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Acting Commissioner Sir Paul Stephenson QPM
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04 December 2008

I am writing to you in relation to the recent Joint Area Review (JAR) of Haringey Children's Services Authority Area recently concluded and published on 1 December 2008.

You will be aware that in addition to the JAR, I also directed that a specific assessment of the police specific aspects of the review be undertaken in order to identify strengths and weaknesses in relation to the MPS handling of the events leading up to the death of Baby P. That work is now concluded. I recognise that many of the principal issues fall to Social Services and Health Care agencies. However, there are some significant lessons for the MPS, around information sharing, supervision and support which if not addressed could in the future lead to the MPS being cited as contributing to failing to safeguard another child. I include a copy of the assessment for your information and action as you see appropriate.

The assessment comments on the following matters;

The Serious Case Review Process
The Management of Case Files
Supervision, capability, capacity and support
Child protection Policy and Standing Operational Procedures
Information and Intelligence Management
Medical Examinations
Meeting Attendance
Protection Placement
Performance Management
Governance and Accountability.



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You will note that where appropriate., reference is made to the recommendations made by Lord Lamming in relation to the Climbie enquiry (2003), current ACPO guidance or the Joint Area Review itself. Further, some of the developmental areas identified are also the subject of recommendations arising out of the recent HMIC MPS Protecting Vulnerable People report published in 2008. Specifically recommendation 12 is pertinent, with aspects of recommendation 9 in relation to performance management to be considered. Good practice and performance is also noted and referenced within the body of the assessment. I would invite you to consider the contents of the assessment and will await your response in relation to factual accuracy in due course.

HMIC consider however, that in view of the seriousness of the events surrounding the death of Baby P and the procedural vulnerabilities identified as a result of the above assessment, that further focused work is necessary. HMIC therefore propose to conduct in the near future targeted assessments in other parts of London. To ensure a joined up and rounded approach to the issue, discussions are in hand with Ofsted and the Health Care Commission. Assistant Inspector of Constabulary Vic Towell will liaise with DAC Janet Williams as to how these assessments will be taken forward. It is anticipated that this work will commence in late February 2009.

In conclusion, I would like to thank MPS staff for their support and engagement with this review process. I appreciate that the circumstances surrounding the death of Baby P has had a profound impact on staff morale. My staff have commented to me, that nonetheless all staff spoken to during the process were constructive and helpful, expressing a desire to learn from these terrible events. Please thank your staff on my behalf and commend them for their professionalism.

DENIS O'CONNOR
Acting Chief Inspector of Constabulary

Cc: Commander Allan Gibson



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Joint Area Review Haringey Children's Services - MPS Assessment of investigation and partnership working.

This assessment provides a overview of the effectiveness of the MPS response to the events leading up to the death of Baby P in respect of the investigations made into the allegation of non accidental injuries made in December 2006 and the following June 2007. The assessment also encompasses elements of the recent Joint Area Review of safeguarding in Haringey, particularly partnership working arrangements as they impact on MPS capability to properly investigate the above allegations and also to contribute to the protection of the child. The assessment is divided into sections as follows;

- The Serious Case Review Process
- The Management of Case Files
- Supervision, capability, capacity and support
- Child protection Policy and Standard Operational Procedures
- Information and Intelligence Management
- Medical Examinations
- Meeting Attendance
- Protection Placement
- Performance Management and Measurement
- Governance and Accountability.

Each section comprises a commentary on assessment findings, an overview of the strengths and weaknesses identified in terms of compliance with Safeguarding Children procedure, Climbie/Laming recommendations (Laming 2003), current ACPO Guidance and the recent HMIC inspection report of the MPS capability in respect of Protecting Vulnerable People (PVP 2008)). HMIC has also noted good practice.

The Serious Case Review Process

The reviews submitted by Whittington Hospital NHS Trust, the Metropolitan Police and Haringey Legal Services were assessed as good. Serious case reviews on behalf of the MPS are carried out by a dedicated and specialist review team in the serious crime review group in SCD20, providing an independent oversight of SCD5. This is good practice and ensures independence and objectivity.

The Management of Case Files

Case file management for individual children and young people is inadequate. Police and health service files are often poorly organised and the process of planning of individual cases is difficult to follow. As the issues relates to the MPS, police files do not establish clear chronologies of events and it is difficult to decipher the key points at which decisions are made.

