·EDINBVRGH·
THE CITY OF EDINBURGH COUNCIL

Item no 8.1
Report no CEC/86/03-04/CE

Caleb Ness Inquiry

The City of Edinburgh Council

16 October 2003

Purpose of report

1. To report on the outcome of the inquiry into the death of Caleb Ness and the follow-up action required.

Background

2. Caleb Ness was born on 30 July 2001 and died eleven weeks later on 18 October 2001. The baby's father, Alexander Ness, pled guilty to culpable homicide and was sentenced in March 2003 to eleven years imprisonment.

3. At its meeting on 20 February 2003, the Council debated what action should be taken following the death of Caleb Ness and the subsequent trial and approved the following motion:

> "The Council:
>
> i. expresses its sincere regret at the death of baby Caleb Ness, who was the subject of Child Protection procedures;
>
> ii. endorses the decision of the Director of Social Work to request the Edinburgh and Lothians Child Protection Committee, to undertake a comprehensive review of the interagency discussions, decision making and involvement with Caleb Ness and his family; this review to be undertaken under the independent chairmanship of a Queen's Counsel or other eminent legal person to be appointed by the Chief Executive, in consultation with the political group leaders;
>
> iii. asks the Child Protection Committee to make its report available to the Council and to the Boards and Trusts of the bodies represented on it and, thereafter, to the Scottish Executive; and
>
> iv. agrees that the review be completed as quickly as possible with the report being submitted to the Council at the earliest possible date."

4. In line with the Council's instructions, I subsequently appointed Susan O'Brien, QC, to lead the inquiry. She was supported in her work by the appointment of two additional inquiry team members. They were Dr Helen Hammond, a Consultant Paediatrician and Vice Chair of the Edinburgh and The Lothians

Child Protection Committee and Mrs Moira McKinnon, Principal Officer (Child Protection) with Glasgow City Council.

5. These arrangements were endorsed by the Edinburgh and The Lothians Child Protection Committee.

Inquiry Team Report

6. The report of the Inquiry Team was received on 3 October 2003. It was considered first by the Edinburgh and The Lothians Child Protection Committee at a special meeting on 6 October 2003.

7. A copy of the report was made available to all members of Council on 9 October 2003. Copies have been circulated also to a range of organisations and individuals. The report is available via the Council's website.

8. The report is comprehensive and thorough. It concludes that the death of Caleb Ness was avoidable and that neither of Caleb's parents should have had unsupervised care of him.

9. The report extensively criticises the child protection arrangements for Caleb and "identifies fault at almost every level in every agency involved". Criticisms are directed at the Department of Social Work and the health agencies in particular. A number of specific practitioner and procedural shortcomings are identified in the report, along with more general communications problems. Action to address these shortcomings will need to be taken by individual organisations as a matter of urgency. In addition, and crucially, action will also need to be taken collectively by all the key agencies involved in child protection.

10. The Inquiry Team's views are concisely and strongly expressed in the Executive Summary of their report. They also make thirty-five detailed recommendations.

Proposals

11. At the time of writing this report the Inquiry Team's report has only just been received. Time is needed, both within the Council and in partnership with other agencies, to consider aspects of the report in detail. I can assure the Council that every recommendation in the report will be implemented and lessons will be learned. It is also necessary to take immediate action in three areas.

Child Protection Register

12. The Inquiry Team point out in their report that some evidence suggested that this (Caleb Ness) was not an isolated case. Currently, there are 342 children on the child protection register in Edinburgh. It is essential that an immediate review of all cases is carried out and I have instructed this. In my view, it is also vital that this review should be scrutinised and audited by an independent review team. I am currently working on the practicalities of this and will liaise with the Leader of the Council and the Group Leaders to ensure its speedy implementation.

Child Protection : Procedures And Practice

13. It is clear from the Inquiry Team's report that there needs to be a comprehensive review of child protection procedures and practice. Members of Council will also be aware that a review of child protection arrangements in Scotland has been identified as a national priority. I submitted an interim report on this matter to the Council Executive on 11 March 2003. A copy is recirculated as an appendix to this report.

