Review of the involvement and action taken by health bodies in relation to the case of Baby P

May 2009

This report details the findings of an intervention that was carried out by the Healthcare Commission, at the request of the Secretary of State for Health in December 2008. The work was carried out between January and March 2009.

The Healthcare Commission was unable to publish this report upon its completion due to a court case that was taking place at that time. On 1 April 2009, the regulatory activities of the Healthcare Commission were taken over by the Care Quality Commission. Therefore the Care Quality Commission is now publishing this report.

The Care Quality Commission is the new independent regulator of health, mental health and adult social care. Before 1 April 2009, this work was carried out separately by the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection.

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Introduction

On 3 August 2007 at 11.30am, the mother of a 17-month old boy, Baby P, called the London Ambulance Service. On arrival, the paramedics took Baby P to North Middlesex University Hospital. He was pronounced dead at 12.10pm. A post mortem was completed and gave a provisional cause of death as a fracture/dislocation of the thoraco-lumbar spine.

The mother of Baby P, her partner and the lodger living at the household were charged with causing or allowing the death of a child. On 11 November 2008 at the Old Bailey, the two men were found guilty. The mother had previously pleaded guilty to this charge.

From 22 December 2006, Baby P had been the subject of a multi-agency child protection plan involving social services, health services and the police.

On 11 November 2008, a serious case review into the death of Baby P was published by Haringey's local safeguarding children board, as required by the Government's statutory guidance *Working Together to Safeguard Children*. On 1 December 2008, the Secretary of State for the Department of Children, Schools and Families announced that the serious case review should be redone, because the original review was deemed to be inadequate. The second review has been submitted to Ofsted and an executive summary will be published at a later date.

On 12 November 2008, the Secretary of State requested a joint area review (JAR) of safeguarding in the north London borough of Haringey, in conjunction with Ofsted, the Healthcare Commission and HM Inspectorate of Constabulary. The JAR report was completed and shared with the Secretary of State on 1 December 2008.

In addition to the JAR and at the request of the Secretary of State for Health, the Healthcare Commission reviewed Baby P's care in relation to the involvement and action taken by health professionals. This has involved considering the actions of, and care provided by, four NHS trusts involved in the case:

- Haringey Teaching Primary Care Trust.
- North Middlesex University Hospital NHS Trust.
- The Whittington Hospital NHS Trust.
- Great Ormond Street Hospital for Children NHS Trust

This consideration has involved a review of documentation, including action plans that followed the original serious case review completed in November 2008.

We contacted the four trusts and requested information to show what improvements had been made since the death of Baby P. As part of this process, we also visited the four trusts over a two-day period, which involved us

interviewing a number of different staff and making observations in the accident and emergency (A&E) departments at the acute trusts. We have reviewed the progress made to date against the trusts' action plans, reviewed the trusts' policies and procedures in relation to safeguarding, and considered areas for further improvement.

The Healthcare Commission was also requested, by the Secretary of State for Health, to conduct a review to ensure that NHS trusts across England are meeting their obligations to safeguard children. The findings of this review are due to be published later this year.

Investigating serious failings in healthcare

The Healthcare Commission conducted investigations into the provision of healthcare by, or for, English NHS bodies under section 52(1) of the Health and Social Care (Community Health and Standards) Act 2003. As part of this function, 'interventions' were undertaken when this was considered to be the most proportionate and practical means of identifying the need for, and bringing about, sustainable improvements in the service concerned.

This intervention considered:

- The action taken by the trusts in response to recommendations from the original serious case review.
- Safeguarding practices within the trusts.
- The way in which each trust works with other agencies involved with the safeguarding of children.
- Further work that the trusts individually need to undertake to improve safeguarding practices.

The strategic health authority for London was informed of the concerns, in line with standard procedures, and was kept up-to-date with our progress throughout the intervention.

Our approach

Our investigation team worked with the trusts to establish the extent of the concerns and to make recommendations for improvement, where appropriate.

As part of this process, we asked for documents from the four trusts for review, we spoke with staff at each trust, and we made observations on A&E wards at the two acute trusts during a two-day site visit. In addition to staff from the Healthcare Commission's own investigation team, the team on this occasion included two external advisers – a consultant nurse for vulnerable children and a consultant paediatrician for community child health. The advisers provided guidance throughout the process.

As a result of the findings, we have made five specific recommendations to the individual trusts. The recommendations and the rationale leading to them are set out in this report.

Background

Local population

According to the latest mid-year estimates from the Office for National Statistics, the population of the London Borough of Haringey in 2007 stood at 224,700. Of this population, 34.4% belong to a black and minority ethnic group and Haringey ranks as the fifth most diverse borough in London. Haringey is also a relatively deprived borough, with the Index of Multiple Deprivation ranking it as the 18th most deprived borough nationally, and the fifth most deprived borough in London.

Provision of paediatric services

Haringey Teaching Primary Care Trust (PCT) and North Middlesex University Hospital NHS Trust provide paediatric services through contracts with Great Ormond Street Hospital for Children NHS Trust (referred to throughout this report as Great Ormond Street Hospital).

At North Middlesex University Hospital NHS Trust, Great Ormond Street Hospital has been contracted to provide the paediatric service since 1 April 2005. Great Ormond Street Hospital is responsible for providing the child protection service, maintaining the list of children who are subject to a child protection plan, and providing education and training opportunities. As part of the partnership agreement, Great Ormond Street Hospital is contracted to provide:

- Managed paediatric services based at North Middlesex University Hospital NHS Trust.
- Paediatric advice to North Middlesex University Hospital services.
- Governance, handling of complaints and performance management relating to the management of the paediatric service.
- Consultation on any changes to the paediatric services that may impact on other services provided by North Middlesex University Hospital NHS Trust.

The paediatric staff are employees of Great Ormond Street Hospital and operate in line with the human resources, governance and other appropriate policies of Great Ormond Street Hospital.

The partnership between the trusts is supported by a partnership management board, which was established for the purposes of performance management. Great Ormond Street Hospital is responsible for the corporate and clinical governance functions, and reports to the Great Ormond Street Hospital board.

Great Ormond Street Hospital took over the provision and management of the paediatric medical staff from Haringey Teaching PCT in May 2003. The paediatric medical staff included all doctors who were working in paediatric services at

Haringey Teaching PCT. The management of medical staff involved Great Ormond Street Hospital taking responsibility for clinical governance, human resources and training of the medical staff. Great Ormond Street Hospital was also responsible for taking a lead on child protection and ensuring that the child protection policies, since April 2005, of both Great Ormond Street Hospital and North Middlesex University Hospital NHS Trust were consistent.

Since May 2003, medical staff employed by Great Ormond Street Hospital who work in Haringey Teaching PCT, have worked in accordance with Haringey Teaching PCT's child protection policies and procedures. Since April 2008, all staff have continued to follow the child protection policies and procedures of Haringey Teaching PCT, which are based upon pan-London policies and procedures*, while these are being integrated with the policies and procedures of Great Ormond Street Hospital.

A partnership agreement was set up on 1 May 2003 to detail the mechanisms by which Great Ormond Street Hospital and Haringey Teaching PCT work together strategically and operationally. Great Ormond Street Hospital has been working with Haringey Teaching PCT to ensure that appropriate local training courses are provided to support medical staff to work effectively within local policies and procedures, and to support multi-disciplinary training approaches. This also includes the appropriate management of all other relevant staff and the relevant estates and facilities functions.

Since April 2008, Great Ormond Street Hospital has been responsible for providing all child health services at Haringey Teaching PCT. The arrangements regarding responsibilities and governance are the same as those for North Middlesex University Hospital NHS Trust, as outlined above.

Declarations relating to core standards and compliance by the trusts

Every NHS trust in England is responsible for ensuring that it complies with the Department of Health's core standards, set out in *Standards for Better Health*. These relate to minimum standards that trusts should be meeting in the delivery of care and services to patients. As part of the current annual health check process, we ask all trusts to assess their performance against the standards and publicly declare this information. If a trust is to declare compliance with any of the standards, it must meet the requirements of that standard consistently for the entire year.

The standards cover areas such as clinical quality, safety, whether patients are treated with dignity, and the trust's action to control infection and ensure cleanliness. If the trust's board is not satisfied that the standards are being met, it must take appropriate action.

*Pan London child protection procedures are under the auspices of the non-statutory London Safeguarding Board.

The Commission cross-checks the declarations using publicly available information from sources such as clinical audits, surveys and performance data from other regulators. Using all of this information, the Commission's regional teams target inspections to check that trusts have performed at the level that they actually declared. All non-compliance with the standards is followed up.

The core standards relevant to this report are:

1. **Safeguarding children:** Healthcare organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations (standard C2).
2. **Recruitment and training:** Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake (standard C11a).
3. **Mandatory training:** Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes (standard C11b).
4. **Professional development:** Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives (standard C11c).
5. **Public health partnerships:** Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by cooperating with each other and with local authorities and other organisations (standard C22a), and by making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships (standard C22c).

