free from harm. The annual *Safe Taysider* event was effective in helping children know about the range of services that had a role in keeping them safe. Education staff had appropriate arrangements for supporting children educated at home and for tracking children missing from education.

Almost all children were aware of ChildLine and how they could use it to get help for themselves or others. Children understood the role of the Child Protection Officer in their school. They had limited awareness of local contact numbers to report their concerns to other services. Young people received very effective advice on sexual health, relationships and healthy lifestyles from staff at *The Corner* and through the *cool2talk* website. School nurses provided helpful drop-in advice sessions in some schools. Children and parents who responded to school inspection questionnaires felt that staff knew children well and helped to keep them safe.

Some examples of what children said about keeping themselves safe.

"Go to your head teacher or the Child Protection Officer if you've got problems"

"Drugs can confuse you, you can get addicted to them or you can die."

"www.cool2talk.com is a good website - you can post questions about any worries and they get back to you."

"You can speak to guidance staff. You can trust them to help."

Immediate response to concerns

The immediate response to concerns was unsatisfactory. There were major weaknesses in the identification of children who needed protection. Staff across services did not always respond quickly enough to children who were at risk of significant harm. They did not always report their concerns until the child's circumstances had reached crisis point. Children who were referred to the Social Work Access Team (SWAT) did not always receive help at the right time. Too often children were referred back to staff who had raised initial concerns to monitor their circumstances. There were some significant delays in protecting children at risk of neglect or emotional abuse, particularly those affected by parental substance misuse. Some children were left for too long in circumstances which placed them at risk of significant harm. Once children were identified as being at risk of abuse, police and social workers generally took immediate action to safeguard the child and made appropriate use of Child Protection Orders and other emergency powers. However, the actions to protect children were sometimes delayed as social workers were not immediately available to contribute to initial discussions. There were no designated placements for children who needed to be accommodated in an emergency out-of-office hours.

Meeting needs

Meeting children's needs was weak. The health and education needs of vulnerable children and those at risk of abuse and neglect were not always met well. The approach taken to ensure children received medical treatment when their parents did not keep appointments was not always effective. The health needs of school-aged children on the CPR were not always assessed or met. The risks to vulnerable children living in difficult home circumstances often increased when they were excluded from school or provided with part-time education. Some voluntary services were making significant improvements to children's lives.

Health and social work staff in *New Beginnings* worked well together to help substance misusing pregnant women prepare for parenthood and to meet the needs of their newborn babies. However, the range of services to provide early and intensive support for vulnerable families with babies and very young children did not meet demand. The Community Support Team supported families experiencing crises during evenings and weekends and were effective in preventing children becoming looked after away from home. Services to help school-aged children living with parental substance misuse and domestic abuse were limited. Children experiencing severe neglect often remained too long in situations without sustained improvement in their circumstances. Many children were helped to remain in the care of other family members when their parents were no longer able to look after them. However, these family carers did not always get the support they needed. There were shortages in local foster care places and no respite foster carers to help vulnerable children remain at home. Some children experienced significant delays while waiting for permanent new families.

Children looked after away from home did not routinely have an early health assessment or plan to meet their health needs. A looked after children's nurse provided counselling to children in residential settings and to care leavers to

ensure their health needs were met. Children with disabilities and their families benefited from residential respite and befriending services. Specialist services helped children at risk of sexual exploitation and those whose sexual behaviours posed a risk to others. Children's mental health services helped some children to recover from abuse and trauma. However, there were gaps in the range of these services and children often experienced lengthy delays before receiving the help they needed.

4. How well do services promote public awareness of child protection?

Services had developed a range of publicity materials to raise awareness about the protection of children. Relevant telephone contacts for members of the public to report concerns were not well advertised. The Children and Young Person's Protection Committee (CYPPC) provided an informative website which advised the public on how to report their concerns about children. Social work and police services were available to respond to members of the public at all times.

Being aware of protecting children

The promotion of public awareness was satisfactory. The CYPPC had produced materials to publicise the message that, *Child protection may not be your occupation but it is everyone's job*. Recent campaigns included advertisements on local radio and displays of colourful posters and leaflets in local buses and public offices. The CYPPC website clearly explained what to do to report concerns about children at risk of abuse and neglect. It provided helpful information and good links to other relevant websites. Publicity materials did not always provide a telephone contact to direct concerns. Telephone numbers and the address for the CYPPC website varied across materials and publications. The NHS Tayside and Tayside Police websites provided clear information about keeping children safe and guidance on how to report concerns. It was not easy to find this information on the Tayside Police website. Information about child protection on Dundee City Council's website was limited. Vulnerable children and families had not been involved in the development of awareness raising materials. The success of publicity campaigns had not been evaluated.