14. Following discussion with the Scottish Executive and partner agencies I will report to the next meeting of the Council in November on detailed terms of reference for the review and who will carry it out. I envisage working closely with the Chief Executive of NHS Lothian to establish a dedicated, joint team to undertake this review reporting directly to us both. I also intend to seek the involvement of the Inquiry Team in some capacity with this review and with the actions referred to in paragraph 12 above.

Staffing Issues

15. While the Inquiry Team's report says that "no single individual should be held responsible" I intend nevertheless to review the performance of Council staff in this matter. I recognise that child protection work is demanding and places considerable responsibility on members of staff. It is also important that relevant procedures are in place to support frontline staff. However, if, following a detailed review within Council procedures, it is found that any member of staff failed to do their job properly appropriate action will be taken. I have instructed the Director of Corporate Services to initiate the necessary action.

16. On a specific point I have instructed the Director of Corporate Services to prepare a report on the concern expressed by the Inquiry Team that someone in the Social Work Department interviewed key witnesses after the Inquiry started.

Recommendations

17. It is recommended that Council:

    (i) express again its sincere regret at the death of Caleb Ness;

    (ii) accept the report of the Inquiry Team, led by Susan O'Brien, QC, and thank them for producing such a thorough and comprehensive report;

    (iii) note that I have instructed the preparation of an initial report on the inquiry findings which will be submitted to the Council meeting in November; and

    (iv) approve my proposals to initiate immediate action, as detailed in paragraphs 12 to 16, in relation to the Child Protection Register; Child Protection Procedures and Practice; and Staffing Issues.

TOM AITCHISON
Chief Executive

9/10/03.

Appendices	Appendix - Report to the Executive of the Council on 11 March 2003 on Child Protection
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APPENDIX

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THE CITY OF EDINBURGH COUNCIL

Item no
Report no

Child Protection

Executive of the Council

11 March 2003

1 Purpose of report

1.1 To report on the publication by the Scottish Executive of a major report entitled "It's everyone's job to make sure I'm alright", a report of the Child Protection Audit and Review.

2 Scottish Executive Report

2.1 Towards the end of 2002 the Scottish Executive published a major report on child protection. A copy of the Executive Summary and Recommendations are attached as appendices to this report. Copies of the full report are available from Group Rooms, the Council Information Centre and the Scottish Executive website.

2.2 The Scottish Executive report represents a wide ranging examination of child protection in Scotland. The main conclusions of the review are:

- many examples of children being protected and helped;
- well motivated and committed staff;
- many children are living in conditions and under threats that are just not tolerable in a civilised society;
- children, their parents, the public and some professionals too often do not have confidence in the system;
- children and their families do not always get the help they need when they need it;
- some children remain unprotected;
- occasionally disclosure of abuse makes matters worse for a child;
- there is duplication of effort and energies are diverted into meeting system requirements rather than the real needs of children; and
- agencies are not able to always respond effectively to some problems – parental drug or alcohol misuse, domestic abuse and neglect.

2.3 Seventeen principal recommendations are made in the report. Some are directed to the Scottish Executive and others to local authorities and other agencies. Broadly, the recommendations can be grouped into the following categories:

- information;
- quality and performance;
- leadership and authority;
- knowledge and skills;
- planned early intervention; and
- reducing duplication.

3 Child Protection Summit

3.1 A child protection summit was held in Glasgow on 18 February 2003. A senior audience of Council Leaders, Chief Executives, Chief Constables and others was addressed by the First Minister and the Minister for Education and Young People.

3.2 The First Minister emphasised the need for effective joint working between elected representatives and professionals and across professional boundaries. A copy of a press release issued by the Scottish Executive is also attached to this report. In the press release the First Minister emphasised the need for action to improve radically child protection and announced that immediate action is to be taken as follows:

- a three-year reform programme for child protection services;
- an expert team to oversee reform and tackle poor performance locally;
- a tough new inspection system to ensure reform is delivered;
- a Children's Charter setting out the support that every child has the right to expect; and
- increased investment in helplines, including cash to allow Childline Scotland to increase by 60% the number of children it helps.