Haringey Teaching PCT, The Whittington Hospital NHS Trust and Great Ormond Street Hospital declared that they complied with each of the relevant core standards for each of the three years 2005/06, 2006/07 and 2007/8. North Middlesex University Hospital NHS Trust declared that it had not met standards C11b and C11c in 2005/06, but that it complied with all the others. The details are shown in the following table. None of these trusts were subject to risk-based inspections that are triggered by concerns when reviewing documentation pertaining to trusts. In addition, none of the trusts were subject to random inspections to check the level of compliance declared.

The reason that risk-based inspections were not triggered for these trusts lies primarily in the absence of sufficient, appropriately-weighted information within the Healthcare Commission’s cross-checking system to trigger an inspection when compared to other standards and other trusts. We are taking steps to address this, as detailed at the end of this report.

Trusts' declarations from the last three annual health checks

		Trust			
Trust's declaration	**Year**	Haringey Teaching PCT	North Middlesex University Hospital NHS Trust	Great Ormond Street Hospital for Children NHS Trust	The Whittington Hospital NHS Trust
Core standard C2	2005/06	C	C	C	C
	2006/07	C	C	C	C
	2007/08	C	C	C	C
Core standard C11a	2005/06	C	C	C	C
	2006/07	C	C	C	C
	2007/08	C	C	C	C
Core standard C11b	2005/06	C	N/M	C	C
	2006/07	C	C	C	C
	2007/08	C	C	C	C
Core standard C11c	2005/06	C	N/M	C	C
	2006/07	C	C	C	C
	2007/08	C	C	C	C
Core standards C22a & C22c	2005/06	C	C	C	C
	2006/07	C	C	C	C
	2007/08	C	C	C	C

Key:
C – compliant with the standard
N/M – standard not met

National review of services for children in hospital

The Healthcare Commission's review of services for children in hospital, conducted in 2005/06, assessed whether children were able to access local, child-appropriate hospital services, provided by staff who were experienced and trained in the care of children. The criteria for the review were:

- Children have access to child-specific services.
- Children have access to care that is local to their homes.
- Services are staffed by appropriate levels of trained staff.
- Staff have child-specific training.
- Staff have the opportunity to maintain their skills.

The three hospital trusts serving Haringey were included in this review. Within the overall ratings, trust were assessed on levels of basic training in child protection. This review was followed up during 2008/09 and the results were published nationally in March 2009.

In the 2005/06 review, the scores for the trusts involved were as follows:

	Great Ormond Street Hospital	Whittington Hospital	North Middlesex University Hospital
Child protection training for:			
Day care nurses	63%	83%	100%
Consultant anaesthetists	18%	88%	No data
Consultant surgeons	35%	75%	13%
Emergency care nurses	n/a	23%	100%
Overall rating (all aspects)	Excellent	Fair	Good

In the 2005/06 review, a performance threshold, or minimum requirement, was set for 90% of relevant groups of staff to have basic training in child protection.

Summary of the contact that health professionals had with Baby P

During the period 1 March 2006 to 3 August 2007, a number of health professionals had numerous contacts with Baby P. A full chronology of the involvement of the health professionals is detailed in the appendix.

In summary, health professionals' involvement included the following:

- Six recorded visits by Baby P to an acute hospital (excluding his birth and death). Of these, two were to the North Middlesex University Hospital A&E department, one was to The Whittington Hospital paediatric emergency clinic and three were outpatient appointments (one for paediatric assessment and two for X-rays). The last visit to an acute hospital, excluding at his death, was on 19 July 2007.
- Fourteen recorded visits to the GP practice (last visit made on 26 July 2007).
- One recorded visit to the specialist child health service, where a consultant paediatrician saw Baby P (made on 1 August 2007).
- Five recorded visits by a health visitor in which Baby P was seen at home (last visit made on 2 March 2007).
- Six recorded visits to the child health clinic (last visit made on 18 July 2007).
- Two recorded visits to walk-in centres (last visit made on 19 July 2007).
- One recorded contact specifically with the midwife (made on 21 March 2006).
- Nine recorded attendances by Baby P's mother at Mellow Parenting sessions*, but only five of these were with Baby P (last attendance on 19 July 2007).
- Sixteen recorded contacts between Baby P's mother and the primary mental health worker (last contact made on 5 June 2007).

* Mellow Parenting sessions are designed to help families with relationship problems with their infants and young children, including families where there are child protection issues. Families can be referred by health or social care professionals.

Reviews already undertaken in relation to Baby P's death

Local safeguarding children boards

Local safeguarding children boards are responsible for developing policies for safeguarding and promoting the welfare of children living in the area of the local authority, in relation to the training of people who work with children or in services affecting the safety and welfare of children.

The core objectives of local safeguarding children boards are set out in s14(1) of the Children Act 2004 as follows:

- To coordinate what is done by each person or body represented on the board for the purposes of safeguarding and promoting the welfare of children in the area of the authority.
- To ensure the effectiveness of what is done by each such person or body for that purpose.

The board is also responsible for ensuring the effectiveness of serious case reviews.

Serious case review

The tragic death of Baby P led to a serious case review by Haringey's local safeguarding children board, as required by the Government's statutory guidance *Working Together to Safeguard Children 2006*.

The final report was published on 11 November 2008. The review provided recommendations to ensure that lessons were learned from the incident, which included recommendations to the health services involved.

On 1 December 2008, the Secretary of State for the Department of Children, Schools and Families, announced that the serious case review should be redone, because the original review was deemed to be inadequate. The second review has been submitted to Ofsted, and an executive summary will be published at a later date.

Independent review commissioned by Great Ormond Street Hospital

In January 2008, Great Ormond Street Hospital commissioned an independent review of the consultant community paediatrician who worked at St Ann's

Hospital, part of Haringey Teaching PCT, and who had seen Baby P for a paediatric assessment two days before his death.

The report of this independent review, dated May 2008, made recommendations regarding training and identified actions to improve child protection in the services provided by Great Ormond Street Hospital at both Haringey Teaching PCT and at North Middlesex University Hospital.

The General Medical Council (GMC) reviewed the concerns raised that related to this consultant's fitness to practise. The consultant was referred to the GMC's Interim Orders Panel on 11 August 2008. The committee imposed conditions on the consultant's registration that allowed her to continue to work as a paediatrician under supervision.

In September 2008, when the trial of the mother of Baby P, her partner and the lodger commenced at the Old Bailey, the consultant was referred back to the panel for a review of her conditions. The panel made no changes to the conditions at that time.

On 21 November 2008, the GMC's Interim Orders Panel reviewed the case for the third time and decided that it was in the public's interest to suspend the consultant's registration pending the outcome of the investigation into her conduct. This was most recently reviewed on 12 February 2009, when the order of suspension was maintained and will be reviewed on 18 June 2009.

On 28 January 2009, the GP involved in the care of Baby P was suspended from Haringey Teaching PCT and was referred to the GMC. On 17 February 2009 the GMC's Interim Orders Panel suspended the GP from the register for an 18-month period, which will be reviewed after six months, while an investigation into his conduct is undertaken.

Joint area review of safeguarding

On 12 November 2008, the Secretary of State for Children, Schools and Families commissioned a special joint area review (JAR) of safeguarding in Haringey. The JAR inspection was carried out between 13 and 26 November 2008 by a multidisciplinary team of seven inspectors from Ofsted, the Healthcare Commission and Her Majesty's Inspectorate of Constabulary.

The remit for the inspection was to undertake an urgent and thorough inspection of the quality of practice and management of key services that contribute to the effective safeguarding of children in the local area. It identified a number of serious concerns in relation to safeguarding of children and young people in Haringey. The contribution of local services to improving outcomes for children and young people at risk, or requiring safeguarding, is inadequate and needs urgent and sustained attention.

Summary of the actions of health professionals in relation to the case of Baby P

The following section describes the involvement of each of the four trusts with the care of Baby P. This section draws on information gathered during our review of Baby P's medical notes, the serious case review, the joint area review and the independent review undertaken by Great Ormond Street Hospital. We have also reviewed any subsequent actions taken by the trusts in order to improve their safeguarding processes.

Designated and named professionals
The terms 'designated professionals' and 'named professionals' refer to professionals with specific roles and responsibilities for safeguarding children. All primary care trusts (PCTs) should have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service's contribution to safeguarding children across the PCT area, which includes all providers of healthcare. All NHS trusts providing services for children should identify a named doctor and a named nurse to lead on safeguarding children. The focus of the named professional's role is to safeguard children within their own organisation. Named professionals should support the trust in its clinical governance role, by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of the trust's clinical governance system. Named professionals also have a key role in ensuring that a safeguarding training strategy is in place and is delivered within their organisation. Designated professionals provide advice and support to the named professionals in each provider trust. In serious case reviews, designated professionals should review and evaluate the practice and learning from all health professionals and providers who are involved within the PCT. PCTs should ensure that they establish levels of designated and named professionals that are proportionate to the local population and that take into account any complex arrangements by providers of services. The roles of designated and named professionals should always be explicitly defined in job descriptions, and sufficient time and funding should be allowed to enable them to fulfil their child safeguarding responsibilities effectively.