Police and social work services provided a contact point at all times for the public to report concerns. Specialist family protection police officers and the social work child protection duty team were available during office hours. Outside of office hours police and social workers responded to child protection concerns. Sometimes there were difficulties in obtaining a prompt response from the out-of-hours social work service. Not all staff working out-of-office hours were trained to carry out joint interviews of children who may have been abused. The role of SWAT in responding to concerns about children was not widely understood and was not well publicised. The approach to providing feedback to members of the public who had raised a concern about a child varied.

5. How good is the delivery of key processes?

Overall, staff took care to help children and families understand what was happening when they were the subject of concerns. Children and families were encouraged and assisted to take part in decisions about their lives. Staff across services shared information about children in need of protection effectively. There were significant delays in assessing risks to children, particularly those affected by parental substance misuse and neglect. Some children were left for too long in circumstances which placed their safety at risk. The planning to reduce risks and meet the needs of vulnerable children was not always effective.

Involving children and their families

Overall, involving children and families in key processes was satisfactory. Most children and families understood what was happening when there were concerns about children's safety. They were given the opportunity to express their views. Panel members encouraged parents and children to take part in discussions. They were sensitive to the feelings of children and offered them the opportunity to be seen on their own. *Having Your Say* forms were distributed prior to all Children's Hearings, but few were completed. Children and families were able to take part in court proceedings in comfortable surroundings in the Children's Hearing Centre. Family support workers involved parents in agreeing support plans. Parents were regularly involved in discussions about child protection plans and understood what needed to change to reduce the risks to their children. Parents were included in meetings arranged by *New Beginnings* to share concerns about unborn children. Chairs of child protection case conferences and child care review meetings took time before meetings to explain to families what was going to happen. Parents were usually involved in child protection case conferences and core group meetings. However, the support to help children and families prepare for decision-making meetings was inconsistent. Some parents did not receive copies of reports for meetings in enough time or have opportunities to discuss or agree the content with staff. Although parents were informed that their child was to be discussed at JATs, they and their children were not always fully involved in developing and implementing support plans. Children were too readily excused from attendance at child protection case conferences and Children's Hearings. Children and families did not routinely benefit from an independent supporter to help them participate in child protection meetings. Social workers did not always actively encourage the involvement of fathers who did not have the care of their children. Social workers often reported an interpretation of the views of children and parents instead of recording their stated views and wishes. There was no process for parents and children to appeal decisions made by child protection case conferences about children's names being on the CPR.

Services had suitable policies and procedures for dealing with complaints. Information about how to make a complaint was widely available in leaflets displayed throughout public offices. An independent Complaints Committee reviewed complaints about social work services if these were not resolved locally. Police and health services regularly reviewed and analysed the range and nature of complaints about their services. Children looked after away from home in

residential placements were well informed about their rights and how to make a complaint.

Sharing and recording of information

Overall, the processes for sharing and recording information to protect children were good. Most staff were clear about the importance of sharing information when there were concerns about children. There was guidance to ensure they shared relevant information on children and families. A range of multi-agency meetings provided regular opportunities for staff to exchange information on vulnerable children. Staff across services built up positive relationships with each other which assisted formal and informal sharing of up-to-date information. However, there were occasions when some staff did not recognise the significance of the information they held and did not make this known to other services.

Particular features of information-sharing included the following:

- An effective and accessible electronic information system for staff in social work services to record information.
- The co-location of family protection police officers and social workers in Seymour Lodge helped to ensure prompt exchanges of information when child protection concerns were identified.
- Social workers, health visitors and family support workers regularly shared information on vulnerable young children.
- Effective processes to support the sharing of information to protect vulnerable unborn babies.
- Some health staff did not gather or share all relevant information known to them about children at risk of abuse and their family circumstances.
- There was no system to alert school nurses that a child's name was on the CPR.
- Information was not routinely gathered from staff working in voluntary services when there were concerns about children.
- Important and relevant information was not always shared by Tayside Substance Misuse Services (TSMS) with staff working with children.
- Staff from adult and children's mental health services did not always share relevant information when there were child protection concerns.

The quality of managing and recording information was variable across services. Information in social work files was well organised. Health and education records were not always written clearly and did not assist staff to plan and review progress. The practice of maintaining dated lists of significant events in children's lives varied. There were some very detailed examples prepared by social workers. Others omitted significant detail and events. It was not always possible to tell from records

when children on the CPR had been seen by social workers. Managers were not consistent in reviewing and recording decisions in case files.