4 Next Stage

4.1 The issues raised in the child protection report require detailed consideration by the Council and partner organisations. The Executive is aware that at its last meeting the Council endorsed the decision of the Director of Social Work to ask the Child Protection Committee to undertake a comprehensive review of various matters related to the death of Caleb Ness. I shall report further on how the Council should respond to the Scottish Executive review of child protection once the review of the Caleb Ness case is concluded.

5 Recommendations

5.1 It is recommended that the Executive:

(i) note the publication of the Scottish Executive report and the First Minister's announcement on the way forward; and

(ii) note that I will report further on how the Council should respond to the issues raised in the report.

Tom Aitchison
Chief Executive

Appendices	Appendix 1 Executive Summary Appendix 2 List of Recommendations Appendix 3 Scottish Executive Press Release
Contact/tel	Tom Aitchison 0131 469 3002
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Executive Summary

The Child Protection Review

This report presents the findings of the Child Protection review. The central part of the review was an audit of the practice of police, medical, nursing, social work, Scottish Children's Reporter Administration, and education staff. The audit was based on a sample of 188 cases which covered the range of possible concerns about children from early identification of vulnerability to substantiated abuse or neglect.

The views of children and young people, parents and the public have contributed to the findings of the Child Protection Review which are outlined in this report. Eleven children were interviewed as part of the case audit and a further 21 children and young people with experience of the child protection system were interviewed by voluntary organisations. We included the views of 217 children and young people who discussed their experiences and concerns with ChildLine Scotland. Parents were interviewed in the audit in relation to 17 children. In addition, the findings have been informed by the views of 100 parents and other members of the public who rang ParentLine Scotland. A study of public views of child protection also contributed to the findings as did the large consultation exercise which involved parents, the public and professionals.

A literature review, analysis of child protection guidance, analysis of deaths of looked after children and information provided by speakers at a conference on child protection in other countries also informed the review.

This report outlines the findings. It presents recommendations which are based upon these findings. The recommendations are aimed at reducing child abuse and neglect in Scotland and improving services for the children who experience abuse and neglect.

The findings of the review

The circumstances of abused and neglected children

The review found that children experience very serious levels of hurt and harm and live in conditions and under threats that are not tolerable in a civilised society. Many children in the case audit and those who phoned ChildLine Scotland were experiencing serious physical abuse and sexual assault. Some children had been suffering chronic neglect for many years. Many children in the audit and those who phoned ChildLine had experienced more than one form of abuse or neglect and large numbers were living with parental substance misuse or witnessing domestic abuse on a regular basis. Sibling or peer abuse was a feature of many of the cases in the audit and was reported by many of the children who phoned ChildLine. The review findings indicate that the effects of abuse and neglect are considerable including children getting into trouble, running away from home, becoming pregnant, self harming and attempting suicide.

Protecting children

The review found that some children remained at risk of significant harm even though most children in the audit had been known to agencies for a considerable time and there had been previous referrals for many of them, There were examples of cases where neglect continued for some years and where children or their older siblings had been previously registered as being in need of protection.

Children and young people expressed mixed feelings about whether or not the child protection system had protected them. Some children who took part in the ChildLine study or who were interviewed by voluntary agencies said they were glad they had told someone about the abuse and that they now felt protected. Some children said they felt protected now they were in foster or residential care. Other children said they were more vulnerable after reporting abuse or that their position was no different. One of the reasons why some felt that the system had not protected them was because the person who had abused them had not been prosecuted. Similar views were also expressed by parents and children participating in the audit and callers to ParentLine. A small proportion of children felt they were not protected in residential care. They indicated that although they had been taken away from the person who abused them they were now vulnerable to other risks. The analysis of the deaths of looked after children indicated that in some cases agencies might have done more to protect the children who subsequently died.