The Whittington Hospital NHS Trust

On 11 December 2006, Baby P was referred by his GP to the Whittington paediatric emergency clinic. On seeing Baby P and identifying marks associated with non-accidental bruising, the named doctor for child protection was consulted and an immediate written referral was made to Haringey's children and young people services. On the same day, he was transferred to the paediatric day unit and subsequently admitted to the paediatric ward for further investigation and to ensure his safety. A child protection conference in relation to Baby P was held on 22 December 2006.

We have reviewed actions taken by staff at The Whittington Hospital NHS Trust and consider that appropriate actions were taken at this time.

Haringey Teaching PCT, North Middlesex University Hospital NHS Trust and Great Ormond Street Hospital

We focused on the actions taken by staff working at Haringey Teaching PCT and North Middlesex University Hospital NHS Trust, including Great Ormond Street Hospital staff located within these services, as these account for the majority of contact between the NHS and Baby P.

The paediatric services at both of these trusts are managed by Great Ormond Street Hospital through service level agreements with Great Ormond Street Hospital. Great Ormond Street Hospital employs and is responsible for all staff in relation to paediatrics at these trusts.

Communication between healthcare professionals and partner agencies (social services and the police)

On reviewing the documentation, it is clear that communication between different health professionals was poor, leading up to and around the time of Baby P's death. This was partly the result of inappropriate systems and partly due to staff not adhering to processes. At the same time, communication between the NHS, social services and the police was also poor, with a failure to ensure that these bodies were represented at multi-agency meetings. This had a negative impact both on the care that Baby P received and on the resultant actions taken by health professionals.

Poor communication appears to have been an important factor in the inadequate assessment of Baby P's needs and the subsequent lack of action with regard to child protection. For example, concerns were not highlighted following Baby P's visit to the A&E at North Middlesex University Hospital in July 2007, despite the child being on the child protection register*. It appears that this was primarily due to insufficient knowledge of previous episodes of

* From 1 April 2008, the child protection register was phased out across England and Wales and was replaced with a child protection plan. Every child whose name was on the register was subsequently made the subject of a child protection plan from 1 April 2008.

contact between health professionals and Baby P, and of the concerns regarding non-accidental injuries. In addition, in relation to the two other visits to North Middlesex University Hospital, there appear to have been difficulties in raising concerns, mainly due to confusing information being provided on the child protection summary sheets and referral forms.

There was particularly poor communication between health and social care professionals regarding the nature of the child protection concerns following Baby P's admissions to North Middlesex University Hospital in April and June 2007. The design of the child protection summary sheets and the manner in which they were completed led to a lack of understanding by social care staff of the nature of the health professionals' concerns.

Poor communication and lack of detailed background information about the case also led to delays in making appropriate assessments. For example, at the child protection case conference on 16 March 2007, it was stated in the action points of the case conference that a paediatric assessment was needed. However, the health visitor did not complete a referral for assessment until 10 April 2007. We do not have any information that indicates why the referral took almost a month to be undertaken. It was then delayed further because insufficient information was provided on the referral form. The referral was subsequently rejected by the clinic at St Ann's Hospital until further information was supplied.

Baby P had an appointment with the specialist child health service at St Ann's Hospital (part of Haringey Teaching PCT) on 1 August 2007. He was assessed without a full history of the previous child protection reports, details of previous hospital episodes or any prior history of development and concerns about behaviour being made available to the paediatrician, despite the fact that the initial referral had been rejected on the grounds of insufficient information. However, it was known that Baby P had a child protection plan and had been referred by a social worker, and the paediatrician was misled into believing that the child and mother were accompanied by a 'foster' carer.

St Ann's Hospital, where the assessment was carried out, is notably isolated from a paediatric health professional community. The hospital's consultants did not have any joint meetings or regular interaction with their consultant colleagues from Great Ormond Street Hospital and North Middlesex University Hospital, at which it may have been possible to share concerns, discuss cases and therefore provide a better overview of concerns. The consultant who examined Baby P on 1 August 2007 did not have any direct contact with the social worker assigned to Baby P's care – either prior to or following the assessment – which would have provided an opportunity to discuss the concerns and could have provided the consultant with appropriate background information. At the assessment, the consultant was the only health professional present. Having nursing support on this occasion may have proved beneficial, as nurses often provide a further opinion and additional information.

The Mellow Parenting programme did not share information regarding Baby P's family situation in July 2007 with any other agencies or NHS trusts, despite this

information potentially having significant implications for the care of Baby P within the family home. Haringey Teaching PCT was responsible for the Mellow Parenting programme and Great Ormond Street Hospital has subsequently revised the confidentiality leaflet given to parents to reflect the need for certain information to be shared.

The planning and review of Baby P's case was not helped by the non-attendance of health professionals at child protection conferences and there was, therefore, limited opportunity to discuss health-related issues with the appropriate people. The importance of such discussions was not always recognised and episodes of non-accidental injuries were not followed up each and every time Baby P was seen by a health professional.

We note that the role of the GP in this case also had some responsibility for the care of Baby P. The GP would have received letters that reported Baby P's attendance at hospital and, as the central medical record holder, the GP may have been able to identify the trend of recurring visits to A&E as a signal of potential abuse. The clinical practice of the GP involved in the Baby P case is currently being investigated by Haringey PCT and by the GMC.

Training and observation of child protection procedures

All staff involved in working with children should attend training in safeguarding and promoting the welfare of children, and should have regular updates as part of their educational programme.

We have seen the child protection training programmes for staff at Haringey Teaching PCT and North Middlesex University Hospital NHS Trust, and the attendance records for staff at this training. We were concerned that, in practice, Great Ormond Street Hospital's staff were not clear about child protection procedures and did not fully understand the risk factors in identifying a child in need of support. Evidence of this was seen in the results of the staff survey section of the Great Ormond Street Hospital Child Protection and Training Strategy 2007. Both staff and managers raised these issues as key training requirements.

Safeguarding training

Level 1
All staff working in healthcare settings (clinical and non-clinical) should be trained to this level. They should:

- Understand what constitutes child abuse.
- Know the range of physical abuse, emotional abuse, neglect and sexual abuse.
- Know what to do when they are concerned that a child is being abused.

Level 2
All clinical and non-clinical staff who have regular contact with parents, children and young people should be trained to this level. They should:

- Be competent at level 1.
- Be able to recognise child abuse.
- Be able to document their concerns.
- Know who to inform.
- Understand the next steps in the child protection process.

Level 3
All staff working predominately with children, young people and parents should be trained to this level. They should:

- Be competent at level 2.
- Have knowledge of the implications of key national documents/reports.
- Understand the assessment of risk and harm.
- Understand multi-agency framework/assessment/investigation/working.
- Be able to present child protection concerns in a child protection conference.
- Demonstrate ability to work with families where there are child protection concerns.
- Be able to put into practice knowledge of how to improve child resilience and reduce risks of harm.
- Understand forensic procedures/practice.
- Where appropriate, be able to undertake forensic procedures.
- Be able to advise other agencies regarding the health management of child protection concerns.
- Be able to contribute to serious case reviews or equivalent process.

Level 4
Specialist roles such as named professionals should be trained to this level.

Level 5
Designated roles should have achieved this competency.

Level 6
Expert level.

When health professionals have concerns, they need to raise these appropriately by following their trust's procedures. Staff should obtain guidance from the named nurse or doctor for child protection at their trust, or designated nurse or doctor, and should ensure, by liaising with social services, that correct child protection procedures are followed. Child protection referrals and a child protection case conference should be initiated in all cases where concerns of neglect or abuse are raised.

On reviewing documentation, it was apparent that this did not occur in several instances in the case of Baby P. For example, following Baby P's admission to North Middlesex University Hospital in April 2007, it was decided, on the advice of the social worker, to discharge the child without a formal discharge meeting or strategy discussion. This is contrary to the London Safeguarding Children Board's standard child protection procedures.

The use of parallel growth charts by staff to monitor Baby P's development was not documented routinely, despite ongoing concerns about his development. At North Middlesex University Hospital, there was also an absence of bone and skeletal surveys that may have provided a clearer picture of the nature of his injuries.

Staffing and recruitment: Haringey Teaching PCT and services provided by Great Ormond Street Hospital

At the time of Baby P's assessment at St Ann's Hospital, there should have been four consultants in post in the special advisory community clinic. However, there were just two consultants working in this service, including the consultant who examined Baby P on 1 August 2007. She was appointed as a locum in January 2007.