The police files contain a range and variety of information from different agencies and from different internal police systems (CAD, Merlin and CRIS), making files difficult to navigate in terms of supervision and extracting information. The only way to obtain an overview of key points at which decisions were made was by researching

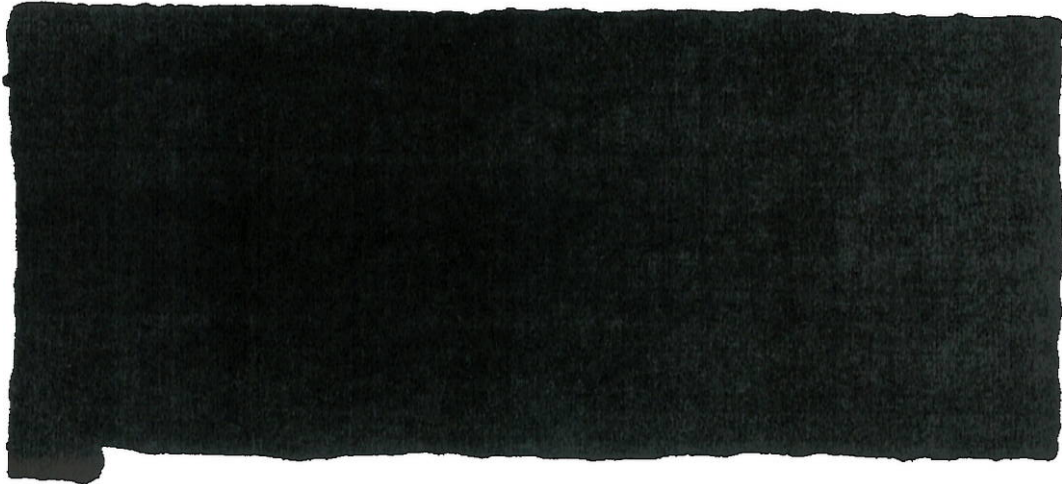
and abstracting the information from individual forms and records. This adversely impacts on the ability and necessity to generate clear audit trails of key procedural events militating against proactive supervision. Supervision provides the safety net for ensuring procedural compliance and enables experienced input into investigations. There are examples where such supervision may have been beneficial in ensuring procedural compliance, (e.g. the absence of the paediatrician at the strategy meeting held in respect of the first allegation on 24/1/2007 was not compliant with the *Working Together* arrangements and the medical evidence could have provided a different assessment of risk) as well as influencing the decisions of the social services in relation to protection arrangements for Baby P, either from the outset or at later review meetings, when police protection was an option not pursued. Further, the ranks and/or designation of those involved in discussions or attending meetings were not always apparent, making the level and quality of supervisory involvement difficult to assess.

The IT systems available to MPS CAIU staff are also an inhibitor to the effective management of information. The CRIS and MERLIN systems require manual trawling and double keying to extract information and are time consuming to supervise. CRIS stores data across a number of different screens and it is not adapted to enable properly structured investigation or supervision activity to be recorded. The quantity of supervision can be monitored but not the quality of intervention. Investigative entries are not mandated being largely free text entries made by the investigation officer. The MERLIN is a system for monitoring activity in relation to all vulnerable children. The system is inaccessible and time consuming to search either for supervision or intelligence.

The quality of the information provided on some of the key documentation was found to be poor. For example, Case Conference reports provided by children's social care on Baby P and his siblings showed that either the following sections had not been completed or the information provided was wholly inadequate - Family and social relationships; Social presentation needs; Self care skills; Parental capacity; Family and environmental factors. It was also impossible to tell how far planned outcomes had been achieved or partially achieved; what actions/services were most effective; and whether there were continuing or newly identified needs. The paucity of information should have generated query from police at least at IO if not supervisory level. Overall, there does not appear to be a mechanism for dealing with what HMIC observed to be a consistent deficiency in the information shared by all relevant agencies. This also pertains to child protection plans which are generally poor. In many cases there is a lack of clarity about what needs to be done, and by whom, to reduce identified risk and there is little evidence of the impact on improving the safety or welfare of the child. Agencies are generally working in isolation from one another and there is evidence of a lack of effective co-ordination to ensure the work is appropriately focussed. A mechanism to address such deficiencies is urgently needed and the MPS should address the issues with its safeguarding children partners as a matter of urgency.

CAIU Supervision - Capacity, Capability and Support

There is insufficient evidence of managerial oversight and decision-making on case records in children's social care services, police and health services. There is also limited evidence of thorough, analytical and reflective supervision to ensure individual casework is carried out effectively. In respect of the police specific records (both paper and electronic), the rank of the police officers involved is not always clearly stated, making it difficult to determine the extent of supervisor engagement with the case.