Staff across services informed children and families about the information they held and the need to obtain their consent to share that information. Overall, staff helped children and families understand why information needed to be shared and the circumstances in which information would be shared without their consent. Some services had produced helpful leaflets for children and families about information sharing. A joint approach to seeking consent to share information from children and parents was under development. Staff across services did not routinely obtain written permission to share information from service users and consent was often provided verbally.

Police officers who monitored sex offenders were co-located with criminal justice social workers. This enabled the effective and efficient exchange of information to help keep children safe from adults who posed a danger to them. There were good links between staff involved in managing sex offenders in the community. Regular Multi-Agency Public Protection Arrangements (MAPPA) meetings were held and information was shared effectively. Police officers gave very good attention to recording all relevant information about adults who might pose a risk to children. Intelligence about sex offenders was recorded immediately on the Scottish Intelligence Database.

Recognising and assessing risks and needs

The recognition and assessment of risks and needs was weak. Most staff, including those working with adults, recognised when children needed help or were at risk of harm. However, not all staff were clear about when and where to report their concerns about children and this caused delays in providing the help they needed. There were occasions when children were referred inappropriately to JATs. A multi-agency pre-referral screening group had reduced the number of children referred to the Children's Reporter. However, decisions about how best to respond to children referred to this group were not always based on an assessment of risks and needs. When children were referred to social work services, social workers did not always respond promptly or carry out an initial assessment of risk on receipt of these concerns. Assessments of risks and needs often took place after the child's circumstances had deteriorated. As a result, some children were left for too long in circumstances which could place them at risk of significant harm. There were inconsistencies in carrying out multi-agency initial referral discussions (IRDs). Health staff were not always involved in the planning of investigations or in decisions about whether a medical examination was necessary. There were some delays in convening child protection case conferences after the completion of child protection investigations.

The quality of assessments of risks and needs was very variable. There was a helpful format for social workers to carry out comprehensive assessments. Some assessments were detailed and clearly identified the risks to children and what helped to keep them safe. However, many others lacked relevant detail and sufficient analysis of risk. Overall, dated lists of significant events were not used effectively to identify patterns of risk. The quality of assessments by health visitors

and school nurses was inconsistent. They did not routinely carry out Family Health Needs Assessments. Approaches to joint assessment of risks and needs were not yet developed. Staff in voluntary services carried out very detailed and comprehensive assessments of the longer term needs of some children. Effective assessments of the risks and needs of vulnerable unborn babies affected by parental substance misuse were carried out by staff in *New Beginnings*. Staff carried out background checks before placing children in an emergency with kinship carers. A full assessment of the suitability of kinship carers was completed by a social worker independent of the case.

Overall, police officers and social workers worked well together to plan and carry out joint investigations of child abuse. Most were suitably trained in joint investigative interviewing of children. There had been recent improvements in the arrangements for forensic medical examinations. There was a rota of paediatricians available to contribute to initial discussions and to carry out medical examinations at all times. However, there were difficulties in obtaining advice from paediatricians out-of-office hours. Where appropriate, medical examinations were carried out jointly by paediatricians and forensic medical examiners. Children were examined in a child friendly environment and paediatricians ensured that children's health needs were followed up.

An effective multi-agency approach to assessing the risks and needs of children affected by parental substance misuse had not yet been implemented. The Children and Young People's Substance Misuse Group was developing a strategy to support children and families affected by substance misuse. Multi-agency procedures which took account of Government guidance, such as *Getting Our Priorities Right* and *Hidden Harm* were provided to staff. However, they were not widely used to inform their approaches to support children living in families affected by substance misuse.

Planning to meet needs

Overall, planning to meet children's needs was weak. Through JATs staff had begun to share concerns and develop plans together to meet the support needs of some vulnerable school aged children. Children on the CPR had an allocated social worker and a child protection plan. However, the quality of these plans varied. Progress for some children was not always monitored well through core group meetings. Planning to meet the longer term needs of children was inconsistent. Children did not always continue to receive help for as long as they needed it after their names were removed from the CPR.