The audit identified occasions when social work did not take action in response to concerns raised by health visitors and education staff who often perceived that their referrals were not taken seriously enough by social work.

Emergency protection measures were used only rarely in the sample of cases which were looked at. Social workers were reluctant to apply for Child Protection Orders unless they could demonstrate immediate risk to a child and in some cases they were concerned about appearing in court and being cross examined about their work. Other agencies were reluctant to seek an order if social work did not think one was necessary. Social workers felt there was little point in seeking exclusion orders which placed responsibility on the other adult in the household to keep the abuser out.

In some cases children were at serious risk from males who were not living in the family home but who visited the house or lived close by. In such cases Reporters had difficulty framing grounds and the hearing system was not an effective way of protecting the child. In other cases children remained at risk due to delays in the hearings system. There were delays when cases went to the sheriff court for proof; delays were also caused by late presentation of reports by social workers.

Meeting needs

The review found that children and their families do not always get the help they need when they need it. Most of the abuse and neglect experienced by children in the audit was caused by poor parenting skills and agencies responded with a range of compensatory measures to improve the day-to-day conditions for children. There was evidence of high levels of home support stabilising situations, particularly where there were problems of substance misuse. In some cases parents were greatly assisted in developing the ability to care effectively for their children. Where support to improve parenting skills was offered the contributions of family centres or nurseries were particularly impressive and in a few cases health visitors played a significant part.

Examples of meeting need included the provision of therapeutic services where children had an opportunity to work through what happened to them, come to terms with it and move towards a different future; remedial health care to address neglected problems, for example, optical or dental treatment; information and guidance about inappropriate behaviour; and change programmes that targeted entrenched problem behaviours.

In too many cases, however, the audit found that children were not receiving the services they needed and many could not access services such as health care if their parents did not co-operate. Where intensive remedial work was provided solely in the home there was little evidence of long-term success. In some cases children were living at home but virtually all the day-to-day and occasional night care was provided by a range of support services rather than by the parents. In reality the local authority was parenting the child.

A few authorities provided directly or commissioned therapeutic support from voluntary agencies and where these were offered they were valued and made a good contribution to the welfare of the children. On the whole, however, there was a shortage of skilled workers with time to offer children practical and emotional support and psychology, psychiatry and specialist counselling waiting lists were so long that children could not gain access in a reasonable timescale. Some of the parents who called ParentLine were frustrated that they could not access counselling services for children or themselves. The audit found that the needs of child perpetrators were particularly neglected, few of those in the sample had the benefit of a programme to address their sexually abusive behaviour.

The audit found that while professionals had children's 'best interests' at heart, they often did not consult with children to determine what their 'best interests' were. The views of children were often not fully considered at case conferences or were presented through third parties. Children who were interviewed by voluntary agencies complained that they were not always listened to.

The audit found examples where parents valued highly the support they were given. Some parents in the audit and those who rang ParentLine often felt they were not kept fully enough informed about what was happening. Some felt overwhelmed at case conferences. Arrangements to provide families with support were variable as was practice in ensuring they fully understood the outcomes of the meeting. Sometimes key family members, such as grandparents, were omitted from discussions. Relatives who took on the long-term care of children often felt unsupported and felt their requests for help were ignored.

Conclusions

The review findings suggest that many adults and children have little confidence in the child protection system and are considerably reluctant to report concerns about abuse or neglect. Many children never tell anyone they are being abused. The child protection system cannot help these children because they never enter the system and do not receive any help. Many referrals come from members of the public but the findings of the review suggest that the system is not always well understood by the public. The public attitudes study found that many adults were concerned that children would be taken away from their families if they reported abuse. Even where people were willing to report abuse they indicated that gaining access to help was not easy.

The review findings also suggest that the child protection system does not always work well for those children and adults who become involved in it. Forty children in the audit were not protected or their needs were not met following the intervention of agencies. A further 62 children were only partially protected or their needs partially met. In 77 cases children were protected and their needs met and in 24 of these cases their needs were well met.