In addition, the current supervisory vacancy [redacted] means that priority is being given to day-to-day team supervision, with pressure being placed on completion of administrative tasks, including compliance with the MPS SOP on supervision.

There is no single point of reference to obtain information on management oversight of cases – for example, information relating to case conference attendance was contained within a paper record in the paper file, while oversight of investigations was contained on the CRIS report.

Although supervision is overseen centrally by SCD Crime Management, there are weaknesses in the process. While the back page of each CRIS is a supervision page and SCD Crime Management can tell whether there has been activity on the on this page, the performance data produced on supervisory activity indicates only that action is being taken by supervisors in completing the supervision page; it gives no indication of the quality of that supervision.

The CAIU Referral Desk structure ensures that managers are involved at the child protection referral stage and that they participate in telephone strategy discussions. However, managers are not normally involved in subsequent strategy meetings. There is evidence of inconsistency in management decision making, primarily in relation to those cases initially assessed as low risk and/or where limited information is available. There is no definable threshold for when a minor neglectful act becomes a criminal offence and each single incident must be examined in the context of other acts of omissions. The possibility of a criminal offence, and the need for an initial criminal investigation, is not always considered. This process of risk assessment is

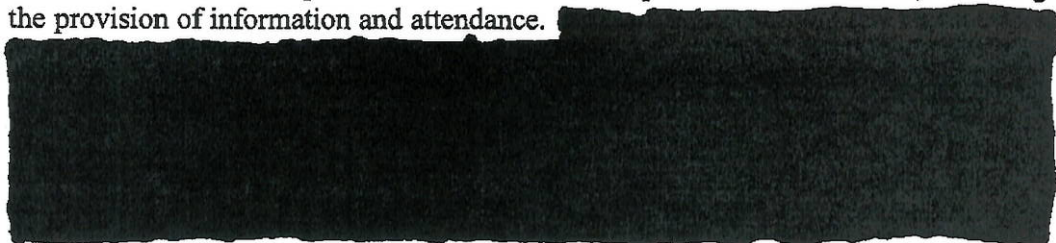
currently undertaken by referral desk sergeants, making this role pivotal to child protection and investigation processes.

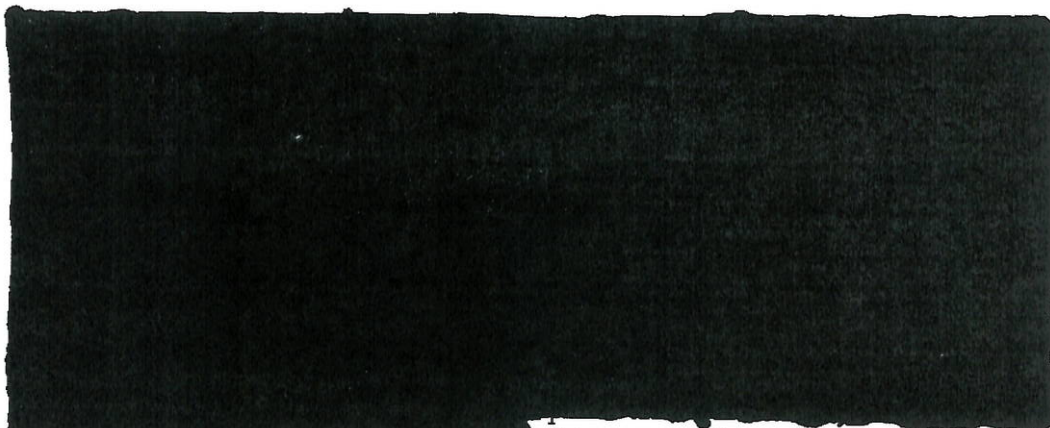
The Referral Desk is staffed by the CAIU Detective Sergeants on a six monthly rota. There is no role-specific training for these responsibilities. The DS performs a key role in risk assessment of incoming notifications, referrals, reports and internal intelligence indicating concerns for children. There was evidence, however, of different decisions being taken by different supervisors as to the route an initial referral would take once received by the police – specifically, whether the case should be allocated for, at least, an initial criminal investigation to be carried out, or whether the case should be referred back to social care for an initial ‘assessment’ to be completed.