Initial child protection case conferences were well attended by staff across services and they provided written reports in advance of these meetings. The minutes were recorded well, but the time taken to send them out to all relevant people varied. The review of progress at subsequent child protection case conferences did not always involve all relevant staff. Police officers, school nurses and staff working with adults did not routinely attend review child protection case conferences. Decisions were sometimes taken without representation from police, health or education. Some children's names were removed from the CPR without clear evidence that the identified risks to their safety had been reduced. Some children benefited from very clear plans. These outlined what needed to change to remove risks and set

timescales for actions. Other plans did not adequately identify what children needed in the short or long term. Social work reports were not always submitted in time to the Children's Reporter. Reporters' decisions were sometimes delayed.

Overall, meetings to make plans to meet children's needs were not coordinated well. Child protection case conferences were not always chaired by managers who were independent of the case. Review meetings for looked after children were not always linked well with other decision-making meetings. Late reports from social workers contributed to delays in holding some meetings. There were significant delays in the planning for children in need of permanent family placements.

Child protection plans were monitored through multi-agency core group meetings. There were inconsistencies in how these meetings were organised and recorded. Core group meetings did not always take place as regularly as set out in the child protection plan. Child protection plans did not always take full account of relevant changes in children's circumstances. There was no agreed way to record the exchange of information or changes to plans. Some children benefited from continued support provided through multi-agency network meetings once their names were removed from the CPR. However, this did not happen for all children. For some children there was no coordination of continued support and services were withdrawn too quickly.

6. How good is operational management in protecting children and meeting their needs?

Policies and procedures did not provide sufficient guidance to staff. Integrated children's services were planned jointly. Plans had limited impact on improving the lives of children in need of protection. Management information was not used well to identify joint priorities for service improvement. Children and families were often involved effectively in the development of individual services. All services had sound practices for the safe recruitment of staff. Arrangements for the training and development of staff were effective.

Aspect	Comments
Policies and procedures	Policies and procedures were weak. Individual services had easily accessible policies and procedures to guide staff in protecting children. However, some were out of date and not always consistent with inter-agency child protection guidelines. They did not always provide staff with adequate guidance to ensure consistency of practice within and across services. The effectiveness of policies and procedures was not evaluated. There were important weaknesses in the joint review and updating of policies.
Operational planning	Operational planning was weak. Planning for the Integrated Children's Services Plan (ICSP) was led by the Council's Corporate Services. Relevant partners were involved in planning groups which had benefited partnership working. There were helpful links between the work of the CYPPC and the ICSP. The ICSP linked to the Council's Single Outcome Agreement and the Dundee Partnership Plan. Staff had very limited awareness of the ICSP and its relevance for their work. The 2005-08 ICSP had not been evaluated to identify the impact on vulnerable children. The draft 2009-11 ICSP did not yet have a sufficient focus on improving outcomes for children in need of care and protection. The collection and use of management information for child protection was improving. However, it was not yet routinely analysed or used jointly to inform planning or policy.

Aspect	Comments
Participation of children, their families and other relevant people in policy development	<p>The participation of children and families in policy development was satisfactory. Some individual services had successfully involved children and families to inform developments. Children were fully involved in the running of <i>The Corner</i> and NHS Tayside had developed a very successful website www.cool2talk.com in partnership with Dialogue Youth. The active City-wide pupil council provided opportunities for school pupils to be actively involved in a wide range of matters. A consultation on youth homeless services had led to changes in housing policy. Vulnerable children and families had not been involved in developing or reviewing the work of the CYPCC. Children and families were not involved in the development or review of integrated children's services plans.</p>
Recruitment and retention of staff	<p>Overall, the recruitment and retention of staff was satisfactory. Safe recruitment practices were in place across all services. Retention levels in most services were good. There were difficulties in recruiting sufficient numbers of health visitors. The number of social workers was not sufficient to respond quickly to the needs of all referred children. A collective approach had not been taken to workforce planning. All services had carried out enhanced disclosure checks on newly appointed staff who were involved in direct work with children. Most services had effective procedures for investigating alleged abuse by staff. The arrangements for dealing with allegations against staff in education establishments relied heavily on internal investigations by senior staff.</p>
Development of staff	<p>Staff development was good. Training in child protection, including effective inter-agency courses, was available to a wide range of staff. The CYPCC had produced a very helpful DVD for new staff across services. This provided basic instruction on child protection. There was no agreed policy across services on who should receive the appropriate level of training. Some important groups of health staff did not attend inter-agency training because of their workloads or rota systems. Training provided by the CYPCC was routinely evaluated and had led to improvements in staff development programmes. Frontline health staff and police officers did not receive consistent supervision of their child protection work.</p>

7. How good is individual and collective leadership?

Individually, services had given priority to child protection. Staff were clear about their responsibilities to keep children safe. A collective vision for children in need of protection had not yet been established. Chief Officers had not provided clear direction to the CYPPC or taken sufficient collective responsibility for leading and directing services to protect children. There was a growing commitment to partnership and joint working. The approaches to self-evaluation were not systematic and did not lead to actions to fully support continuous improvement.