The service also included two associate specialists and three junior doctors. There was a designated nurse and a named nurse for child protection employed by Haringey Teaching PCT in post. However, the role of the designated doctor and named doctor for child protection at the time of Baby P's death was fulfilled by Great Ormond Street Hospital's leading consultant for community paediatrics. The designated doctor for 'looked after'* children had been on sick leave for over a year.

The independent review that was commissioned by Great Ormond Street Hospital after the death of Baby P highlights serious concerns about the way in which the clinic at St Ann's Hospital was organised and run. The report states that the shortfalls included:

* A child has 'looked after' status if they have been provided with accommodation for a continuous period longer than 24 hours, in circumstances set out in the Children Act 1989. It can also refer to a child who is placed in the care of a local authority under part IV of the Children Act 1989 (that is, under a care order).

- Too few staff.
- No nurse to help in the clinic and the doctors having to weigh and measure the height of patients.
- Difficulties linking with North Middlesex University Hospital NHS Trust.

The review also identified concerns about the level of administrative support and highlighted the need for a sufficient number of administrative staff, to ensure that all the necessary background information could be collected prior to consultations with children at the clinic.

The shortfalls in staffing levels also appear to have affected the length of time that Baby P waited for an appointment with the specialist child health service. The service's operational policy refers to the current standard that all new patients referred to consultant-led clinics must be seen within 11 weeks of the referral being received.

The serious case review published in November 2008 included the following statement from a consultant in community health at Great Ormond Street Hospital about Baby P's appointment on 1 August 2007:

"This was not seen as an urgent child protection medical and he was seen about 8 weeks later. Unfortunately, due to recent staffing problems at the Specialist Child Health Service this is far from being an exceptionally long wait and, in the circumstances, I think the correct priority was attached to this referral."

This eight-week wait was on top of the four-week delay already noted, which arose as a result of insufficient information being provided on the initial referral form.

The independent review raised a number of specific concerns regarding the recruitment processes at the trust. It stated that there was a lack of experience among staff in child protection and court experience of a child protection case (or experience in preparing for one), which would be expected in such a role. The job description for consultants within child protection specified that consultants should be on the specialist register, but the consultant in this case was appointed subject to achieving a certificate of specialist training within six months of the offer, which is in accordance with consultant appointment regulations.

After appointment, there was no specific training programme to develop child protection knowledge and it appears that consultants were isolated and had little involvement with their colleagues from North Middlesex University Hospital NHS Trust or Great Ormond Street Hospital.

The serious case review states that there was a lack of nursing support at the specialist child health service, and that in the consultation and examination of Baby P on 1 August 2007, there was no nurse to support the consultant and to discuss the case.

In addition, although both the social worker and the health visitor who made the initial referral in relation to Baby P were informed of the appointment at the specialist child health service at St Ann's Hospital on 1 August 2007, neither attended the appointment. If they had been present, the consultant could have been made aware of Baby P's history and the previous episodes of care at North Middlesex University Hospital and The Whittington Hospital. In addition, the consultant could also have been made aware of the identity of the friend of Baby P's mother. The consultant was misled into believing that this woman was the child's foster mother and may, therefore, have relied on this friend's views as being impartial.

Response of the trusts and improvements made since the death of Baby P

We requested information from each of the four trusts to check what progress had been made since the death of Baby P in response to the independent review commissioned by Great Ormond Street Hospital and the serious case review. Once we had reviewed this information, we visited the trusts to observe how the changes were working in practice.

Great Ormond Street Hospital produced two action plans. One was in response to recommendations made in the serious case review by Haringey's local safeguarding children board that related to its services. The other was in response to recommendations made in the independent review that it commissioned to look into the actions of the consultant community paediatrician. In addition, Haringey Teaching PCT has informed us that it produced an action plan in response to the 'individual management review' that was undertaken by its community services.

Action plan in response to recommendations from the serious case review

The serious case review was completed in November 2008 and made a number of recommendations to the agencies involved in the care of Baby P, including recommendations for healthcare professionals.

The action plan identifies steps to address the problems with communication and the lack of shared information between health professionals. The named nurse and doctor for child protection employed by Great Ormond Street Hospital at North Middlesex University Hospital NHS Trust are responsible for linking with paediatric staff at North Middlesex University Hospital and the Whittington Hospital. In addition, they are responsible for making sure that medical reports are copied to Haringey Teaching PCT's designated doctor and nurse if child protection concerns arise. A new protocol or pathway for information sharing is now in place, having been implemented over the period of April to August 2008. Furthermore, all child protection medical examinations are now carried out at North Middlesex University Hospital as opposed to St Ann's Hospital, and have been since May 2008. The child development centre continues to operate from St Ann's Hospital.

The serious case review identified a particular problem with the referral process and the delay in appropriate assessments being undertaken, and made a number of recommendations about this. The action plan for Great Ormond Street Hospital indicates that the trust has reviewed and updated its operational policy, information standards, prioritisation criteria and referral criteria as of August 2008. This information has been circulated to the relevant health and

social care agencies and, since August 2008, mechanisms have been in place for this to be shared with key partnership agencies.

An intake administrator has been identified as being responsible for ensuring that all required information is received before assessments are carried out at the specialist child health service clinic in Haringey Teaching PCT. An information checklist has been created for this purpose and circulated to the administrative team. The trust informed us that it now routinely undertakes audits of referrals, but we have not been provided with any evidence of this to date. In addition, North Middlesex University Hospital has amended its child protection sheet to ensure that the sheet is more comprehensive and robust.

There are also further recommendations from the serious case review regarding the child protection referral process. They propose that Great Ormond Street Hospital and North Middlesex University Hospital NHS Trust should review, in consultation with the Haringey children and young people's service and the Metropolitan Police Service, the structure and completion of referrals. North Middlesex University Hospital NHS Trust now exclusively uses the inter-agency referral form, which is deemed good practice, and medical advice is now sought through the internal electronic system, which provides a more robust referral system.

The serious case review made recommendations to update training in child protection. In response, the action plan states that all training and education had been reviewed, as of June 2008, to ensure that it complies with the latest national guidance. Great Ormond Street Hospital staff said that the operational policy and child protection procedures were included as part of the induction package from August 2008. Great Ormond Street Hospital provided evidence that indicates that mandatory training has been introduced to reinforce the child protection and safeguarding issues during an assessment. It is our understanding that this was implemented by ongoing training and briefings that took place throughout 2008.

Action plan in response to the independent review of the consultant community paediatrician

The independent review of the consultant paediatrician made recommendations relating to the services of Great Ormond Street Hospital. In response, Great Ormond Street Hospital services at North Middlesex University Hospital and Haringey Community Child Health Services have been jointly managed since April 2008.

We have been informed that work is in progress to help team-building between the two organisations. The lead doctor for child protection at Haringey Teaching PCT has been based at the North Middlesex Hospital site since September 2008, in a purpose-built, multi-professional child protection unit. This role is being integrated into the team of staff employed by Great Ormond Street Hospital at North Middlesex University Hospital NHS Trust. Due to sick leave, the role of the named doctor for child protection at Haringey Teaching PCT has

been temporarily covered by the designated doctor. However, we understand that a permanent appointment to this post was made on 29 January 2009.

As of June 2008, a social worker is now present when a child attends a child protection assessment, and this is routinely audited. Although paediatric staff at Great Ormond Street Hospital agreed that a social worker is present for the majority of assessments, they reported that frequently it is not the child's allocated social worker who attends. As such, the social worker who is present often has only limited knowledge of the child.

With regard to training, the recommendations from the independent review proposed that the trust review its guidelines for assessing children with suspected abuse and neglect. This resulted in the action plan for Great Ormond Street Hospital, which ensured that all policies and procedures were reviewed in June 2008 and were circulated to stakeholders by November 2008.

The recommendations highlight the need to improve the number of consultant staff in the community child health service, and the urgent need to appoint a named doctor in child protection at St Ann's Hospital and a highly skilled nurse within the clinic at St Ann's Hospital. One locum consultant was successfully recruited in May 2008 and two permanent consultants were recruited in July 2008. The trust took steps to recruit for the named doctor post and placed three advertisements since January 2008. As mentioned above, an appointment was made to this post on 29 January 2009. The vacant post had been covered by the designated doctor on an interim basis until this time. The named child protection nurse for Great Ormond Street Hospital at North Middlesex University Hospital has been available since May 2008 to support the community child protection assessment service. However, there continues to be insufficient children's nurses to support this service.

However, the action plan does not address the recommendation that doctors should not be appointed unless they meet the core requirements of the job description. The trust believes that the appointment panel was correctly constituted and the appropriate process was followed, since the consultant was appointed subject to achieving a certificate of specialist training within six months of the offer.

Furthermore, the action plan does not indicate any actions taken to provide additional training for any appointed doctors who do not meet the criteria of the job description.