In addition, there was evidence that social workers are not always updating the police with the outcome of their ‘assessments’ in these circumstances, with obvious implications for delaying any criminal investigation. Finally, there was evidence of social workers effectively carrying out initial investigations on behalf of the police. This appeared to be the case in the initial stages of the allegation made on the 1/06/2007 (a Friday) when the social worker did the preliminary work, the investigation not being pro-actively pursued until the following Monday.(4/06/2007).. Baby P at this stage was already on the protection register and was also evidently displaying evidence of long term neglect (weight loss, head lice, dirtiness, infected wounds to his head, earache and discharge and bruising to his body). It was wholly desirable for an investigator to be present at the child’s medical examination and for a supervisor to be in attendance at the referral and strategy meetings.

Climbie/Laming recommendation 93 requires the attendance of supervisors of all referral and strategy meetings. HMIC found that the direct involvement of police supervisors in strategy discussion and/or meetings is unsystematic, particularly beyond the initial referral stage, with the evidence suggesting that these are generally undertaken by investigating officers. Detective Sergeants within the CAIU also carry their own investigative workload. Previous HMIC inspections (PVP 2008) have identified the need to ensure that supervisors have the capacity to balance effectively their day-to-day supervisory commitments with specific responsibilities, such as strategy discussions, and their own investigative workload. Serious crime directorate resources were reviewed in 2006 and, as a result, the Haringey CAIU has been allocated additional resources, effectively doubling the number of Detective Constable Investigators. However, the CAIU has been carrying a supervisory vacancy (in line with the current organisational vacancy requirement) for some time, which has resulted in gaps in supervision at operational level.

Further, the Police Conference Liaison Officer (PCLO) role is critical within the CAIU in relation to the police contribution to child protection conferences, including the provision of information and attendance.





It is apparent that police decision making in relation to this outcome was not cognisant of all information available about the family and their circumstances. It is, therefore, conceivable that, had there been police representation at the review case conference, there would have been a different outcome in terms of investigation of the assault and/or protection arrangements.

The strategy discussion should be viewed as a flexible process, which can be adapted to suit the level of risk relative to the case. In the case of Baby P the strategy meeting was a key decision making arena, particularly in relation to protection. Every effort should have been made to ensure that key professionals took part in the process. For example, the strategy meeting on the 24/1/2007 was held in the absence of the examining paediatrician. The CAIU should be represented by a supervisor, who should agree to the timing and location of the meeting, and who should be prepared to make representations to ensure attendance by key partners with important information to contribute and to challenge where appropriate other agency views (such as EPO threshold when discussions concerning the best protection arrangements for Baby P were held). This is supported by ACPO Guidance.

Climbie/Laming recommendation 94 requires that supervisory officers from the outset play an active role in ensuring a proper investigation. The current supervisory capacity clearly had an impact in respect of the investigation into the first allegation made in December 2006 in respect of Baby P. There may also be an issue of capability, since the details recorded on the CRIS did not contain any structured investigation plan or consistent evidence of pro-active supervision requiring, suggesting or querying action/inaction. There was an unacceptable delay in relation to seeking further medical advice as requested by the CPS and the allocation of a second investigating officer when the original officer left the command was not expedited. The investigation subsequently through inactivity exceeded the six month threshold, wherein a charge of common assault may have been possible.

The swift actions of the second investigating officer in terms of both picking up the December '06 allegation in respect of Baby P and then taking on the new allegation in June '07 are to be commended. The later active engagement of supervisors is also commendable, if wholly to be expected.

The MPS should consider;

- the development of a staffing model to set resource levels, but with flexibility to allow for periodic growth or shrinkage depending on demographic profile and work load;
- effective IT support, not only as a tool for practitioners and supervisors, but to allow for a range of quality-assurance and audit information to be accessed; or routine analysis of such information collected from other IT and data sources (for example, supervisory caseload spreadsheets, agreed data sets provided routinely to Performance Managers); and
- Programmed audits, reviews or health checks which focus specifically on supervisory engagement, capability and capacity.

Policy and Standard Operating Procedures (SOPs)

Policies and SOPs are robust and comprehensive and training is compliant with the Climbie/Laming recommendations. However, there is a need to test the workability of the existing SOPs. The SOP on supervision, for example, is reliant for compliance on adequate supervisory staffing levels. The MPS must also ensure that training equips supervisors for referral desk duties (as stated, this is a crucial role within the CAIU) and secondly, the MPS should improve the provision and timing of training for new post holders incoming to SCD5. HMIC has found that training provision can initially lag behind the investigative workload as staff are allocated cases that they have not always been trained to deal with (this is a demand management issue).