Good practice included the provision of help to parents and children as and when it was needed, timely responses, early thought and preparation, and properly addressing the source of the risk. Sometimes agencies did all they could but outcomes for children did not improve. While some parents who received considerable support were able to improve their parenting skills and the situation improved for their child(ren), other parents were unable or unwilling to change despite high levels of intervention.

Outcomes for children were found to be highly dependent on social work doing well. Where social work performed well outcomes were generally good and when they performed less well outcomes were generally poor. While good outcomes were assisted by the work of all agencies they were less dependent on other agencies.

Where children were not protected or their needs were not met this was often the result of poor assessments and enquiries which were not sufficiently extensive. Longer-term assessments of risks were often particularly poor. Poor assessments were characterised by failure to consider the pattern of previous events; insufficient use of inter-agency information, especially health and education information; insufficient attention paid to the role of at least one key person in a child's life; lack of focus on the child and inadequate assessment of parents' ability to make use of the support on offer and to change quickly and sufficiently enough to offer children an acceptable level of care.

Practice was generally better for new babies where parents had a learning disability, mental health problem, or drug problem. In such cases health services arranged for pre-birth or pre-discharge meetings with the other key agencies. These worked well when all the key agencies attended, a multi-agency plan was made and the individual workers each played a part in implementing it.

Where, to secure their safety, children were placed successfully in foster care their circumstances, particularly material and health circumstances, often improved. Schools often noted improvements in the attitude and performance of older children following fostering. There were also cases, however, where foster carers could not cope with the behaviour of children. Occasionally children were sent back home from foster or residential placements against their will.

Good workers made a difference to the outcomes for children. In a number of instances, particularly in relation to drugs or alcohol misuse, where strong supportive relationships had been established between social workers and misusing parents, workers were able to address the problems and parents were very positive about the support they received.

Where the child protection system relied on criminal prosecution to protect children outcomes were not always good because the abuser was not always prosecuted or convicted and often remained a threat. In such cases victims were left vulnerable and felt they had not been believed.

Parents do not always feel that the child protection system is working effectively. They are not always happy with the response they receive from child protection agencies. People contacting ParentLine were often concerned about a perceived lack of activity on the part of agencies and felt they received a lack of feedback after making a referral.

The report contains 17 recommendations. The recommendations identify action that can be taken immediately to protect children and improve services as well as action that needs to take place over a longer time scale.

List of Recommendations

Recommendation 1: All agencies should review their procedures and processes and put in place measures – to ensure that practitioners have access to the right information at the right time, and in particular to ensure that:

- Where children present to medical practitioners with an injury or complaint, practitioners must consider what further information is available from their own or other agencies *before they rule out* the possibility of continuing risk.
- Where children present to any hospital, there should be in place mechanisms for checking other health records to ensure a pattern of injuries is not being missed.
- Where there have been concerns about possible abuse or neglect, schools, police, health service and social work service files should contain a succinct, readily accessible chronology of events or concerns which can be easily referred to should a further incident or concern arise. This chronology should contain information relating to the child and, where known, information relating to other people in the child's life, for example, any previous deaths of children of a mother's new partner.
- Courts should ensure bail address suitability checks are undertaken in cases where the alleged offence is against children, or in the case of domestic abuse, where children may be at risk.
- Caldicott guardians in Health Boards and Trusts should ensure that health professionals are aware of their responsibilities towards the care and protection of children. In particular they should ensure that where children are at risk of abuse and neglect information is shared promptly with other relevant professionals in line with the General Medical Council and the Scottish Executive guidance on when medical confidentiality can be breached.

Recommendation 2: Through the Child Protection Committees all agencies should improve access to help for children who have been abused or neglected by:

- providing for single-page contact information for telephone directories, public phones and the web, which identifies local contact points in health services, local authorities, police services, SCRA and the voluntary sector;
- providing for services users and referrers, information about how to access help for children about whom they are worried. This should include information about how and when children and young people will be consulted, what will happen after a referral is made and what, and how, feedback to people who refer concerns will be provided.