Visits to the four trusts

As part of our intervention, we visited the four trusts that were involved in providing care to Baby P. The purpose of our visits were to meet with staff of varying grades and with different responsibilities, to assess how effective the safeguarding processes are within each trust. In addition, we were looking to determine whether the recommendations made following the serious case review had been implemented and if the trusts needed to carry out any further work.

Our findings are summarised in six key areas and are broken down to reflect our observations at each trust individually. The common themes that arose from our review of documentation and our visits to the trusts were:

- Lack of communication.
- Shortage of staff.
- Lack of training.
- Absence of child protection supervision.
- Lack of awareness of child protection procedures.
- Inadequate governance.

Communication

The Whittington Hospital NHS Trust
Staff reported that the presence of on-site social workers from Islington social services department has had a significant impact on improving communications between health and social care staff, allowing frequent discussions of new referrals as well as ongoing cases. In contrast, staff reported that the communication with Haringey social services is not as effective, primarily as a result of social workers not being based on-site. A joint review, with a doctor and a social worker working as a team and making joint decisions, is an excellent model of practice that should be instilled as normal working practice.

Paediatric services managed by Great Ormond Street at North Middlesex University Hospital NHS Trust
Staff disclosed that problems with communication between health and social care professionals remain an ongoing issue. While there are some social workers based in the trust, they also carry community workloads and therefore only have limited attendance at the hospital. The attendance of healthcare professionals at child protection case conferences remains poor. This is largely attributed to the timing and location of conferences, with doctors, in particular, being unable to attend off-site conferences due to their clinical commitments.

Some staff reported that feedback from case conferences is inconsistent and, when minutes from the conferences are circulated, they are usually not received until the date of the next case conference for that child. At this time, no specific audit has been undertaken to determine the scale of this problem.

An area of serious concern was the communication following the submission of child protection referrals to social services. Some staff that we spoke to were under the impression that it was sufficient to send a referral to social services by fax, and that a follow-up call from the referrer was not necessary. Both the local and pan-London procedures say that, while a follow-up call by the referrer is seen as best practice, a discussion between the social worker and referrer is essential – this is causing confusion among staff. However, it appears that healthcare professionals believe that it is the responsibility of social service staff to initiate this communication, and that after they send a referral letter they have relinquished responsibility.

There appears to be a lack of effective links between named and designated professionals for child protection within the area and the surrounding boroughs, through which they can discuss issues and share best practice. Although the midwifery service has strong, evidence-based governance systems, it seems to be separated from the rest of the children's services at the hospital and in the wider health community. This has the potential risk of isolating professionals from safeguarding processes. The trust has identified this risk and has responded by ensuring that the named midwife has the support of an experienced midwife who has worked for many years in the area of safeguarding children.

Some good practices, in terms of communication, were also noted. For example, North Middlesex University Hospital NHS Trust has made provision for the electronic recording of child protection register alerts on their patient administration system since April 2005. These alerts include children on the registers of both Enfield and Haringey boroughs. In October 2005, the trust also implemented an alert for unborn children. The trust has modified the system since its implementation. It now includes the named key worker within the patient administration system screen shot, and has changed the child protection register status to 'Haringey Child Protection Plan' or 'Enfield Child Protection Plan', to enable identification of borough and to reflect the change from 'Register' to 'Child Protection Plan'.

Another positive development was the automatic referral notification system. This automatically informs all members of the trust's safeguarding team by email whenever a referral to social services is sent.

Paediatric services managed by Great Ormond Street Hospital at Haringey Teaching PCT

Staff at Haringey Teaching PCT raised the issue that communication was difficult with the local safeguarding children board. Despite the board including representation from the Haringey Teaching PCT and Great Ormond Street Hospital partnership, this board was seen as being 'closed off' and uncommunicative. However, staff at the trust recognised that the board's

structure was changing and they expected that it would be more communicative in the future (although no evidence was provided to support this view). The attendance of health professionals at child protection case conferences is still below the desired levels, with paediatricians and GPs finding these conferences particularly difficult to attend due to clashes with clinical activities. Feedback from case conferences is also inconsistent and staff at the trust reported that often either no feedback is provided or the minutes are received on the day of the next case conference for that child.

There are ongoing communication problems with social services in Haringey, with health visitors and school nurses stating that they are finding it particularly difficult to put through referrals. Primarily, this is because they make their referrals at the end of their working day and social services are sometimes difficult to contact at this point in the day due to staff handovers.

Staff report that the attendance of social workers at child assessments is still inconsistent, despite this being identified as a major shortfall in the serious case review and the fact that it is a requirement of accepting an assessment in the operational policy of the specialist child health service. When a social worker does attend, they are often not the child's allocated social worker and therefore have little knowledge of the child or their family background.

While it does appear that St Ann's Hospital is now receiving previous medical reports prior to assessments, this does not seem to be a two-way process, with paediatric staff reporting that notes from assessments undertaken at St Ann's Hospital are not being duplicated into the child's records at North Middlesex University Hospital prior to assessments being conducted there.

Haringey community children's health services continue to appear to be rather isolated from the rest of the partnership organisations. Staff working at The Whittington Hospital NHS Trust and North Middlesex University Hospital NHS Trust reported that they chose to consult and gain advice from designated staff in other local areas rather than Haringey, which is of concern. However, as Great Ormond Street Hospital has been providing the service since April 2008 and is strengthening the safeguarding staffing structure, this may serve to improve communication.

Staffing

The Whittington Hospital NHS Trust

We did not observe any staffing or recruitment difficulties within this trust during our visit.

Paediatric services managed by Great Ormond Street at North Middlesex University Hospital NHS Trust

There have been ongoing difficulties here, particularly regarding the recruitment of senior staff nurses and staff for the paediatric assessment centre.

This has affected Great Ormond Street Hospital's ability to recruit sufficient staff to run a 24-hour paediatric A&E department, and the availability of the named doctor for child protection to run the appropriate number of programmed activities per week. Problems with retention and sickness absence have also meant that staffing levels in A&E for paediatric services have fallen below those recommended by national guidelines. This has rendered the service potentially vulnerable, especially the out-of-hours service. The problem has become further compounded by an increase in the number of children with child protection concerns that are coming to the trust. However, the trust is taking some steps to address this situation, mainly by employing a consultant in A&E with an interest in paediatrics.

Paediatric services managed by Great Ormond Street Hospital at Haringey Teaching PCT

The children's services at Haringey Teaching PCT have been subject to chronic recruitment problems for many years and are still noticeably understaffed. Great Ormond Street Hospital has been unable to recruit and retain a sufficient number of paediatricians, and the post of named doctor for child protection was vacant for a long time, despite this role being part of the statutory guidelines. The named doctor post was recruited to on 29 January 2009. Before this, the role was being covered by the designated doctor, which we see as unsatisfactory, given the demanding and serious nature of both of the roles.

Due to the recruitment problems, there is also an insufficient number of health visitors, school nurses and support staff, which is resulting in current staff having to take on excessive workloads in what is already a demanding and challenging environment. These recruitment difficulties have been further exacerbated by the media attention since the case of Baby P was highlighted, resulting in even higher staff turnover in some areas due to the pressure of working for a trust that is so much in the public eye.

We have been informed by Haringey Teaching PCT that it has committed additional resources to the children's community health services and, with the additional funds, health visitor posts have been rebanded to bring them in line with some neighbouring boroughs. Haringey Teaching PCT is also increasing the number of nursing and consultant staff.

Recruitment of appropriate individuals at North Middlesex University Hospital and Haringey Teaching PCT

Given the challenging nature of safeguarding children in boroughs such as Haringey, the historic problems and the recent drive for large scale improvements in services, we are concerned at the relative inexperience of some of the key health professionals at the trust, which has resulted in a potential lack of experienced clinical leadership in some areas. While this potential inexperience has been identified in particular areas and there are plans in place to resolve it, we feel that, given the ongoing recruitment difficulties, it is important that the trusts give this a high priority due the significance of clinical leadership in improving services.

Training

The Whittington Hospital NHS Trust

The hospital induction, which is attended by all new staff, includes safeguarding training at level 1, delivered in a multi-disciplinary manner. During this session, staff are made aware of the way in which they should escalate any safeguarding concerns.

Although general feedback from staff regarding training in safeguarding was positive, it was reported that the training received by midwives at level 2 was separate from the training for nurses. While we recognise that midwives have specific training needs that are not applicable to other groups of staff, it would be beneficial to have part of this training together, as this would provide an opportunity for the different staff groups to share their learning and gain a better understanding of each others' roles.

Paediatric services managed by Great Ormond Street Hospital at North Middlesex University Hospital NHS Trust

At the North Middlesex University Hospital NHS Trust, all staff have received safeguarding training at level 1 and there is an ongoing training programme in place to ensure that all relevant staff receive training at level 2, including those who work within A&E, with levels 3 and 4 as required for specific staff. As a number of staff are undertaking child protection medical assessments, we strongly advise that an emphasis needs to be placed on these staff being trained to level 3 in safeguarding, as a minimum.

