Issue area of public concern related to the care profession – the death of baby p...

The issue/area of concern raised in this report is as to how Peter’s death happened in the first place.

Peter Conelly also known as ‘ Baby P’ was born in London, on the 1st March 2006, he sadly died on the 3rd August 2007 age 17 months. He died after receiving/suffering more than 50 injuries over a period of 8 months. During this time he was repeatedly seen by Haringey’s Children’s Services and its NHS professionals –

At the beginning of these 8 months Peter’s mother’s boyfriend moved into the home they shared, and this was kept from the police and the social workers. On Dec 11th 2006 Peter was taken to hospital with extensive bruising, the doctors referred the case to the Metropolitan Police’s Child abuse investigation team and Peter was given to a family friend to be looked after. The police then arrested Peter’s mother on suspicion of assaulting her son, she denied the claims. Peter was then placed on the child protection register. After just five weeks of being cared for by the family friend Peter was returned to the care of his mother. The police passed a file about Peter’s injuries to the CPS (crown prosecution service), which requested further investigation. A little later the family are moved to a larger house and Haringey council appoints Maria ward as the family’s new social worker. Once again Peter is admitted to hospital, this time with more bruising, black eyes and swelling on his head. Peter’s mother justifies his injuries by telling the hospital they were caused by Peter being pushed into a marble fireplace by another child; this incident was not reported to the police, and Peter is later discharged from hospital. In June 2007 Peter’s mother’s boyfriend’s

brother moves into the home with a 15 year old runaway, that he called his girlfriend.

Later in June Maria Ward the families social worker alerts police after seeing bruises and scratches on Peter's face and officers interview Peter's mother under caution, once more she blames another child for the marks. In July, lawyers advice Haringey council social workers that they cannot legally take Peter into care. Later on in July Ms Ward makes a pre arranged visit to the families' home and manages to miss injuries as Peter was deliberately covered in chocolate to hide them. Police then hand over further reports to the CPS, including statements from 2 doctors saying that Peter's bruising was suggestive of " non accidental" injury, but prosecutors decide that there is not enough evidence to start a case. On Aug 1st Peter is taken to a child development clinic where the paediatrician decides she cannot carry out a complete check as Peter was miserable and cranky, and on the 2nd Aug police tell Peter's mother she will not be prosecuted. Finally on 3rd Aug a 999 call is made at 11. 36am. Four minutes later the paramedics arrive to find Peter lying in a blood spattered cot. He was pronounced dead on arrival at the hospital. An attempt was made to cover the crime, as Peter's clothes and bedding were removed and dumped.

Baby Peter was failed by police, social workers, doctors and lawyers. Leading to his death.

After his death there was a post mortem where Peter's injuries became apparent, he had swallowed a tooth after being punched, he had a broken back, broken ribs, and mutilated fingertips and had fingernails missing. It is

believed he already had some of these injuries when taken to see the paediatrician for his development check, which would explain why he was miserable and cranky. The police immediately started a murder investigation and arrested his mother. During the murder trial Peter's mother, boyfriend and the boyfriend's brother were all convicted of causing or allowing the death of Peter

The case caused shock and concern among the public and the parliament; this was partly because of the magnitude of Peters injuries. It was found incomprehensible how adults could commit such terrible acts of evil against such an innocent young child and of course they were angry that no one had stepped in to prevent this tragedy from happening. It was also partly because Peter lived in the same borough of London, under the care of the same Child Care authorities that had already failed ten years earlier in the case of Victoria Climbie, this case had already led to a public enquiry into why this had happened and had led to measures being put into place to prevent this happening again, yet it had once more happened again. Peter it seems was failed by police, social workers, doctors, and nurses etc. He had had in total 60 visits from agencies over the 8 months. It was felt that had these people done their jobs properly Peter could have been saved.

There were a lot of questions and concerns raised in this case. Examples of these are – How when Peter's mother named her boyfriend as next of kin, and even told the authorities that she had a boyfriend, yet not once did they ask who he was, ask to meet him or investigate his background, had they done they would have found that he had a ' violent' background. Then there's how the paediatrician Peter was taken to for a developmental check

didn’t spot that Peter had a broken back and neglected to carry out a full check up on the grounds that the child was ‘ miserable and cranky’. Lastly throughout Peter’s ordeal, social workers took a sanguine view of Peter’s injuries. Even when doctors thought that the injuries had been inflicted deliberately, these were ‘ discounted’, and attempts to improve how Peter was looked after with a child protection plan proved useless because the officials refused to challenge Connelly’s failure to follow it.

After the case and the conviction of Peter’s mother, boyfriend and the boyfriend’s brother the secretary of state for children, schools and families, Ed Balls, instructed Ofsted, along with the Healthcare Commission and the chief inspector of the police, to carry out an urgent review of services to children and young people in Haringey, with particular regard to safeguarding, and a joint area review was made. As a consequence of the review, both the leader of Haringey council and the lead member for child services resigned from their jobs. The findings from the inspection leading to the review pointed to a strong weakness in the safeguarding and child protection arrangements in Haringey, and it also showed that the arrangements for leadership and management of safeguarding by the local authorities and its partner agencies in Haringey were insufficient. In light of this it has now been decided that ofsted will carry out annual reviews of the children’s services across the country. This is a small amount of what has been agreed that they need to do – They are trying to improve control of safeguarding arrangements, and establish a better assessment. They are going to use earlier intervention strategies and establish a better system of monitoring the quality of practice.

This case has no alternate/different points of view. The public has shown nothing but dismay and raged over the incompetence of the authorities/services involved. You can see in this report how the case has affected service provisions and methods of working and there has since been progress made, with less cases like this re occurring.