Information and Intelligence Management

There were a number of commonly occurring themes in relation to intelligence management as follows:

- Lack of integration of IT systems remains a barrier to effectiveness, particularly in relation to access to information, co-ordination of intelligence and the flow of information, and effort (for example, double-keying).
- There is a need to ensure that strategic intelligence requirements are properly managed and co-ordinated through the established National Intelligence Model (NIM) infrastructure, to improve tasking and co-ordination at all levels.
- There is further scope to exploit the use of analysis and intelligence techniques (such as NIM problem profiles and intelligence-led problem solving) across all four PVP areas; HMIC note that analytical capability is also an issue for the MPS.

In respect of Child Abuse investigations, the PNC is routinely checked, enables the flagging of ViSOR subjects and this, together with criminal intelligence checks, provides information on an offender's background. However other important information (such as an offender's risk management level and details of the risk management plan) from ViSOR is not being routinely obtained to inform risk assessment and decision-making.

The collection and management of all the available intelligence is a crucial aspect of creating effective child protection as well as informing the investigative process. There was a lack of pro-activity on the part of the police in communications with other involved professions (crucially health and the social services) during ongoing

investigations, specifically in terms of the outcomes of home health visits and protection plan visits. For example key information could have been retrieved which affected Baby P's protection arrangements' such as the visit on the 6.3.07 visit by a social worker which established that the family dogs remained in household in spite of decision to return the child being contingent on alternative arrangements.

Internal Information Exchange

Within the MPS, child abuse investigation management falls under the remit of a centralised specialist crime directorate unit (SCD5), with domestic violence, race, homophobic and rape investigations, missing persons, and the management of MAPPA offenders and PDPs falling under the remit of the violent crime directorate (VCD). Previous HMIC inspections (PVP 2008) have identified the need to improve liaison and information exchange processes between the centralised CAIU and the other VCD business areas to ensure there is greater integration between the functions (such as accessing information contained in ViSOR as outlined above) . The introduction of accredited Public Protection Desks on BOCUs, with responsibility for collecting and disseminating public protection related intelligence to the relevant specialist units, should assist information management. However, it is important that the impact of this new structure is assessed to ensure that streamlining of processes has not resulted in gaps in information flow. In particular, there are indications that CAIUs are not always receiving required information in domestic violence cases.

Monthly MAPPA meetings are chaired by the delegated DI and the CAIU always have a representative at these meetings (for Level 2 offenders). However, there was no indication of relevant information being passed back to practitioners on the CAIU. In addition, there was a lack of knowledge amongst CAIU officers of the MAPPA processes, together with those for the identification, assessment and management of Potentially Dangerous Persons, resulting in significant opportunities being missed to include the use of such processes to assist in the management of risks presented to children by individuals falling within these categories.

Medical Examinations

While CAIU investigators generally attend examinations in sexual abuse cases, they do not regularly attend examinations in cases of suspected physical abuse. Medical examinations in suspected physical abuse cases are arranged and attended by social workers unless there is a need to retrieve evidence or where police information is crucial to the examination. ACPO guidance suggests that Forensic medical examinations should be undertaken at the earliest opportunity and the child should be accompanied by an officer from the CAIU. Cases of abuse in which the victim does not require urgent medical attention allow for a medical examination to be carefully planned. The purpose of any forensic medical examination in such cases is to assess the medical needs of the child and record any evidence relevant to the case. In both of the Baby P allegations, police officers were not present at the medical examination, when key decisions in respect of protection were made by social workers. Being present at the examination would secure the first account, enable immediate photography of the victim, discussion with the medical examiner as to the nature of injury and probable cause, as well as enable the informed challenging of the appropriateness of decisions in relation to protection issues.

In short attendance at medical examinations where physical injury is alleged ensures compliance with the 'Golden Hour' principles of investigation, and HMIC would expect to see that where referrals are subject to proper risk assessment, that such attendance becomes routine where appropriate. ACPO guidance further suggests that the investigating officer should meet with the paediatrician or forensic physician prior to an examination to discuss the purpose of the examination. As the forensic medical examination is part of the criminal investigation, the investigating officer or an officer acting in support of the investigating officer should remain present or near to the place where it is being undertaken. In neither allegation in relation to Baby P is this recorded as having occurred. HMIC considers that there were opportunities lost to secure evidence from the body of Baby P at the medical examination, as well as to properly discuss the range and extent of injuries and neglect with the paediatrician, enabling informed challenge as to the protection arrangements made by the social services in both allegations.

Meeting Attendance

There are frequent unacceptable and extreme delays in distributing in distributing to partner agencies the minutes of key meetings, such as child protection conferences, core groups and statutory reviews of looked after children and young people. This means that information and follow-up action required is not effectively and promptly communicated to all agencies involved with the child and his/her family. While acknowledging responsibility for producing the minutes of these meetings rests with children's social care, the MPS in order to overcome this in relation to strategy meetings has produced its own form, the 'Substantive Strategy/Planning Meeting Record' to record details of the meeting. The attending police officer makes their own notes, including decisions and agreed actions, which the chair is then asked to counter-sign at the time. Whilst this process is in place as a solution to address the shortcomings of other partners it is in the circumstances good practice.

Protection Placements

Guidance to staff about placement of children with family or friends is contained with the London Child Protection Procedures. This focuses on situations where children and young people may be accommodated or placed as an emergency placement while carers are being fully assessed.

[REDACTED]

[REDACTED] These arrangements [REDACTED] care for Baby P in his own home while supervising access by [REDACTED] were in hindsight clearly inadequate to protect the child and more robust oversight and challenge to the decision making may have altered these arrangements. Laming recommendation 100 specifically requires training that enables officers to

challenge the views of other professionals from other agencies. HMIC is of the view that the protection issue was not pursued vigorously enough in both allegations, particularly in the second when the child was once again the subject of a suspected NAI while already under protection.

Performance Management and Measurement

The MPS current performance management structure for SCD5 is embedded and seeks to;

- provide the structure for ownership and accountability;
- allow for trends in both good and poor performance and practice to be identified;
- assist in the identification of gaps in service provision and help prioritise areas for improvement
- enable the optimum use of resources.

However there is a need to review the performance management information gathered since it is predominantly focused on outputs such as detection levels. While there are some qualitative measures, they do not encompass the full range of activities undertaken in the 'child protection' process. The MPS needs to develop a suite of performance measures which enables the accurate capture of both the range and outcome of key activities pertinent to child protection. Current good practice is reflected below and maybe of assistance in terms of enabling the MPS to collect and use what information is useful, as opposed to what is readily available. HMIC are of the view however that, performance is also intrinsically linked to supervision capability and capacity and again the available IT inhibits the exercise of this function as described above, as does the issue of staffing levels.

Performance Measures

Although there are currently no national performance indicators in the area of child abuse investigations, the absence of Statutory Performance Indicators (SPIs) has not prevented a number of forces from developing a range of comprehensive performance measures. The following example is taken from Northumbria Police which obtained an 'Excellent' grading following the Protecting Vulnerable People inspection in 2007.

Those highlighted in yellow form part the SCD(5) Child Abuse Investigation Command monthly performance data currently collected.

Good Practice - Child abuse investigation performance measures

- Number of joint visits carried out (percentage investigations)
- Number of initial Case Conferences (percentage attended)
- Number of review Case Conferences (percentage attended) **Note: the MPS measures the number and percentage of Review Case Conference reports completed, not the number and percentage attended – see last highlighted bullet point**
- Intelligence items submitted
- Detection rates

- Number of children taken into police protection
- Number of Child Concern Notifications received
- Number of requests for disclosure of material in family proceedings
- Number of s47 (child at risk) investigations
- Number of IMPACT Nominal Index (INI) checks carried out (percentage for s47 enquiries)
- Quality of Child Concern Notification
- Quality of assessment of risk posed to child
- Action taken to safeguard and promote child welfare
- Police checks including INI carried out to required standard
- Intelligence placed on criminal intelligence system and correctly rated
- Safeguarding of siblings/other children considered
- Information shared to assess child's needs (e.g. conference reports)
- Strategy discussion
- Participation in reviewing outcomes to child
- Referral of offender to MAPPA or non-MAPPA considered
- Police protection considered/carried out/correctly reviewed

Governance and Accountability

The MPS specialist crime directorate structure provides for clear accountability and the accountability framework is also available on the force intranet. HMIC note that;

- There are links between the accountability for performance management with management information being used as a diagnostic tool to identify problems and inform improvement;
- There are internal scrutiny arrangements with regular audit, review or 'health checks' to test compliance with policy and consistency in service delivery;
- There are effective governance and lines of communication, with routine and structured consideration of performance at business group and unit level.
- There is active monitoring of outcomes when action has been taken to address areas for improvement.

That said there is an overarching caveat in that the effectiveness of governance is reliant on the quality of the performance management information captured and used. As stated above, this requires review.