Staff commented on how easy it can be to become unfamiliar with policies and to lose skills in the area of child protection. In light of this, staff perceive the A&E department to be a potentially vulnerable setting, particularly after 7pm and at weekends when the paediatric A&E department is closed.

Staff at North Middlesex University Hospital NHS Trust report that the training programme delivered by Great Ormond Street Hospital is of a high standard and involves weekly training sessions, which they find extremely beneficial.

Paediatric services managed by Great Ormond Street Hospital at Haringey Teaching PCT

All staff at the trust have received training in safeguarding at level 1, and some staff reported that they had received training at level 2. They stated that, although they had access to more advanced multi-agency safeguarding training, they felt unable to make training a priority due to the low levels of staffing at the trust.

GPs have received the mandatory safeguarding training at level 1 although, given their pivotal role in safeguarding, an emphasis needs to be placed on GPs being trained to level 2. We were informed that there is a desire to train GPs to level 2. However, this is perceived to be rather ambitious due to GP's clinical commitments.

Safeguarding supervision

Safeguarding supervision helps to ensure that healthcare professionals are clear about their roles and responsibilities in relation to safeguarding children. It also serves to help in an individual's professional development and is a primary source of support for staff.

The Whittington Hospital NHS Trust

Staff reported that there is no formal safeguarding supervision system in place that incorporates reflective practice. However, there are weekly multidisciplinary team meetings for safeguarding and child protection staff. In addition, named professionals have the opportunity to attend monthly peer support meetings but, at present, these meetings have not been given priority due to work commitments.

Paediatric services managed by Great Ormond Street Hospital at North Middlesex University Hospital NHS Trust

While there are weekly multidisciplinary team meetings for safeguarding and child protection staff at the trust, staff reported a lack of safeguarding supervision. In addition, they disclosed a lack of formal one-to-one meetings with their line managers or supervisors.

While staff reported having good working relationships, particularly in the A&E department, some staff reported feeling isolated in their role, and that such supervision would provide an element of support to them.

Paediatric services managed by Great Ormond Street Hospital at Haringey Teaching PCT

A number of staff reported that they were not currently receiving any form of safeguarding supervision. Despite this, staff were aware of the appropriate person to approach if they wanted to discuss a case or raise concerns. In general, staff reported that they felt able to access supervision if they needed it. However, due to time constraints, supervision was not being made a priority.

Staff reported feeling isolated at St Ann's Hospital and, due to the low staffing levels, reported that there is little sense of team working. In addition, due to the shortage of staff within St Ann's Hospital, peer supervision does not appear to be a viable option at this time.

Child protection awareness

The Whittington Hospital NHS Trust

There are clear and robust arrangements for child protection at this trust. There appear to be appropriate staff in safeguarding roles and staff within these roles work closely together. Staff report that awareness of child protection concerns within the trust has increased among all staff, even those who would not

necessarily have contact with children as part of their day-to-day role. Some staff attributed the increase in awareness to be more of a result of changes in the attitude of staff rather than changes to policies and procedures.

In relation to policies, the local child protection procedures have recently been updated and copies of the London safeguarding procedures are also accessible electronically or in paper form.

Staff reported that they consult the list of children who are subject to child protection plans if concerns have arisen during their assessment of a child. This list is kept in a locked location within the hospital and it is updated weekly by social services. Staff reported that, if a child is not on the list but concerns remain, they would continue to raise their concerns with a paediatric consultant.

The trust has a paediatric liaison nurse who is responsible for checking daily all records of children that have visited the A&E department.

Paediatric services managed by Great Ormond Street Hospital at North Middlesex University Hospital NHS Trust

Paediatric staff at the trust reported that child protection awareness within their service is very high and that systems are robust. Outside paediatric services, there was a general feeling that awareness has improved but could still be better. Staff felt that after 7pm, once the paediatric A&E department had closed, there was a potential weakness in the system. However, paediatric staff said that they are receiving more referrals from the A&E department and more discussions about child protection are taking place. All the staff we interviewed said that they are aware of the referral process and how to escalate child protection concerns. The trust has recently reprinted and reissued its ‘child protection’ pledge cards for all staff, advising what process to follow and agency to call in the event of any concerns.

We were informed that the liaison health visitor reviews the records of all the children who attended the hospital during the preceding 24 hours, picking up any child protection concerns that may have been overlooked.

Paediatric services managed by Great Ormond Street at Haringey Teaching PCT

Staff report that awareness of child protection issues has increased significantly in the last 18 months. Staff thought that this was reflected by the reported increase in the number of child protection referrals.

Staff informed our investigations team that they would not assess a child unless the notes and information relating to that child, as per the checklist, were available. However, some staff raised concerns that it was the responsibility of one doctor to conduct all child protection medical assessments. Staff recognised that this is potentially risky practice and stated that having other members of the team also undertaking these assessments would enable them to share learning and prevent professional isolation. In addition, if the doctor

were to go on leave, this could prove problematic. Staff reported that they would welcome a rota system where appropriately trained staff are each involved with such assessments.

We were informed that, if a request for a child protection assessment is received, it is now given priority over other assessments. Although this could be considered good practice, there is a risk that, if child protection concerns are not picked up and the right assessment is not selected (as in the case of Baby P), then such children could experience a dangerously long wait for an assessment. However, we also note that the trust had revised its care pathway to ensure that referrals contain accurate information, which should minimise the risk of inappropriate referrals.

Some staff at the trust believed that GPs should be the initial coordinating point of call for all child protection matters, as the GP would tend to be the healthcare professional with the most knowledge of, and contact with, the child. It is acknowledged that the pivotal role of the GP was identified in the recommendations of the original serious case review. As a result, a lead GP from the Haringey Teaching PCT clinical executive committee has been nominated to coordinate the implementation of this recommendation, and to ensure that GPs and their practices are aware of their crucial role in child protection.

Governance

The Whittington Hospital NHS Trust

The trust holds bi-monthly child protection team meetings that report to the clinical governance group, and the child protection team also produces an annual report that is presented to the trust's board. The trust has ensured that it pays attention to the need for audits and the reporting of statistics to its governance committee and in regular formal reports to the board, including the number of child protection referrals made by trust staff to social services.

Paediatric services managed by Great Ormond Street Hospital at North Middlesex University Hospital NHS Trust

North Middlesex University Hospital NHS Trust holds quarterly safeguarding meetings chaired by the director of nursing (the executive safeguarding lead) to provide the trust's board with information on safeguarding. These are supported by weekly caseload reviews and monthly operational safeguarding meetings.

Staff reported that there is still confusion regarding some areas of the partnership arrangement and lines of accountability between North Middlesex University Hospital NHS Trust and Great Ormond Street Hospital. Staff said that the lines of accountability and professional responsibilities regarding safeguarding also become unclear for children who are not specifically under the care of a paediatric consultant, such as those that attend North Middlesex University Hospital for elective surgical procedures. Reporting arrangements, such as those for handling complaints and the number of child protection

referrals made, are submitted to one or other of the trusts according to the contractual governance arrangements, but there appears to be an insufficient transfer of information to both trusts. This indicates a potential gap in performance management and the partnership management board should ensure that a whole system approach is taken with regard to safeguarding, so that governance responsibilities for the service are more collaboratively taken on by both trusts.

At North Middlesex University Hospital NHS Trust itself, staff reported that there has also been a lack of auditing to monitor important areas of the child protection system, such as the notification aspect of the referral system, the new escalation protocol, attendances at child protection case conferences and the receipt of minutes from these conferences. Although prospective audits have been planed, given the number of changes to these systems and the drive for improvement, there is a danger that trusts can lose sight of the need to check that new procedures, as well as existing ones, are actually working effectively in practice.

Paediatric services managed by Great Ormond Street at Haringey Teaching PCT

Haringey Teaching PCT participates in monthly performance meetings with Great Ormond Street Hospital (as the provider of services), and quarterly meetings at which Great Ormond Street Hospital provides exception reports. In addition, Haringey Teaching PCT produces an annual child protection report that is presented to the trust's board. Despite this, there is a potential danger that Haringey Teaching PCT, as the commissioner of services, could be over-reliant on Great Ormond Street Hospital, as the provider of services, to alert them of any issues with the service for the purposes of scrutiny and performance management. Haringey Teaching PCT should be encouraged to implement its own separate overview performance checks of the service, independently of Great Ormond Street Hospital.

There have been difficulties in the past concerning the PCT's relations with the local safeguarding children board. More recently, the PCT had concerns regarding the quality and process of the serious case review relating to Baby P, which reported into the safeguarding board. Subsequently, Haringey Teaching PCT formally raised these concerns with both the local authority and director of children's services. As a result of the concerns, it was agreed that a 'challenger' would be appointed to work alongside the report writers in the final stages to comment constructively on the serious case review.

The difficulties in the relationship between Haringey Teaching PCT and the local safeguarding children board may have been due to the reported uncommunicative nature of the board and its failure to share information as described by Haringey Teaching PCT. As such, the board has the potential to greatly improve following its restructuring, and with the PCT fully asserting its role in the local safeguarding of children. The Haringey health safeguarding group, where all health partners come together and meet every quarter to share learning, provides an opportunity for informed governance and improvement.

There appears to be a lack of auditing of many of the safeguarding features of the children's health services in Haringey, such as attendances at child protection case conferences, reports sent to these conferences and minutes circulated and received from them. Given the recent changes being made to local safeguarding systems and processes, it is important that the trusts do not overlook the need to ensure that these changes are having a positive impact on practice.

Conclusions

This report focused on the involvement of the health professionals in relation to the Baby P case, and has included a review of safeguarding practices within the trusts and specific actions taken by the trusts in response to the serious case review. This report has also considered how trusts assure themselves that they are meeting their obligations in relation to safeguarding children. It is important to place this onus upon the trusts, as regulators alone can never ensure that those who provide services on behalf of children always do so appropriately and safely. It is the responsibility of those who run the services to ensure that the right overall systems are in place and that they can check that these systems are working properly.

We have not re-investigated the detailed circumstances leading up to the death of Baby P but have focused on whether further action is required in relation to the case. We have visited the trusts involved to get a clear understanding of safeguarding practices, and reviewed the implementation of actions as a result of the serious case review. We have not undertaken an analysis of the arrangements for managing the performance of the trusts, nor have we analysed reports relating to incidents or complaints at the trusts, or conducted in-depth interviews with a wide-ranging selection of staff at the trusts concerned.

We acknowledge the inherent limitations in reviewing the health-related aspects of a case that is so closely intertwined with actions taken by the local authority, social care services and the police. With this in mind, we have shared our findings with the independent chair of the Haringey local safeguarding children board, who has conducted the new serious case review, as the board was responsible for reviewing issues arising from this case that were not within the remit of the Healthcare Commission. We also shared our findings with Lord Laming, to help inform his independent report on child protection, published in March 2009.

We have identified systemic failings in a number of areas leading up to the death of Baby P, in particular:

- Poor communication between health professionals and between agencies, leading to a lack of urgent action with regard to child protection arrangements, and no effective escalation of concerns.
- Lack of awareness among some staff about child protection procedures, and a lack of adherence, by some staff, to these procedures.
- Poor recruitment practices combined with lack of specific training in child protection, leading to the risk of some staff being inexperienced in the arrangements to protect the safety of children.
- Shortages of staff at St Ann's Hospital, leading to delays in seeing children. This included shortages in consultants, nurses and administrative staff.
- Failings in governance in the trusts concerned, excluding the Whittington Hospital NHS Trust.

We have also noted that, since the time of Baby P's tragic death, robust actions have been taken by the trusts in response to these serious shortcomings, once they had been identified. It is clear that positive action has been taken in response to the recommendations from the serious case review undertaken in 2008. The trusts have also improved the arrangements in place to safeguard children who attend health services. However, there are some important improvements that still need to be made and we set out below five specific recommendations that are addressed to the four trusts.

We are concerned that (with the exception of two specific standards in 2005/06) the boards of all four trusts declared themselves as complying with all of the core standards relating to safeguarding children, recruitment and training, mandatory training, professional development and public health partnerships, for each of the three years we looked at. In light of the shortcomings highlighted throughout this report, we are reviewing the declarations made by each of the trusts and making representations concerning the rigour of the standard, and the need for the regulator to have access to all relevant data from which it can determine the degree of risk to which children may be exposed.

More broadly, we are conducting a national review to ensure that all NHS trusts across England are meeting their obligations to safeguard children. The findings of this review are due to be published later this year, and will provide a benchmark set of indicators enabling NHS organisations, commissioners and strategic health authorities to compare safeguarding systems with other, similar trusts and therefore improve where necessary. These data will also enable the Care Quality Commission (the successor to the Healthcare Commission) to assess risk of non-compliance with standards and inform further inspection work on safeguarding arrangements which is being proposed jointly with Ofsted under the Comprehensive Area Assessment from April 2009.

On 12 November 2008, Lord Laming was asked by the Secretary of State for Children, Schools and Families to prepare an independent report on progress against the recommendations made after the Victoria Climbié inquiry. The report aimed to identify any barriers to effective, consistent implementation, and recommend whether additional action is needed to overcome them. Lord Laming published his findings in March 2009, and concluded that child protection issues in England have not had "the priority they deserved" and many of the reforms brought in after Victoria Climbie's death in 2000 had not been properly implemented. Lord Laming also identified a lack of communication and joined-up working between agencies.

On 1 December 2008, the Secretary of State stated that the serious case review had missed important opportunities to ensure that lessons are learned, and subsequently asked for it to be redone. The second serious case review has been submitted to Ofsted and the executive summary will be published at a later date.

The findings of this report have already been shared with the independent chair of the Haringey local safeguarding children board, who has undertaken the new

serious case review. In addition, Lord Laming has been provided with a copy of this report, in order that his work can be further informed.

Recommendations

It is the responsibility of the trust board of each trust to assure themselves that there is an effective system in place for child protection. Bearing this in mind, and taking into account what we have found out from our intervention of the four trusts concerned, we make the following recommendations:

Recommendation 1
All four trusts should ensure that their staff are clear about child protection procedures and have received safeguarding training to a level that is appropriate to their role, as set out by the Royal College of Paediatrics and Child Health.*

Recommendation 2
Haringey Teaching Primary Care Trust and North Middlesex University Hospital NHS Trust must work with Great Ormond Street Hospital for Children NHS Trust to ensure that their staffing arrangements have a sufficient number of appropriately qualified paediatric staff available when required, in line with established guidelines.

Recommendation 3
Great Ormond Street Hospital must review the adequacy of consultant cover at St Ann's Hospital.

Recommendation 4
All four trusts need to establish clear communication and working arrangements with relevant social services departments and, in particular, ensure that there is no delay in establishing contact between agencies once a safeguarding referral has been made to social services.

Recommendation 5
The boards of all four trusts must assure themselves on the adequacy of the system as a whole. Specifically, the trusts must ensure that appropriate arrangements are in place to enable:

- Safeguarding supervision.
- Staff to attend multi-agency child protection case conferences.
- Appropriate training to be undertaken.
- Signing off the trusts' own declarations against core standards, assuring themselves that they can do so and do so adequately.

These recommendations have already been accepted by each of the trusts concerned. The Care Quality Commission, as the new regulator, will work with

* Royal College of Paediatrics and Child Health, *Safeguarding Children and Young People: Roles and Competences for Health Care Staff***,** April 2006. This publication was produced by relevant professional bodies as an intercollegiate document.

the strategic health authority, NHS London, to monitor the implementation of these recommendations.

Appendix: Health Contact with Baby P from 1 March 2006 to 3 August 2007 (including contact by Baby P's mother with primary mental health worker)

Acute hospital contact	General practitioner (GP) contact	Specialist child health service/ paediatrician contact	Health visitor	Primary mental health Worker (PMHW) (contact with Baby P's mother)	Other	Notes
01/03/06						Baby P born at North Middlesex University Hospital.
03/03/06						Baby P discharged home.
					21/03/06	Midwife saw Baby P's mother and Baby P, Baby P had thrush advised to see GP.
			22/03/06			First health visitor visits Baby P at home for new birth assessment.
	24/03/06					Baby P seen by GP re thrush, medication prescribed.
				07/04/06		Baby P's mother sees PMHW.
					07/04/06	Baby P's Mother and Baby P seen at child health clinic.
	13/04/06					Baby P's Mother attended 6-week post natal check with GP.
					04/05/06	Baby P's Mother and Baby P attended child health clinic.
				19/05/06		Baby P's mother sees PMHW.
	22/05/06					Baby P's mother visits GP on advice of PMHW. First immunisations.
	28/05/06					Baby P seen by triage GP: vomiting after feeds 'impression gastroenteritis'. Ambulance service transfer. Seen by GP while on holiday in East Anglia.
				09/06/06		Baby P's mother sees PMHW.
				30/06/06		Baby P's mother sees PMHW.
				28/07/06		Baby P's mother sees PMHW.
				03/08/06		Referral made by PMHW to HARTS, Family Welfare Association.
				11/08/06		Baby P's mother sees PMHW.
				25/08/06		Baby P's mother sees PMHW.