Recommendation 3: The Scottish Executive should, in consultation with service providers, draw up standards of practice that reflect children's rights to be protected and to receive appropriate help. All local authorities, health boards, police services and SCRA should undertake regular audits of practice against these standards and report on them annually to the Scottish Executive and local Child Protection Committees.

Recommendation 4: The Scottish Executive should revise the remit of the Child Protection Committees to include:

- Annual auditing and reporting, to constituent agencies and to the Scottish Executive, on the quality of agency and inter-agency work.
- The provision of information to members of the public, volunteers and other professionals.
- Assisting a wider range of organisations to help prevent abuse and neglect through training for staff and volunteers.
- The development of safe recruitment practices for agencies working with young people.

Recommendation 5: Local authority Chief Executives, in consultation with other services, should review the structure, membership and scope of the Child Protection Committee covering their authority and report to their Council and partner agencies on whether it is best constituted to take on the responsibilities for assuring the quality of agency and inter-agency services and the recommendations about their role contained in this report.

Recommendation 6: The Scottish Executive should consult on how child fatality reviews should be introduced in Scotland. This should include consultation on how they should be conducted, how review teams should be constituted, to whom they would report and what legislative framework is required to ensure their effectiveness.

Recommendation 7: The Scottish Executive should strengthen the current arrangements for the development and dissemination of knowledge about abuse and neglect. In particular it should identify:

- the most effective arrangements for recording and collating examples of effective practice;
- the delivery of staff training across all disciplines or agencies;
- the best means of disseminating research findings and best practice; and
- the links between research and knowledge and staff education and training and how this can be consolidated.

Recommendation 8: The Scottish Executive should initiate a long-term study of the effectiveness of current methods of responding to abuse and neglect. The study should follow children from infancy to adulthood.

Recommendation 9: Children's Services Plans should be developed so that they include clear plans for the implementation of national priorities and demonstrate the application of resources to these outcome targets set out in *Building a Better Scotland*.

Recommendation 10: Local authorities' plans for integrated children's services, as the overarching plans and drivers for all local children's services, should develop *positive childhood* initiatives. These should be lead by a children's rights rather than a public service perspective and should promote every child's rights to life, health, decency and development. The Executive should support this with a public campaign.

Recommendation 11: The Scottish Executive should:

- Advise on how agency resources can be pooled and what systems may best be deployed to ensure the most effective joint commissioning of services on behalf of children.
- Commission a study of the costs and benefits of the current child protection system in Scotland and identify costed alternative options for improving outcomes for children.

Recommendation 12: There needs to be a new approach to tackling risks and the needs of the most vulnerable. As a first step this should start with assessment of the needs of all new-born babies born to drug- or alcohol-misusing parents; parents who have a history of neglecting or abusing children and parents where there have been concerns about previous unexplained deaths in infancy. The inter-agency assessment and subsequent action plan in respect of each child should clearly state:

- standards of child care and developmental milestones the child is expected to experience or achieve;
- resources to be provided for the child or to assist the parents in their parenting role; and
- monitoring that will be put into place along with contingency plans should the child's needs fail to be met.

Recommendation 13: In keeping with the philosophy of the Children (Scotland) Act 1995, agencies referring to the Reporter should indicate what action they or their agency has undertaken to achieve change through consent and why compulsory measures of supervision may now be necessary.

Recommendation 14: The Scottish Executive should review the grounds for referral to the Children's Hearing system. Specifically, it should explore the feasibility of grounds being framed to reflect more clearly the needs of the child and to be more closely aligned with definitions of need outlined in the Children (Scotland) Act 1995.

Recommendation 15: In order to meet the shortcomings identified in this report, developing linked computer-based information systems should include a single integrated assessment, planning and review report framework for children in need. For those in need of protection the framework should include reason for concern, needs of the child, plans to meet them and protect them when necessary, and progress since any previous meetings. This core assessment, planning and review framework should be accessible and common to all partner agencies, multi-agency case conferences and the Children's Hearing. Arrangements should be made for appropriate access to information by agencies in other areas should children or their families move.