Vision, values and aims

Overall, the vision, values and aims to protect children were weak. Individually, services had established a vision, values and aims for keeping children safe. Chief Officers had not yet created a shared vision or clearly communicated their collective responsibilities for the protection of children. Overall, staff understood the direction in their own service or department, but were not aware of a collective vision for protecting children and meeting their needs.

- Elected members recognised their responsibilities for child protection. The Chief Executive of the Council was committed to ensuring children were kept safe and to developing approaches to corporate parenting to improve outcomes for children looked after away from home. Staff understood their responsibilities for protecting children. However, they were not aware of the vision for the protection of children.
- The Chief Executive of NHS Tayside had established a clear vision for the protection of children. The Child Health Commissioner and Nurse Consultant took effective action to communicate this vision and as a result priority was given to child protection. Staff were aware of the work of the Child Protection Action Group and most were aware of their individual responsibilities to keep children safe and healthy.
- The Chief Constable of Tayside Police had effectively communicated a clear vision for the protection of children. Child protection was a strategic priority. The Divisional Commander ensured that staff at all levels clearly understood their individual and collective responsibilities for the safety and welfare of children.

The Chief Officer's Group (COG) had only very recently been established. The Strategic Planning Group (SPG) for children's services and the CYPPC had responsibility for establishing and communicating priorities for services to protect children. However, managers and staff across services were not clear about the roles, responsibilities or priorities of these groups or who was accountable for leading child protection. The Council had included the protection of children as a target within the Single Outcome Agreement. Staff successfully promoted equality and diversity and tailored services to meet the needs of the people using them.

Leadership and direction

Overall, leadership and direction was weak. Strong leadership and clear accountability for the protection of children was provided for staff in police and health services. Chief Officers had started to meet regularly and the COG was beginning to take on collective responsibility for protecting children. The membership, purpose and remit of this group were under development. The COG did not yet have a strategic overview of services to protect children across all services. The CYPPC had reported annually to Chief Officers. It also reported to the SPG which had responsibility for planning and improving services for all children. There was, until very recently, an insufficient focus on children in need of protection.

Chief Officers had not given sufficient direction to the work of the CYPPC. It met regularly and was well attended. Members were not fully aware of the effectiveness of key processes or the impact of services to protect children. The CYPPC had not reported on recent achievements or set clear and agreed priorities for its business in the current year. Trends in child protection enquiries and children on the CPR were considered. The impact of the work of the CYPPC on joint working and improving practices to protect children was limited.

Chief Officers gave priority to resourcing services to protect children in their own service. The CYPPC was supported by a Lead Officer and an administrator. There was funding for communications and staff training. Joint funding had been agreed to create an improved purpose built family protection unit to replace Seymour Lodge. The leadership and direction provided by senior managers across services had not led to a joint approach to the prioritisation of resources to meet the needs of children in need of protection.

Leadership of people and partnerships

Leadership of people and partnerships was satisfactory. Elected members and Chief Officers across services were committed to partnership and joint working. Partnership working was improving. However, Chief Officers had not given a strong enough lead on the importance of partnership and joint working to meet the needs of children in need of care and protection. Integrated working was promoted through the SPG and CYPPC. These groups provided opportunities for relevant partners to work and plan together. Collaborative working had a positive impact for some children and families.

There were some examples of effective joint working. Social work and police worked together effectively in the Family Protection Unit at Seymour Lodge. JATs were developing joint working and multi-agency support for vulnerable children. Joint working in New Beginnings addressed the needs of unborn and newborn babies effectively. Partnership working was being promoted through the multi-agency team co-located at Menzieshill and multi-agency pre-referral screening groups were established. Social work child and family locality teams were organised around school clusters. A multi-agency plan to address the impact on children of parental substance misuse was still under development.

The voluntary sector was a major partner in delivering services to vulnerable children and was represented on the CYPPC and planning groups. Their contribution to partnership working and providing services was valued. Funding for some important voluntary sector services had recently been reduced. The Council, health, police and other partners had not yet developed joint strategies to tackle the impact on children of parental substance misuse and domestic violence. There were weaknesses in the strategic leadership of partnership and joint working to address these major issues.

Leadership of change and improvement

Leadership of change and improvement was weak. Across services there was a commitment to self-evaluation of services to care for and protect children. Work had been undertaken to evaluate some areas of service. However, within and across services, the approach to self-evaluation was not sufficiently systematic or robust. An external consultant's evaluation of inter-agency child protection policy and practice had recommended that a system of self-evaluation should be developed as a priority. This recommendation had not been implemented. Chief Officers and the CYPPC had not given a strong enough lead on the importance of self-evaluation in building capacity for service improvement.

Overall, there was not a systematic approach to self-evaluation of child protection in Council services. Social work services had carried out a number of audits and review activities. A Best Value review of residential placements had taken place and social work records were audited regularly. Education and leisure and communities Services had developed and implemented self-evaluation tools for child protection. Quality assurance processes were not rigorous enough to ensure consistent and effective practice in key areas of work.

Joint approaches to self-evaluation and improvement of child protection were not well developed. The CYPPC had led a multi-agency self-evaluation of one case of a child on the CPR. Surveys of staff and of children and families participating in child protection case conferences had been carried out. The CYPPC made limited use of inspection reports, the work of other child protection committees or significant case reviews. A joint analysis of a recent case had been carried out and a significant case review commissioned. Areas for development were identified as a result of these activities. However, joint improvement plans were not always developed or implemented effectively.

8. How well are children and young people protected and their needs met?

Summary

Inspectors were not confident that all children who were at risk of harm, abuse or neglect, and in need of protection, were identified and received the help and support they needed. A range of services provided effective support to vulnerable families. The sharing of information about children in need of protection worked well. However, the immediate response to concerns about children who may be at risk of harm, abuse or neglect did not always lead to a prompt assessment of risk. Many

children did not receive help until their situation had reached crisis levels. There were delays in assessing risks to children, particularly those affected by parental substance misuse and neglect. Some children were left in situations of risk for too long without adequate protection or support. Staff did not have clear guidance, policies and procedures to carry out robust assessments of risk and needs.

The Chief Officers, the CYPCC and the individual services they represent should work together to make improvements to strengthen services to protect children. In doing so they should take account of the need to:

- improve the actions taken in immediate response to concerns about children;
- improve the processes of assessment of risks and needs and the system for jointly assessing the risks associated with parental substance misuse;
- improve the processes for joint planning to meet children's individual needs;
- review and update policies and procedures to guide staff in their work to protect children;
- improve the joint planning of integrated children's services to take full account of the needs of children at risk of harm, abuse and neglect;
- provide clear leadership and direction to the work of the Children and Young Person's Protection Committee; and
- introduce a systematic approach to self-evaluation across services.

9. What happens next?

Chief Officers have been asked to prepare an action plan indicating how they will address the main recommendations of this report, and to share that plan with stakeholders. Within four months Chief Officers should submit to HM Inspectors a report on the extent to which they have made progress in implementing the action plan. Within one year of the publication of the report HM Inspectors will re-visit the authority area to assess and report on the progress made in meeting the recommendations.

Jacquie Pepper
Inspector
June 2009

Appendix 1 Quality Indicators

The following quality indicators have been used in the inspection process to evaluate the overall effectiveness of services to protect children and meet their needs.

How effective is the help children get when they need it?	
Children are listened to, understood and respected	Satisfactory
Children benefit from strategies to minimise harm	Good
Children are helped by the actions taken in immediate response to concerns	Unsatisfactory
Children's needs are met	Weak
How well do services promote public awareness of child protection?	
Public awareness of the safety and protection of children	Satisfactory
How good is the delivery of key processes?	
Involving children and their families in key processes	Satisfactory
Information-sharing and recording	Good
Recognising and assessing risks and needs	Weak
Effectiveness of planning to meet needs	Weak
How good is operational management in protecting children and meeting their needs?	
Policies and procedures	Weak
Operational planning	Weak
Participation of children, families and other relevant people in policy development	Satisfactory
Recruitment and retention of staff	Satisfactory
Development of staff	Good
How good is individual and collective leadership?	
Vision, values and aims	Weak
Leadership and direction	Weak
Leadership of people and partnerships	Satisfactory
Leadership of change and improvement	Weak

This report uses the following word scale to make clear the evaluations made by inspectors:

Excellent	Outstanding, sector leading
Very Good	Major strengths
Good	Important strengths with areas for improvement
Satisfactory	Strengths just outweigh weaknesses
Weak	Important weaknesses
Unsatisfactory	Major weaknesses

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