				08/09/06		Baby P's mother sees PMHW.
			15/09/06			Home visit by health visitor. Baby P appeared well, had commenced weaning and had thrush on buttocks. Second and third immunisations outstanding.
	19/09/06					Baby P's mother attended GP with Baby P; nappy rash and cough noted, stating Baby P 'bruises easily and she may be accused of hurting him'.
				06/10/06		Baby P's mother sees PMHW.
	13/10/06					Baby P seen by GP. Reported to have accidently fallen downstairs the previous day. No broken bones, but 'bruise left breast, left cranium. Advice given about stair gate'. **Baby P only seven months old, not yet a toddler.*
	17/11/06					Baby P seen by GP for upper respiratory infection and query thrush of groin.
	11/12/06					Baby P seen by GP who referred to hospital. GP recorded additional bruising on right shoulder, breast and sternum.
11/12/06						Baby P (nine months old) seen in paediatric emergency clinic and subsequently admitted to Whittington Hospital with unexplained haematoma. 12/12/06: Strategy discussion at hospital, bruising described as classic non-accidental injury - agreed joint investigation and possible Emergency Protection Order (minutes mention Mr H as friend who helps Baby P's mother). Baby P's mother met with police on ward and provided a variety of explanations for the injuries. *13/12/06: Children and Young People's Service record refers to consultant paediatrician 1 obtaining a second opinion from a consultant radiologist; small abnormality on skeletal survey noted; bone and CT scan to be considered if further concerns.* 14/12/06: Medical report faxed to Children and Young People's Service: 'combination of bruising is very suggestive of non-accidental injury'.
				15/12/06		Baby P's mother sees PMHW.
21/12/06						Baby P attended Whittington Hospital paediatric day unit accompanied by Ms J (described as foster carer) for x-ray (as

						outpatient). Images were not good and planned for repeat in new year.
					22/12/2006	Child protection case conference held in relation to Baby P.
					09/01/07	Baby P attended Child Health Clinic with friend (presumably Ms J), weight increase and recovered from bruises. Thrush again on buttocks and groin – **latter not communicated to GP or social worker 1.*
17/01/07						Baby P's Mother and Ms J attended Whittington Hospital with Baby P. X-ray taken, poor quality film and no abnormality seen.
				19/01/07		Baby P's mother sees PMHW.
	25/01/07					Baby P seen by GP1: nappy rash, impetigo both groins.
			26/01/07	26/01/07		Baby P returned home. Health visitor 1 visited, agreed referral to Mellow Parenting in line with Child Protection Plan. Baby P's mother sees PMHW.
	02/02/07					Second immunisations.
	06/02/07					Baby P seen by GP, showed no signs of neglect.
				18/02/07		Baby P's mother sees PMHW.
			02/03/07			Health visitor visited Baby P, described as thriving and good relationship observed with mother.
					08/03/07	Baby P's mother told the Mellow Parenting co-ordinator that she had no partner at present.
					22/03/07	Baby P attended Child Health Clinic: Baby P said to be physically thriving.
				23/03/07		Baby P's mother sees PMHW.
09/04/07						Baby P's mother presented Baby P at A&E at North Middlesex University Hospital: post head injury. Baby P admitted for observation. History provided was that Baby P pushed by another child and hit his head on fireplace four days previously. CT head scan normal, bruises and scratches on face, head and body (body map). 10/04/07: Baby P's mother was resident in hospital and told nurse that Baby P had knocked his forehead against side of cot on ward (observed by student nurse). Following consultation with manager, social worker 2 advised paediatric registrar that Baby P could go home when medically fit without a discharge

						planning meeting. 11/04/07: Baby P discharged home.
					03/05/07	Baby P's mother attended Mellow Parenting – session 2 without Baby P.
			09/05/07			Health visitor visited Baby P at home.
					10/05/07	Baby P's mother attended Mellow Parenting – session 3 without Baby P.
	18/05/07					Baby P seen by GP; had urticaria, started that morning, covered all over in rash.
					24/05/07	Baby P's mother attended Mellow Parenting – session 5 without Baby P.
01/06/07						Social worker 2 visited family and saw marks/bruises on Baby P's face. Baby P assessed at North Middlesex University Hospital. Social worker present throughout. North Middlesex University Hospital records provide two versions of Baby P's mother's explanation involving rough play with another child and bumping into wooden frame of a sofa; grab marks found on right lower leg, which Baby P's mother attributed to her grabbing Baby P to prevent him falling off a sofa. Baby P observed during consultation to have good bond with mother, to play happily, banged his head once and fell twice during consultation; agreed Baby P to go home with mother with Ms J staying over the weekend; situation to be reviewed on Monday 04/06/07 – no health representation at strategy meeting on 04/06/07.
				05/06/07		PMHW wrote to social worker 2 advising of discharge of Baby P's mother and that she does not want any further counselling at present.
					06/06/07	Baby P seen at clinic. MMR outstanding. Hair loss in places and comments column suggests weight loss.
	07/06/07				07/06/07	Baby P's mother attended Mellow Parenting – session 7 without Baby P. Baby P attended GP with unidentified 'abrupt and argumentative lady' for immunisation. Advised to return for MMR in one month.

					21/06/07	Baby P's mother and Baby P attended Mellow Parenting session.
					05/07/07	Baby P's mother and Baby P attended Mellow Parenting session 11.
					09/07/07	Baby P's mother took Baby P to a walk-in clinic (reason not stated but report sent to GP confirms Baby P's attendance was due to earache and discharge, Baby P said to have fungal infection to head and prescribed antibiotic and fungal cream).
					12/07/07	Baby P's mother attended Mellow Parenting session 12 without Baby P.
					18/07/07	Baby P to clinic. Health visitor 3 told social worker 2 that Baby P's mother had taken Baby P to health clinic; Baby P's ear infected and had a small bruise under the chin, reported to be caused when he struggled as Baby P's mother was cleaning his ear; had lost weight.
					19/07/07	Baby P's mother presented Baby P at walk-in-centre with rash on scalp, itchy left ear discharge and swelling in ear lobe.
19/07/07						Baby P's mother and Baby P presented at A&E (North Middlesex University Hospital): bloody scabs on scalp, infected scalp, itchy hives and head lice, 'looks grubby', blood from ear where he was scratching and infected middle finger in nail bed. Baby P's mother gave history of allergic reaction to cheese.
					19/07/07	Baby P's mother and Baby P attended Mellow Parenting session 13. Baby P's mother announced that she was pregnant.
	26/07/07					Baby P seen by GP. GP noted head lice and the healing scabs. There was still fresh blood on 'lower tragus'; Fucidin cream was prescribed and a review arranged.
		01/08/07				Baby P's mother (accompanied by Ms J) took Baby P to appointment with paediatrician for purpose of paediatric assessment; Baby P unwell so examination postponed by three weeks. PCT chronology: in-depth paediatric, social, developmental and family history recorded. History of recurrent bruises and recurrent infections; history of abnormal behaviours head

						butting and banging; numerous bruises noted; weight on 9th centile. Referral to metabolic team at Great Ormond Street Hospital, paediatric dietician, speech and language therapist; blood tests to rule out metabolic, endocrine, growth, immunodeficiency, genetic and coagulation disorders. Baby P's mother advised to take Baby P to A&E/GP if continues to be miserable. Baby P's mother said she had GP appointment the next day. Baby P had "extended infection on his scalp"; he had bruises "in front of his left ear on bony part", "faint bluish". He had "bruises between his shoulder blades extending slightly to the nape of his neck" "numerous, possibly 10-15" "faint bluish except two which were slightly red". Explanation given by mother and Ms J was that he tended to bang his back against the cot. Information not communicated to social worker, and the Children and Young People Services did not receive information from the appointment.
03/08/07						11.30: ambulance called and Baby P confirmed dead on arrival at hospital. 06/08/07: Post mortem revealed further injuries, a tooth was found in Baby P's colon and eight fractured ribs on the left side and a fractured spine were detected. The provisional cause of death was described as a fracture/dislocation of the thoraco-lumbar spine.

Totals:

- There were six recorded visits to an acute hospital (excluding birth and death). Of these, three were to the North Middlesex University Hospital A&E department, one to the Whittington Hospital Paediatric Emergency Clinic, which resulted in admission, and two to the Whittington Hospital as an outpatient for x-rays, and three were outpatient appointments (one for paediatric assessment and two for X-rays). The last visit to an acute hospital, excluding his death, was on 19 July 2007.

- There were 14 recorded visits to the GP (last visit 26/07/07).
- There was one recorded visit to the Specialist Children' Health Service seeing a consultant paediatrician (visit on 01/08/07).
- There were five recorded visits by a health visitor in which Baby P was seen (last visit 02/03/07).
- There were six recorded visits to the child health clinic (06/06/07).
- There were two recorded visits to walk-in-centres (last visit 19/07/07).
- There was one recorded contact specifically with the midwife (visit on 21/03/06).
- There were nine recorded attendances by Baby P's Mother at Mellow Parenting sessions but only five of these were with Baby P (last visit 19/07/07)
- There were 16 recorded contacts between Baby P's mother and the primary mental health worker (last contact 05/06/07).