Recommendation 16: The Scottish Executive in partnership with the regulatory bodies should consult on the minimum standards of professional knowledge and competence required of practitioners who undertake investigations, assessments and clinical diagnosis when working with children and their families. In particular it should establish the minimum necessary qualifications and experience required of those making decisions that fundamentally affect the future wellbeing of children.

Recommendation 17: The Scottish Executive should:

- Establish a national implementation team to take forward the recommendations in the review, in particular the development of standards and local auditing processes.
- Establish a review process for annual reporting on progress and improvements.
- Implement a further national review of child protection in three years' time to be undertaken by a multi-disciplinary inspection team using this report as a baseline against which progress can be assessed.

SCOTTISH EXECUTIVE
News Online

JUSTICE

Final warning for failing child protectors

18/02/2003

If the child protection system continues to fail children it will be replaced, a high-level child protection summit was told today.

First Minister Jack McConnell was speaking in Glasgow at the summit convened after a major review of all child protection services which found that over half of children at risk of abuse or neglect were not adequately protected or cared for.

Many failures in the child protection system have been blamed on senior managers in child protection organisations.

The First Minister said:

"We need urgent action before another Kennedy McFarlane or Caleb Ness dies at the hands of the very person who is supposed to be caring for them.

"Those who run the system have a personal responsibility to radically improve child protection and help children realise their potential.

We have allocated resources and acted on the recommendations, but locally, professional boundaries cannot be allowed to stand in the way of the job we must all do. Scotland's children need to see those barriers removed. They need us all to show leadership and give them the service they have the right to expect. New investment must be matched by reform.

"Radical improvements are essential. But the bottom line is that if the system goes on failing to protect children, then we will not protect the system.

"The least we owe to the tragic victims of abuse or neglect is to give those vulnerable children an absolute guarantee that professional services will not let them down. This is a fundamental right for the 21st century."

The Summit brought together senior local authority, health, police and voluntary sector representatives to thrash out action on the Executive's five-point response to the child protection review.

The immediate action to be taken was:

1. a three-year reform programme for child protection services
2. an expert team to oversee reform and tackle poor performance locally
3. a tough new inspection system to ensure reform is delivered
4. a Children's Charter setting out the support that every child has the right to expect
5. increased investment in helplines, including cash to allow Childline Scotland to increase by 60% the number of children it helps

Minister for Young People, Cathy Jamieson, said:

"We are giving those responsible for running child protection services three years to put things right. Some may complain that this is not enough time but it is a deliberately tight timescale.

"If we continue to drag our heels then more children will die and society will have failed in its duty to protect our children."

The Executive has developed an outline three-year reform programme for agreement and views were also sought on the expert team which will oversee the reform programme and tackle poor performance locally.

A tough new inspection system is being put in place to hold all those delivering child protection to account. The key inspectorates have already met and agreed that the inspections will be against common standards. The inspection report will be published to increase public accountability.

The First Minister also announced that the Executive has commissioned Save the Children to develop a Children's Charter by August to set out the support that every child has the right to expect.

Save the Children will consult with children and young people, parents and professionals, to produce the Charter which will have a significant impact on the reforms.

Mr McConnell also revealed that ChildLine are on course to open their new Aberdeen Centre in the Autumn. This follows immediate increases in investment by the Executive in helplines to boost significantly the number of children they can help.

An audit and review of child protection was announced by the Scottish Executive in March 2001 following the Hammond report into the of Kennedy McFarlane. The multi-disciplinary team were asked to review how well our children are being protected by the range of agencies that work with them. The review team's report **It's everyone's job to make sure I'm alright** (a quote from a child interviewed by the team) was published on November 25, 2002.

Investment in the Changing Children's Services Fund, which funds innovative projects which join up services for vulnerable and disadvantaged, will double from £33 million to £65.5 million between 2002-03 and 2005-06. This was announced by Cathy Jamieson at the Barnado's Conference on November 22 last year.

News Release: