TOWER HAMLETS

Meeting of the

GENERAL PURPOSES COMMITTEE

Thursday, 15 November 2007 at 6.30 p.m.

SUPPLEMENTAL AGENDA

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact:
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Committee:	Date:	Classification:	Report No:	Agenda Item:
General Purposes Committee	15th November 2007	Unrestricted		

Report of:	Title:
Local Safeguarding Children's Board Originating officer(s) **Kevan Collins** **Kamini Rambellas**	**Recommendations from the Review and Evaluation of the Tower Hamlets Safeguarding Children Board** **Wards Affected: (All)**

1. SUMMARY

1.1 The Local Safeguarding Children Board (LSCB) is a statutory requirement established through the Children Act (2004). Safeguarding is a broader concept than that of Child Protection.

1.2 The core objective of the LSCB is set out in section 14 (1) of the Children Act (2004) is as follows:

'To co-ordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area of the authority:

2. RECOMMENDATIONS

The Committee is asked to, note the outcome of the review undertaken and the recommendations arising out of that review with respect to the future functioning of the LSCB.

Local Government Act, 2000 (Section 97)
List of "Background Papers" used in the preparation of this report

Brief description of "back ground papers"	Name and telephone number of holder and address where open to inspection.
Children Act (1989) Children Act (2004) Working Together to Safeguard Children (2006)	Kamini Rambellas – Service Head, Children's Social Care Tel: 020 7364 2213

3. BACKGROUND

3.1 In February 2006 a paper entitled, *'Establishing a Local Safeguarding Children Board in Tower Hamlets', w*as presented to Cabinet recommending that a Local Safeguarding Children Board be established in Tower Hamlets with effect from April 2006.

3.2 The report outlined the proposed structure, governance, and chairing arrangements, and the proposed scrutiny arrangement of the Local Safeguarding Children Board.

3.3 In March 2006 the Director of Research in Practice (RiP) facilitated the first meeting of the Tower Hamlets Safeguarding Children Board.

3.4.1 During its year of inception the Board in line with the work plan has familiarized itself and is satisfied with the current safeguarding systems and structures in place this was achieved by way of report submissions and a presentation.

3.4.2 Below is a list of reports and a presentation submitted to the Board between June 2006 – September 2007: The structure and format of all reports included an introduction, a discussion on issues/information, an analysis of information and data collected, a conclusion and suggested recommendations. This format allowed interaction and discussion to take place between the presenting author/s and members of the board.

- **Co-ordinate local work to safeguard and protect children**

  Three reports were presented to the board:
  1. A review of arrangements for resolving differences of opinion among professional / A report on procedures and arrangements (June 06)
  2. A review of training and workforce development strategies of agencies, multi-agency training and take up by relevant staff (September 06)
  3. An audit of staff awareness of safeguarding issues (November 06)

- **Ensure recruitment and supervision arrangements provide for safe recruitment for suitable staff**

  One report was submitted under this heading:
  1. A report on practice across agencies – to ensure safe recruitment and supervision of staff working with children **(**June 06)

- **Scrutinize practice by considering thresholds operating for response to allegations of abuse or neglect, thresholds for inclusion on the child protection register, thresholds operation when accessing family support or children in need services.**

  Five reports and one presentation focusing on thresholds with regards to specific service areas were presented in January 2007:

  1. Report on thresholds for inclusion on the Child Protection register
  2. Report on the support available to children and families living with Domestic Violence and comment on interagency working / Report on Housing support to families facing Domestic Violence
  3. Report on planning groups working on strategies to respond to Domestic Violence
  4. Report on response to A&E Departments to young people who self harm
  5. Report on Children at risk living with a parent with a mental health problem
  6. In addition the Board received an early intervention presentation(July07)

- **Scrutinize practice in relation to vulnerable groups of children in need of protection**

  Five reports were presented to the Board with regards to practice in relation to children in need of protection:
  1. Ensure services address the ECM 5 outcomes when working with children/ Report on the outcomes for vulnerable children (March 07)
  2. Report on the outcomes and safeguards in place for looked after children (March 07)
  3. Review support to Privately fostered children / CSCI report (June 06)
  4. Review on protocols for joined up working with services for adults with disability or mental health needs. (March 07)
  5. Report on support and safeguards to children in custody (November 06)

- **Scrutinize practice in relation to safeguarding all children in relation to targeted groups**

  Four reports were submitted to the Board:
  1. Report on action to help children keep safe and feel safe – Report on Bullying (June 06)
  2. Report on activities in local communities to help children keep sage on estates and on routes to school (September 06)
  3. Report on MAPPA arrangements and activities (September 06)
  4. Report on management of young offenders who pose a risk to children (September 06)

- **Contribute to planning by scrutinizing work of other local planning groups to promote and safeguard protection of children**

  A review of the Children and Young Peoples Plan (CYPP) was undertaken to address the above (June 06)

- **Scrutinise arrangements for families who move between Authorities**

  Three reports were submitted to the Board:
  1. Report on arrangements across agencies for children including those on the CP register (September 06)
  2. Report on arrangements and activity for children missing from school (September 06)
  3. Report on arrangements for children missing from Care (September06)

- **Put in place arrangements to receive information about child deaths in the area. Consider how unexpected deaths can be reduced**

  Two reports were presented:
  1. Report on child deaths and analysis of contributory factors (May 07)
  2. Report on the role of the LSCB with regards to Serious Case Reviews (SCR) (May 07)
  3. In addition, LSCB heard presentations on two SCR overview reports (July 07)

- **Consider the views of children and families and the public about safeguarding and protection issues in the Borough**

  Two reports were presented:
  1. A report on current activities regarding public awareness of safeguarding and protection issues (September 06)
  2. Report on views of children and families currently available and proposals for extending consultation (September 06)

- **Review and evaluate the effectiveness of the LSCB**

  An external evaluation and review of the Tower Hamlets Local Children Safeguarding Board was carried in March 2007. The Conclusion and recommendations form part of this report.

In addition the minutes of the LSCB have been submitted as part of the APA 2007/8 evidence dataset.

3.5 In March 2007 Research in Practice (RiP) was commissioned by Tower Hamlets Local Safeguarding Board to undertake a review and evaluation of the effectiveness of the Board following its first year of operation.

3.6 This paper highlights the review process; the findings and seven recommendations put forward by RiP. This paper will advise LSCB members of changes to take place in light of the review.

4. BODY OF REPORT

4.1 The Review Process:

4.2 Consultation took place in the form of a series of meetings between January 2007 and March 2007. It was agreed that the method of evaluation take the form of a paper review within a five day framework.

4.3 It was agreed that RiP would review and evaluate:

- Tower Hamlets' LSCB outputs to date
- The structure of the Tower Hamlets' LSCB
- The LSCB fitness for purpose in light of DfES guidance on roles and responsibilities
- Produce a report to include recommendations on the structure and areas for further developments and future evaluations.

4.4. Analysis of information/data (taken from the RiP evaluation report)

The LSCB should consider reviewing the Terms of Reference (TOR). LSCB should set out the TOR together with a vision statement or values and principles together with the structure and work plan

4.5 Further clarity is needed about the ways in which the LSCB links with and works with Tower Hamlets Partnership and there needs to be clearer evidence of the link between the CYPP and the activities of the LSCB

4.6 The Board should consider whether they should have representative from Adult Social Care / Adult Drug and Alcohol Services, Schools and Service for Children with Disabilities.

4.7 The LSCB has been defined as both strategic and operational, therefore it is appropriate for the Strategic Board to have an operational group to coordinate the operational day to day business of the Board and consideration should be given to establish an Executive group.

4.8 Attention needs to be paid to the administrative support for the main LSCB meetings. The minutes of the meetings need to show clearly the decisions that have been made, any action agreed on and the details of who is responsible for carrying out the actions and any date for further review of the issue

4.9 It would be helpful if the work plan were to set out clearly stating the objectives, key activities person/group responsible, timescale and desired outcomes. Clearly measurable outcomes would assist the LSCB in the task of conducting an annual evaluation. It would be helpful if the subgroups had similar work plans which were clearly linked to the overall work plan of the LSCB

4.10 The review identified the need to develop a communication strategy. The development of a web based resource about the Tower Hamlets LSCB and Safeguarding and promoting welfare would be useful to the public and practitioners/professionals.

5. Recommendations/Summary **(taken from the RiP evaluation report)**

5.1 **Constitution** – to consider adopting a constitution that provides greater clarity around the roles, responsibility and accountability of the LSCB.

5.2 **Structure** – to review the structure of the Board and establish an executive board with the Chairs of all Sub Groups reporting to it.

5.3 Tower Hamlets Safeguarding Children Board has agreed to form a local Overview Child Death Panel which will be operating by April 2008.

5.4 **Membership** – to review whether there are sufficient link with adult social care and adult health services (especially substance misuse, mental health and learning difficulties), schools and groups working with disabled children

6. Strategic Plan

6.1 **Work plan** – to review the structure and content of the work plan to provide greater clarity about the work to be done and what has been achieved. More attention is needed to specifying objectives/actions,
lead officer/sub group date of completion and successful outcomes

6.2 **Admin support, finance and other arrangements –** to review the administrative support and other arrangements for the Board and its sub-group so that (a) there is sufficient administrative capacity, (b) minutes of meetings record more clearly the decisions taken, the action agreed, the person responsible for agreed actions and the timescale for agreeing the action and (c)

there is greater congruence between the minutes, the schedule of reports submitted to the Board and the Board work plans.

6.3 **Communication** – To increase understanding of the role and work of the Board and how the work relates to its overall objectives. To make that information easily accessible on the website for the benefit of the public, Board members and relevant agencies

6.4 **Management Information** – To consider using a recording and management information system that would enable all agencies working with children and families to adopt a similar approach to considering and recording information on the needs of the children and families they are working with, realistic outcomes to be achieved in light of the needs identified and available resources to meet them; and the extent to which the outcomes have been achieved. To link this work with the implementation of the Common Assessment Framework (CAF), and the development of a performance management framework by the Performance and Quality committee.

6.5 **Access to Services** – to widen the Board's objectives of ensuring children are safe from significant harm. To do this by monitoring whether families can access preventative and early intervention support as well as services for higher levels of need, with a view to ensuring that support is available at the earliest possible stage.

6.6 **Action**

On 20th March 2007 LSCB members agreed with the recommendations presented and concluded that the tangible aspects arising from the event should be consulted on and developed.

7. COMMENTS OF THE CHIEF FINANCIAL OFFICER

7.1 This report requests the committee to the recommendations and areas of future development of the Tower Hamlets Safeguarding Children Board.

In 2007-08 the Directorate is in receipt of the Children's Services Grant, a specific formula grant utilised to fund additional statutory activities under the Every Child Matters agenda and part of which is earmarked for the further development of the role of Local Safeguarding Children Boards and to support the establishment of new child death review processes.

From 2008-09, this grant is be delivered via the Revenue Support Grant and the Directorate has requested growth in the 2008-09 Budget preparation process to continue developing the role of THSCB as set out in the recommendations.

8. CONCURRENT REPORT OF THE ASSISTANT CHIEF EXECUTIVE (LEGAL)

The Local Safeguarding Children Board is a Statutory Board required to be established by the Children's Services Authority, pursuant to section13 (1) of the Children Act (2004).

A Local safeguarding Children Board shall have as its objective

> *a)To Coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of the children in the area of the authority by which it is established; and*
> *b) to ensure the effectiveness of what is done by each person or body for these purposes*

A Local safeguarding Children Board shall have such functions in carrying out its objectives as the secretary of state may by regulations prescribe. These functions have been set out at regulation 5 of the Local Safeguarding children's Boards Regulation (2006).

The Tower Hamlets Safeguarding Children Board was established by the Children's Services Authority, to operate from April 2006. Having established the Safeguarding Children's Board the Children's services Authority is required pursuant to Section 13(7) Children Act (2004) to co-operate with each of their board partners in the operation of the Board.

Local Authority elected members retain no operational control over the Local Safeguarding Children Board. Their role, as set out in Working Together to Safeguard Children; through their membership of governance bodies such as the cabinet of the LA or as scrutiny committee or a governance board, is to hold their organisation and it's officers to account for their contribution to the effective functioning of the LSCB.

The Tower Hamlets Safeguarding Children Board, having commissioned a review of their procedures has considered and accepted the recommendations of that review, as set out in the report. Those recommendations are in accord with the functions and objectives of the Safeguarding Children's Board as set out above.

It is appropriate that the committee be aware of these recommendations.

9. EQUAL OPPORTUNITIES IMPLICATIONS

None

10. ANTI-POVERTY IMPLICATIONS

None

11. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

None

12. RISK MANAGEMENT IMPLICATIONS

None

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Committee:	Date:	Classification:	Report No:	Agenda Item:
General Purposes Committee	15th November 2007	Unrestricted		

Report of:	Title:
Local Safeguarding Children's Board	Serious Case Reviews
Originating officer(s) Kevan Collins Kamini Rambellas	**Wards Affected: (All)**

1. SUMMARY

1.1 The Local Safeguarding Children's Board has undertaken two Serious Case Reviews in 2007. These were reported to the LSCB in September 2007 and it was agreed that the Executive Summaries of both Reviews should be reported to Councillors.

2. RECOMMENDATIONS

The Committee is asked to note the content of this report and the executive summaries attached which include recommendations as appropriate to the cases.

2.1 In accordance with Working Together to Safeguard Children (2006),the Local Safeguarding Children's Board will oversee the implementation of the action plan in respect to these reports.

Local Government Act, 2000 (Section 97)
List of "Background Papers" used in the preparation of this report

Brief description of "back ground papers"	Name and telephone number of holder and address where open to inspection.
Children Act (1989) Children Act (2004) Working Together to Safeguard Children (2006)	Kamini Rambellas – Service Head, Children's Social Care Tel: 020 7364 2213

3. BACKGROUND

3.1 Serious Case Reviews:

3.2 When a child dies, and abuse or neglect is known or suspected to be a factor in the death, the Local Safeguarding Children's Board is required to consider whether there are any lessons to be learnt about the ways in which they work together to safeguard and promote the welfare of children. Consequently, when a child dies in such circumstances, the LSCB must always conduct a serious case review into the involvement with the child and family of organisations and professionals. LSCB's are also required to consider whether a serious case review should be conducted where:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
- a child has been subjected to particularly serious sexual abuse; or
- a parent has been murdered and a homicide review is being initiated; or
- a child has been killed by a parent with a mental illness; or
- the case gives rise to concerns about inter-agency working to protect children from harm.

3.3 The purpose of serious case reviews:

- establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
- as a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

3.4 The LSCB must first decide whether or not a case should be the subject of a serious case review, applying the criteria as set out in Working Together. In making this decision where a child has died the LSCB is required to draw on information available from the professionals involved in reviewing the child's death. A Serious Case Review Panel is established involving at least LA

children's social care, health, education and the police, to consider questions such as whether a serious case review should take place.

3.5 Each relevant service is first required to undertake a separate management review of its involvement with the children and family. Relevant independent professionals contribute reports of their involvement. Designated professionals review and evaluate the practice of all involved health professionals and providers with the PCT area. This can involve reviewing the involvement of individual practitioners and Trusts, and advising named professionals and managers who are compiling reports for the review.

3.6 The LSCB then commissions an overview report that brings together and analyses the findings of the various reports from organisations and others, and that makes recommendations for future action. In both cases, independent experts were commissioned to undertake the overview reports and executive summaries.

3.7 In all cases, the LSCB overview report should contain an executive summary that will be made public and that includes, as a minimum, information about the review process, key issues arising from the case and the recommendations that have been made.

4. BODY OF REPORT

41. The first serious case review concerns the case of M. M first became known to Social Services when he was just 14 months old in early 1993.The local authority and other statutory agencies have remained significantly involved with M and his family since that time. M name was placed on the child protection register on two occasions, the latter period of registration lasting several years.

4.2 M was placed in a residential boarding school setting in 2000, this placement was on a voluntary basis, with M's mothers agreement and S20 of the Children Act (1989). The local authority initiated care proceedings in March 2003 with a plan at that time to seek a Care Order in respect of M .However the proceedings concluded in June 2004 in the making of a Supervision Order for 12 months, M remained accommodated, having moved, in 2003, to a different residential school. M continued to have high levels of overnight contact with his family throughout his placements.

4.3 M is currently sentenced to an indeterminate period of imprisonment under Section 226 Criminal Justice Act following his conviction on 18.01.07 for rape and assault on a child.

4.4 As a consequence of this the LSCB decided to ask each agency involved to undertake a review of its involvement. It was subsequently decided in discussion

with the Commission for Social Care Inspection to undertake a serious case review. The Executive Summary of this review is attached (Appendix 1)

4.5 The second serious case review concerns the case of baby E. E had been know to the local authority and other statutory agencies since her birth in September 2006.She died aged 6 months in February 2007. Her body was found with that of her mother and father in the flat that she lived in with her mother

4.6 Because of a previous incident of domestic violence, her father was meant not to know where the family lived - but had resumed his relationship with the mother and been in contact with the family unknown to any member of the professional network for about two months. It is believed that E's father stabbed her mother and then took an accidental Methadone overdose. Both parents died in the flat and E died of dehydration after the death of both of the adults.

4.7 E's mother had two children by a previous relationship, looked after by the children's grandmother, subject to a residence order having previously been on the Child Protection Register in 2 different authorities

4.8 She and E's father had presented as Methadone addicts while she was pregnant and had been worked with by:

- health services
- social services – as a child in need
- police – following a serious incident of domestic violence when E was 2 months old
- substance misuse services – managed within a mental health trust
- another children's services authority

4.9 The LSCB convened its Serious Case Review group on February 27th 2007 and decided to undertake a Serious Case Review with immediate effect. The Executive Summary of this review is attached (Appendix 2).

5. COMMENTS OF THE CHIEF FINANCIAL OFFICER

5.1 This report requests the committee to note the content of the Serious Case review executive summaries and the consequent recommendations.

The majority of the recommendations relate to adhering to existing good practice and can be achieved within the existing resources of the Children's Social Care Budgets. In respect of developing a unified approach to the issue of training and support of Social Workers, in 2007-08 the Directorate is in receipt of the Children's Services Grant, a specific formula grant utilised to fund additional activities under the Every Child Matters agenda and part of which is earmarked for the further development of the Children's Services Workforce.

From 2008-09, this grant is be delivered via the Revenue Support Grant and the Directorate has requested growth in the 2008-09 Budget preparation process to continue developing the specific training as set out in the recommendations.

6. CONCURRENT REPORT OF THE ASSISTANT CHIEF EXECUTIVE (LEGAL)

6.1 Pursuant to Regulation 5 (3) of the Local Safeguarding Children Boards Regulation (2006), The Local Safeguarding Children Board has responsibility for undertaking reviews of serious cases and advising the authority and their board partners on lessons to be learned.

Reviews have been carried out in relation to two cases by the Local Safeguarding Children's Board.

The executive summaries of those overview reports, are, having been suitably anonymised, required to be made public pursuant to Working Together to Safeguard Children.

7. EQUAL OPPORTUNITIES IMPLICATIONS

7.1 None

8. ANTI-POVERTY IMPLICATIONS

None

9. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

Not applicable

10. RISK MANAGEMENT IMPLICATIONS

None

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Tower Hamlets Local Safeguarding Children Board

Executive Summary of the Serious Case Review into the services provided for the infant 'E' and her family during the period December 2005 – February 2007

Prepared for Tower Hamlets LSCB

by Keith Ibbetson July 2007

Executive Summary of the Serious Case Review into the services provided for young person 'E' and her family during the period December 2005 – February 2007

PREFACE

This report is the Executive Summary of the overview report containing the findings of the Serious Case Review (SCR) conducted by Tower Hamlets Local Safeguarding Children Board (LSCB).

The LSCB SCR draws on the findings of individual management reviews conducted within all of the agencies who provided services for 'E' and her family and the Serious Untoward Incident Investigations carried out by NHS Trusts.

This summary contains the following:

1. An overview of the circumstances leading to the death of 'E' and the decision to establish the SCR.

2. The terms of reference of the review

3. A list of the agencies involved

4. A list of key events

5. An evaluation of the services provided and the main findings of the review

6. A summary of the recommendations made by the individual management reviews and the LSCB.

The recommendations are set out in detail in an action plan. The LSCB is responsible for ensuring that they are implemented by the agencies concerned and by the board itself.

Copies of the SCR overview report and supporting documents are submitted to central government bodies for scrutiny.

1 INTRODUCTION

1.1 This report was produced by Tower Hamlets Safeguarding Children Board (THSCB) in order to fulfil the requirements of Chapter 8 of the *Working Together* guidance.[1] This guidance sets out the arrangements for the local inter-agency review of child protection cases where a child has died and abuse or neglect is considered to be a factor in the death and there are important lessons for the local network of agencies with child protection responsibilities. The detailed current arrangements for review of cases by authorities in London are contained in the London Child Protection Procedures.

1.2 The purpose of the report is to review the involvement of agencies with the child 'E' and her family and to highlight any significant findings with the objective of improving local child protection practice. This is the LSCB overview report on the case which is designed to summarise and complement the findings of the individual agency management reviews.

1.3 The review concerns 'E' who was born on 11 September 2006 and died at a time which cannot be determined precisely in the days prior to 19 February 2007.

1.4 E was found dead along with her mother (a woman aged 29 of Irish traveller background) and her father (a man of 49 of black Caribbean background) in her mother's flat in East London on 19 February 2007. At that time 'E' was living with her mother who had been re-housed separately from E's father following a reported incident of domestic violence in November 2006. She had told professionals that she was having no contact with him. On the morning of 19 February a local authority social worker attempted to visit 'E' and her mother at the flat. There was no reply but there were lights on and the flat appeared to be occupied. The social worker called the police who later forced entry to the flat and found three bodies.

1.5 The post mortem findings were that E's mother had suffered multiple wounds to the chest and neck and that there were minor defence wounds on her left hand. This was clearly consistent with a very violent stabbing and the Coroner's inquest found that she had been unlawfully killed. E's father's body was also found in the flat. Blood stained clothes were found in the flat and small traces of E's mother's blood was found on the body of her father. He had changed his clothes and appeared to have made some attempt to clean up the flat. No external injuries were noted but preliminary findings suggest that E's father had died of a drug overdose. The inquest in relation to his death is still to be held so the cause of death remains to be determined.

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v Department of Health, Home Office, Welsh Office, Department for Education and Employment, *Working Together to safeguard children*,*2006*

1.6 E had no external injuries. The inquest determined that her cause of death was dehydatration, caused by the fact that no one cared for her after her mother had been unlawfully killed.

1.7 Very little is known about the contact which had taken place between E's mother and father in the days before the deaths. From evidence given to the Coroner's inquest it is clear that text messages were sent between them over some period of time and that they had resumed a relationship. It is not possible to know how long this contact had lasted because of technical difficulties with the mobile phones used. However it is clear that it had included a period when E's mother had told her social worker and a police officer that she was not having contact with E's father.

2 SCOPE, FOCUS AND TERMS OF REFERENCE OF THE REVIEW

2.1 The *Working Together* guidance makes the Local Safeguarding Children Board responsible for determining the scope and terms of reference of the review in the light of the circumstances of the particular case. At its meeting on 27 February the LSCB serious cases subcommittee agreed that each agency would provide a chronology of its involvement and a management review detailing the period from its first contact with E's mother in Tower Hamlets. The social services review would also take into account the involvement which other authorities had had with E's mother, prior to her moving to live in Tower Hamlets.

2.2 The LSCB agreed that the terms of reference for the SCR would follow those set out in the London child protection procedures as follows:

- to draw together a full picture of the services provided for 'E' and her family;
- to establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children
- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and hence improve inter-agency working and better safeguard children

2.3 The review is not an enquiry into the circumstances or causes of E's death. Although the SCR panel has some information on this, determining the cause of those events has been the focus of police investigations and a coroner's inquest. The task of the report is to examine in detail the planning, co-ordination and delivery of services provided to E, her mother Ms 'E' and the other members of the family. Its responsibility is to determine whether everything that could reasonably have been done was done to minimise risk to 'E' - regardless of the specific circumstances in which she died.

3 AGENCIES INVOLVED

3.1 The following agencies (located in Tower Hamlets or members of Tower Hamlet's Safeguarding Children Board) provided services to 'E' and her family within the period covered by the review and have provided reports:

- Tower Hamlets Council Children's Social Services
- Tower Hamlets Council Adults' Social Services
- Tower Hamlets Primary Care Trust
- Barts and the London NHS Trust
- East London and the City University NHS Mental Health Care Trust (ELCMHT)
- Metropolitan Police Service
- Tower Hamlets Council Homeless Persons Services

Social work services for children and families at the Royal London Hospital are provided and managed by Tower Hamlets Council.

3.2 The following agencies from outside Tower Hamlets were also involved and have provided reports or information for the review:

- Camden Primary Care Trust
- Harrow Children's Social Care – who were involved with the half brothers of 'E' who live in Harrow
- Hertfordshire Children, Schools and Families
- Hackney Children's Services – which provides the social work service at the Homerton Hospital
- Sure Start Children's centres in Tower Hamlets

3.3 Prior to the birth of 'E' her mother received services from Addaction, a voluntary organisation commissioned by Tower Hamlets Drug Action Team providing community drugs treatment.

4 OVERALL EVALUATION OF THE SERVICES PROVIDED FOR 'E' AND HER FAMILY

Introduction

This section provides an overview of the principal findings of the Serious Case Review (SCR) in relation to the standards of practice and the services provided for 'E' and her family. It deals with events from the perspective of the

overall provision and co-ordination of services. It must be considered in addition to the more detailed comments on practice set out in individual agency management reviews.

The SCR addresses three overall tasks.

a) The first of is to establish whether there is evidence that the deaths could have been prevented by different professional action? This is not the principal task of the SCR but in a case such as this it is clearly a matter of legitimate public interest that this should be fully evaluated.

b) The second is to establish whether the services to 'E' and her family met the professional standards that should have been expected.

c) The third is to establish what lessons must be learnt from this case so that services can be improved in future and to make relevant practical recommendations so that this can happen.

Could the deaths have been prevented by different professional action?

There have been extensive police enquiries into the deaths of 'E', 'M' and PF. Coroner's inquests have now been concluded in relation to the deaths of 'E' and M. The inquest into the death of PF will be held at a later date. As a result of the police enquiries and the evidence presented at the inquest, some basic facts are known about the deaths. The following are judged to be relevant to this question:

- The verdict of the inquest was that 'E' died of neglect as a result of the unlawful killing of her mother

- It is almost certain that PF killed E's mother and therefore was indirectly responsible for E's death - though no specific finding was made at the inquest on this, no other line of police investigation is being followed.

- The precise causes of PF's death are yet to be determined, but all the indications are that he caused it himself through a drug overdose.

- The review has no evidence at all about PF's motivation or the reasons for his actions.

Very little is presently known about the events which led up to the deaths and as both the key participants are dead these may never be fully understood. In particular:

- It is not clear what contact there was between PF and 'M' from the end of November 2006 onwards when she was moved to new accommodation as a result of her report of domestic violence

- It is known that text messages were exchanged between the two from 18 December onwards

- It is not clear when face to face contact between the couple resumed and how often the couple were in contact

- It is not clear if the contact was with the agreement of both parties or if the contact was coerced or motivated by the need for drugs, money or some other factor.

As there had been contact between the couple as early as 18 December it is clear that 'M' deceived professionals about this because she stated on a number of occasions to the police and her social worker that there was no current contact. Her reasons for lying are impossible to establish.

There is no evidence whatsoever that any of the professionals working with 'E' and her mother knew that her parents were having contact. It is clear that had either the police or children's social services known that E's parents were back in contact with one another they would have been required to respond to protect 'E' and her mother. Exactly what they would have done would have depended on the circumstances but taking into account the swift action that was taken in November to protect 'E' and her mother after the first allegation of domestic violence, it seems almost certain that the immediate response would have been an appropriate.

'E' died because she was in her mother's care at the time of her death and was not looked after following her mother's killing. Professional intervention could only have prevented E's death if she had already been removed from her mother's care before she was murdered. The SCR panel found that even taking into account all the information available now, the SCR found no instance of any failure on the part of 'M' herself to care properly for 'E'. There would have been no grounds to remove 'E' from her mother's care. The panel of course recognised that 'M' exposed her daughter to risk from PF by allowing contact, but it is clear that 'M' and PF deliberately hid this contact from all the professionals dealing with them.

Given all the circumstances described above it is clear that key events leading to E's death took place outside of the knowledge and control of professionals working with the family. The SCR panel therefore does not believe that the deaths would have been prevented by different professional action.

Did the services provided to 'E' and her family meet the standards that should have been expected? What lessons must be learnt from this case so that services can be improved in future?

The task of the SCR is to form a full and balanced overview of the involvement of professionals with the family so as to establish how services need to be improved in the future.

Many of the services which 'E' and her mother needed to meet their needs were provided in an effective and professional fashion. For example:

- the care provided by hospital antenatal services

- the services provided by midwives and health visitors in the community
- health care offered when ‘E’ suffered routine childhood illnesses
- the assessment of M’s history of drug misuse and the provision of basic treatment for her drug misuse
- the response of her social workers and the police service when ‘M’ alleged that she had been the victim of threats and a very serious assault in November 2006
- the steps provided to assess and meet the family’s housing need.

However taking into account all of the information available to it, the shared view of the SCR panel is that there were a number of points when professionals involved should have responded differently and provided a more effective service. Taking the overall pattern of events, these points usually occurred when the professionals involved failed to:

- take a full account of the complex history of the case,
- scratch beneath the surface of the initial positive presentation of events or
- work effectively across agency boundaries both within children’s services and between services for children and services for adults.

The SCR panel believes that different action at these points would have led to a far better shared understanding of the needs of ‘E’ and the risks that she might face and a better co-ordinated and more active intervention to safeguard and promote her welfare. These themes and the specific points in the case history are discussed in more detail in the paragraphs which follow.

Specific comments on practice and professional standards

1. Relevant background family information was not sufficiently taken into account when the main decisions and plans about E’s level of need were made. These relied too heavily on the favourable current impression made by her parents.

2. Social services did not share sufficient information about E’s mother’s parenting of her older children with other agencies. The assessment and plan were made by social services and agreed with the family before the main background information had been obtained from Harrow – an authority that knew E’s mother well - or there had been proper discussion with other agencies.

3. It was known that E’s father was using a false identity but this was not fully investigated, although this was said to have been the source of conflict between E’s parents.

4. The following agencies were involved in providing services during E’s

mother's pregnancy:

- Hospital social work team
- Adults social services care manager
- Specialist Addiction Unit
- Specialist Midwife Substance Misuse
- Health visiting service

Although the correct referrals were made from one team or service to another, there was insufficient co-ordinated assessment and planning. There was very little information sharing after the initial referrals and no meeting was co-ordinated until a few days before E's birth. No active consideration was given to convening a pre-birth child protection conference. The timing of the pre-birth strategy meeting was outside that required by the child protection procedures and because it was so soon before E's birth it could not significantly influence decision making.

5. Adult drug services made no substantial input into planning and decision making prior to E's birth.

6. Key professionals were absent when the strategy meeting was held.

7. Although individual workers offered a high level of service after 'E' was discharged from hospital, the level of communication between agencies was low and both of the allocated social workers failed to coordinate the input of the agencies involved. The supervisors responsible for the two social workers failed to ensure that they carried out this responsibility.

8. Given that it concerned a vulnerable new born infant, the parenting assessment at the Tower Hamlets Family Centre received too low a priority.

9. There was considerable confusion in the professional network (and on the Tower Hamlets records) about who the new social worker was. There is no evidence that the details of the transfer arrangements were notified to professionals who should have known.

10. The immediate response to the report of domestic violence on 29 November was appropriate and all of the agencies involved worked together effectively to provide immediate protection. However the longer term follow up failed to recognise that 'E' might be at a higher level of risk and to ensure that there was enough communication between all the agencies involved over this. The gravity of the attack and the fact that E's mother had not reported it for over three weeks should have caused a re-evaluation of the level of risk to 'E'. There

should have been at least a strategy meeting to consider the incident and its implications in detail.

11. Even after the first incident of domestic violence, the social worker from the Family Support and Child Protection Team took no responsibility for ensuring the overall co-ordination of service provision for 'E'. There is no written record of a plan of intervention to indicate what level of contact there should have been and what the purpose of the intervention was. The activity of the social worker seems to have been entirely a response to events as they unfolded.

12. The social worker had only four face to face contacts with E's mother and 'E' between 24 November and 19 February. Given the circumstances this was too few.

13. Throughout the period when 'E' was living in the community, agencies worked in isolation from one another. There is no evidence of collective working towards shared objectives. In the case of the health service, this meant that the case was treated as a reasonably 'routine' one, because the mother was meeting her daughter's needs and attending appointments as required. In the case of the adult drug agencies it meant that treatment for drug problems was being provided with insufficient reference to the input from social services, so there was no systematic way of sharing information about important developments. Adult social services were only seen as being involved as potential funders of a drug rehabilitation service.

14. When 'E' and her mother were moved back to Tower Hamlets from the hotel in Hackney, there was no consultation about where to rehouse her. Once the move had taken place and the social worker had been informed there was no strategy to ensure that all the key professionals knew about the change of address.

15. No one in the professional network really knew E's mother well or anything about her social network. It is striking that there is no information whatsoever about how and with whom E's mother was planning to spend the Christmas period.

16. When she was admitted to the Royal London Hospital on 15 January the admission appears to have been treated routinely and no information about it was passed to social services staff, even within the hospital.

A number of more general themes emerged throughout the case:

17. All the professionals dealing with E's mother took almost everything she said at face value, seldom challenged it or took the opportunity to verify it with other professionals or the records.

18. There were a number of examples of professionals not being clear what information they were entitled to share or taking a very long time

to share information that should have been provided routinely. For example:

- between hospital social services and housing
- between the SAU and social services
- between social services and health agencies

19. Some professionals paid little attention to the baby and the interactions between the parents and the baby. In particular:

    - It is often unclear from the SAU chronology whether the baby was with E's mother during her appointments and if not where she was
    - The family support and protection team social worker rarely comments on the child's health, development or on interaction with the parents.

20. The quality of record keeping in a number of agencies was below the standard required. The majority of the agency management reviews have noted instances in which key events, important decisions and the reasons for them or key conversations with service users or other professionals were not recorded.

21. Harrow Children's Social Care were providing services to E's half brothers. There were a number of occasions in the case history when the contact between E, her mother and her sons had implications for the wellbeing of both sets of children. It should have been obvious to social workers in both boroughs and their seniors that regular communication between the two social workers involved was necessary and all parties should have taken the initiative to ensure that it happened.

5 RECOMMENDATIONS

The agency management reviews made recommendations for action in the following areas:

Metropolitan Police Service (MPS)

The report sets out the steps which have been taken to ensure that specific local errors and deviations from established practice are not repeated and the discussions which have taken place with the officers and staff concerned. It makes a specific recommendation in relation to procedures in relation to the management of abandoned calls from mobile phones.

Tower Hamlets Children's Social Care

The report makes recommendations for action in relation to the following:

- practice in relation to checks made with other agencies
- completion and recording of the core assessment
- recording standards
- assessment of the significance of E's mother's care of her previous children and the evaluation of neglect
- the application of the thresholds for Section 47 child protection enquiries
- practice and management of practice around the birth of 'E' including the strategy and discharge meetings
- handover arrangements to the community based social work team
- the practice in relation the observation of children
- the decision not to complete a parenting assessment
- assessment of domestic violence and the mother's pattern of drug misuse
- use of recording systems

Tower Hamlets Council Adult Social Services

The report makes recommendations for action in relation to:

- involvement of adult services workers in pre-birth assessment and planning or in the hospital discharge arrangements for the infant
- mechanisms to co-ordinate discussions between adults and children's services about the funding of a detox. placement for the mother and her infant
- earlier consideration of joint funding.

Barts and the London NHS Trust (BLT)

The report makes recommendations for action in relation to:

- Training about domestic violence
- Procedures for gathering information about domestic violence
- Child protection training arrangements for all maternity, A&E and paediatric staff including consultants and junior doctors

- Ensuring that there are comprehensive records of child protection training received by all staff
- Management of records of discharge and children in need meetings
- Management of the Gateway Midwifery Team
- Arrangements for paediatric cases to be brought to psycho-social meetings

Tower Hamlets Primary Care Trust (PCT)

The report makes recommendations for action in relation to:

- notification to health visitors when responsibility for a patient changes because of change in GP practice
- arrangements for transfer of records via the child health department
- consistent application of the levels of risk and need set out in current risk assessment and management arrangements
- the need to give specific consideration given to ethnicity in relation to the service provided to members of the traveller community
- response to the history of domestic violence
- communication between health visitors and other agencies particularly drug agencies and social services
- training and supervision of temporary staff
- the need for staff to be proactive in communication with other agencies and to seek updates and review of work where there is known to be multi-agency involvement

East London and The City University Mental Health Trust (ELCMHT)

The report makes recommendations on:

- interagency liaison and information sharing – in particular the lack of engagement with formal interagency child protection procedures.
- quality of recording
- the need to include care of pregnancy within care planning process and documentation in drug services
- the need to ensure that the quality of risk assessments and risk management is subject to regular monitoring and audit

- supervision standards

- the need to ensure the systematic review of caseloads within the Specialist Addictions Service.

- training for staff regarding safeguarding children, domestic violence and vulnerable adults

- the need for a shared care protocol within the Specialist Addictions Service for the care of pregnant women who substance misuse.

- the need for a Domestic Abuse Strategy within the ELCMHT.

Tower Hamlets Council Homeless and Housing Advisory Service (HHAS)

The report makes recommendations on:

- the need for more extensive consultation with other agencies when making decisions about very vulnerable clients

- the need to clarify the role of the Homelessness Social Work Service which is already part of HHAS.

Additional Serious Cases Review Panel recommendations

The LSCB is recommended to make copies of the overview report available to both the Tower Hamlets Drugs Action Team and the Tower Hamlets Domestic Violence Forum so that they can consider what action to take in the light of the findings.

The LSCB was asked to consider how to secure a better understanding of domestic violence and drug misuse in services to safeguard children in Tower Hamlets, including reviewing the membership arrangements of the LSCB to include those with expertise in these fields.

The SCR panel also made recommendations in the following areas:

- policy, practice and training in relation to domestic violence

- pre-birth assessment of pregnant drug users

- the involvement of parents in assessments, even when they live away form their children

- review of current information sharing protocols and arrangements to ensure that they are effective

- review of procedures for key workers and lead professionals

- notification of other professionals when a member of staff ceases to be involved with a case

- planning and reviewing services for children in need

- the work and practice of Children's Centre and other early years resources when providing services for children in need

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Tower Hamlets Local Safeguarding Children Board

Executive Summary of the Serious Case Review into the services provided to 'M' and his family

Prepared for Tower Hamlets LSCB

by Bernard Monaghan July 2007

1. INTRODUCTION

1.1 This report is an executive summary of the Overview Report of the M Serious Case Review. The review covers the whole of the contact M had with the statutory services. Each agency that had contact with M contributed its own individual report to the case review.

2. BODY OF REPORT

2.1 The first serious case review concerns the case of M. M first became known to Social Services when he was just 14 months old in early 1993.The local authority and other statutory agencies have remained significantly involved with M and his family since that time. M name was placed on the child protection register on two occasions, the latter period of registration lasting several years.

2.2 M was placed in a residential boarding school setting in 2000, this placement was on a voluntary basis, with M's mothers agreement and S20 of the Children Act (1989). The local authority initiated care proceedings in March 2003 with a plan at that time to seek a Care Order in respect of M .However the proceedings concluded in June 2004 in the making of a Supervision Order for 12 months, M remained accommodated, having moved, in 2003, to a different residential school. M continued to have high levels of overnight contact with his family throughout his placements.

2.3 On 22.08.06 the Metropolitan Police arrested M following an allegation of rape and indecent assault of a 7-year-old female child.

M is currently sentenced to an indeterminate period of imprisonment under Section 226 Criminal Justice Act following his conviction on 18.01.07 for rape and assault on a child.

2.4 As a consequence of this the LSCB decided to ask each agency involved to undertake a review of its involvement. It was subsequently decided in discussion with the Commission for Social Care Inspection to undertake a serious case review. The Executive Summary of this review is attached (Appendix 1)

3. SERVICES INVOLVED WITH THE FAMILY

The Metropolitan Police Service.
Tower Hamlets Primary Care Trust.
Barts and The London NHS Trust
Tower Hamlets Children's Services
East London and the City Mental Health NHS Trust
Special Education Needs Service
Educational Psychology Service

Residential Schools
Tower Hamlets and City of London Youth Offending Team.

4. CONTRIBUTORS TO THE REVIEW

The Metropolitan Police Service
Tower Hamlets Primary Care Trust
Barts and the London NHS Trust
Tower Hamlets, Children's Social Care
East London and the City Mental Health NHS Trust
Special Education Needs Service
Educational Psychology Service
Tower Hamlets and City of London Youth Offending Team
Independent Reviewing Officer for the Residential Schools.
Tower Hamlets Legal Services
Educational Psychology Service.

5. TERMS OF REFERENCE

5.1 The terms of reference for the overview report were set out in a letter from the Corporate Director (Children's Services) dated 14.03.2007.

The overview report of the M Serious Case Review will cover the whole of M's contact with the statutory services and in particular cover four specific issues.;
What informed the decision of Children's Social Care to not continue with its application for a care order in respect of M;
What significance did not having a care order have on the conduct of the case;
What risk assessments were made of M's behaviour and how was this risk managed by the services involved;
What risk assessment was made of M's situation prior to the sexual assault.

5.2 The LSCB Serious Case Review Group was composed of representatives, with expertise in the field of child protection, from Tower Hamlets Children's Social Care, the Educational Psychology Service East London and the City Mental Health NHS Trust, The Metropolitan Police Service, Tower Hamlets Primary Care Trust, Barts and The London NHS Trust Maternity Services, Tower Hamlets Council.

5.3 The Overview Report was compiled by Mr. B Monaghan, an independent person with thirty years experience in the field of statutory and voluntary child care.

6. FAMILY MEMBERS

The significant family members in M's life are his Mother, Father and Grandmother.

7. COMMENTS OF THE OVERVIEW REPORT AUTHOR

It needs to be acknowledged that from a young age M was displaying very worrying behaviour. It was and continued to be behaviour that by its nature disturbed and worried the professionals who were involved. As he grew older the behaviour was rightly seen as a threat to himself and to others. It will not be common for child care workers to have to respond to and work with children with these needs. It is unlikely that there will be many colleagues in the team or section who will have had to deal with similar challenges. There are no studies upon which to base population estimates of the prevalence of sexually abusive behaviour, although estimates of officially known cases over a year suggest that about one in1,000 12-17 year-olds is identified as displaying abusive behaviour. (The needs and effective treatment of young people who sexually abuse: current evidence. Sect 2.4.4 DOH and Home Office –October 2006).There was no indication in this case that the workers responsible discussed the case with senior management for advice and direction or were advised to seek a consultation with established experts in the field of young people who sexually abuse. Consideration needs to be given as to how and when experienced advice and expert guidance is provided to child care workers who become responsible for cases where very worrying behaviour is being presented by the child.

The opinions of the two expert witnesses did pose a significant obstacle to the Children's Service workers to establish before the Court that a Care Order was necessary to exercise greater control over the placement and the contact arrangements in this case. The workers appeared to believe, or were advised to believe, that greater weight and more value would be placed on the evidence of the child psychiatrist and the Guardian. This , it appeared to them ,was not to give equal weight to the history of the involvement and the attempts to make a difference over a long period. This may have been another example where workers who perceived their status to be lesser than the "experts" had a reluctance to challenge the opinions of "eminent " practitioners. Training for child protection officers must equip them with the confidence to question the views of professionals in other agencies, including doctors, no matter how eminent those professionals appear to be.) This issue is not only a matter of training but it also impacts on the relationship of authority between Children's Service workers, their middle managers and the legal advisors involved. It may be appropriate for junior officers to know that senior managers are to be

consulted on particularly contentious child care cases where the firm, evidenced views of the workers are challenged by independent experts. Junior officers, in these circumstances, may require wise and experienced assistance to pursue the case in court.

It has been recognised that the desire on the part of Children's Service workers to work in partnership with parents can be prolonged or pursued when there is mounting evidence that it is not meeting the best interests of the child involved in the partnership. This can occur where this particular principle of the Children Act 1989 is given greater attention or prominence than the need to put the interests of the child as the first consideration. The responsible worker has always to bear in mind their statutory and authority role of, primarily, promoting and protecting the interests of the child.

The response of disguised compliance by Mother to the requirements made of her may well have masked the actual contribution she was making to enabling the changes to be made by M in his behaviour. This passive co operation can also make the taking of more robust action more difficult.

The decision to place M in both residential boarding schools was in part to provide him with therapeutic input to help him with his dangerous and his sexualised behaviour. Those involved in finding and choosing these schools thought that the schools would provide this therapy. There did not appear to be any questioning of the value of the therapy provided or whether it was creating change in M's behaviour for the better. The social worker who has to decide on the provision of therapeutic help for a looked after child should have access to expertise that can assist in the evaluation and decision- making about the appropriateness of a particular therapy.

In previous Overview Reports the harmful impact of exposure to domestic violence for children has been discussed and improvements to the services' response to it recommended. A study found that for children who had been abused that exposure to persistent violence within the family may be a particularly important risk factor for them in re- enacting sexually abusive behaviour. (Skuse et al, 1998 Risk factors for development of sexually abusive behaviour in sexually victimised adolescent boys. BMJ 1998;317:175-179)

In October 2006 the Department of Health and Home Office published; *The needs and effective treatment of young people who sexually abuse: current evidence*. This document draws upon various sources in order to provide a base line of evidence on the needs and effective treatment of young people who display sexually abusive behaviour. It is a source of advice to practitioners. It offers opinions on the matters to be considered to develop a strategy for response to similar cases of abusing young people in the future.

There are some forms of behaviour exhibited by a looked after child that is extraordinary in comparison to those of other looked after children. There may be organisations that have developed a well-tried method of responding to these extraordinary needs, but their activities are not well known to fieldworkers because of the specialisation or the narrow field of operation. It would seem beneficial to identify these tested specialist resources either locally, in the Resources Team, or in a regional databank where social workers can gain good quality information to assist them to meet the needs of very challenging children. I understand that work is underway at the Pan-London Contracts Team to provide this type of information.

The document "*The needs and effective treatment of young people who sexually abuse: current evidence*" was not available to assist the workers in this case. It was published after M committed his offences. There is a need to train front line supervisors and their staff about the identification, significant factors and treatment responses for young people who sexually abuse. A similar approach may be of value to these staff for a number of other "extraordinary" behaviours they may encounter with children on their caseloads.

Informing practitioners about developments in child care practice, new approaches to issues developed from research or different treatment methods has proved difficult in the past. The merit of finding a way within a department of ensuring its workforce is informed about recent research and practice findings to enable better informed responses to be made to children's difficulties is worth pursuing.

Consideration needs to be given in the appropriate Assessment Training to cover the issue of assessing any new person who assumes the care of a child for its likely impact and suitability.

The need to identify and respond to depression in new mothers remains important.

There needs to be no unnecessary delay in obtaining expert assessments of worrying behaviour in young children.

Child-care workers responsible for the placement of children need to ensure that units, that claim to provide specialised help or therapy, have competent staff and are equipped to do so. The agencies need to consider how this capacity may be improved and how to best equip their workers responsible for placing children to have the necessary information and expertise to fulfil this requirement.

As part of the allocation process a new worker should be provided with a specific period of time to read and familiarise themselves with the previous history and information on the case file. Managers need to make clear, as part of the allocation process, that the new worker is

given specific time and is expected to read and reflect upon the previous history and activity of the case.

8.0 THE AUTHOR OF THE OVERVIEW REPORT WAS ASKED TO ADDRESS SPECIFIC QUESTIONS IN THE REPORT

8.1 What informed the decision of Children's Social Care to not continue with its application for a care order in respect of M?

8.1.1 The allocated social worker and her managers would have certainly been influenced by the Children's Guardian and the obvious positive reports of the two psychiatrists who provided reports to the court. The allocated social worker, would have been advised by the experienced Counsel engaged by the Local Authority that the conclusions of the Guardian and her interpretation of section 31 together with the no order principle were sound and to which significant weight would be given by the Court. It would seem that the 'positives' in the family identified by the Guardian and the doctors firmly supported the fact that the Local Authority did not need to share parental responsibility for M with his mother. A Supervision Order was felt appropriate in all the circumstances to meet the needs of M. The filed reports of the two psychiatrists and of the Children's Guardian would have formed the basis of the decision not to seek a Care Order but to pursue a Supervision Order.

8.2 What significance did not having a care order have on the conduct of the case?

8.2.1 In response, it is reasonable to put the qualification in that this is a rather hypothetical/theoretical question in that on the evidence before the Court, in June 2004, it would have been highly unlikely that the Court would have granted a Care Order.

It would appear that there were a number of times when Children's Social Care could and should have sought legal action to safeguard M, where clearly the threshold for intervention was met. There are at least two or three references to seeking legal advice in the case recording but with no follow up information as to why action was not taken. It appears that legal advice was sought in 2000 and the threshold was clearly met, but withdrawn as M was placed at Mulberry Bush School under Section 20, with Mother's agreement.

It has to be speculative what difference obtaining a care order would have actually made to the conduct of this case. However, not having a care order meant that all the steps taken had to be by negotiation with and the agreement of Mother. A care order would have enabled the Local Authority to share parental responsibility with Mother and to have had a more robust position from which to decide on the best plan for M. Without the care order it was not possible to assess M away from his

mother and to assess M's relationship with his father whilst he was away from Mother. Also a care order would have meant the Local Authority was better placed to manage M's contact with Mother, as well as with friends and extended family members. Given all the concerns at the end of the 1990's and the fact that M was so young, it was an appropriate time for Children's Social Care to have attempted legal action to provide more control over the decision-making, placement, contact and planning for M.

8.3 What risk assessments were made of M's behaviour and how was this risk managed by the services involved?

8.3.1 M's name was placed on the Child Protection Register for a long period of time and his situation was monitored and reviewed by the requirements of the Child Protection Procedures. As he was on the Register he had an allocated social worker.

8.3.2 It is not apparent from the reports that during the course of the various agencies involvement with M that there was any formal and definitive use made of the tools or methods associated with a risk assessment analysis.
However there were a number of assessments completed over the period which did address the issues of harm to M and the possibilities of him doing harm to others. In January 2000 the Psychotherapist and the social worker's Core Assessment focused upon the need for a therapeutic placement and M was placed in the Mulberry Bush Residential School in June 2000.

8.3.3 In July 2002 the NSPCC Walksafe Project Report was completed and it concluded that; M should be provided with a specialist resource "where education is an integral future of the therapy and also the therapeutic programmes are designed for young people whose behaviour includes that which is sexually harmful."

8.3.4 In December 2002 a Psychiatric Report was completed by Dr A, Specialist Registrar. It recommended that:
That M is placed in a 52 week school placement "while he spends the remaining 4 weeks of the year with his mother spread strategically over the year.
These recommendations were partially implemented. An attempt was made to find a suitable foster carer but it was not achieved. An alternative residential school, Coxlease, was eventually found and M moved into it in June 2003. A decision was made to commence care proceedings. A thorough assessment of the role and contribution of M's mother was not carried out.

8.3.5 In April 2004 in preparation for the care proceedings Dr M, Specialist Registrar completed a report and concluded, among other matters that, according to family & school there was no evidence of sexually harmful behaviour, therefore the risk is reduced. M was supervised

appropriately & Mother was able to deal with situations that might put M or others at risk.
It was on the strength of this report, an adult psychiatrist report on Mother' s mental health and the lack of support for the care order from the Guardian, that the Children's Social Care workers decided to change their application to the Court from a Care Order to that of a Supervision Order.

8.3.6 In March 2005 a report was completed by the Wessex Youth Offending Team and M was assessed as high risk of re-offending and a high risk to the community. M described as impulsive and admits to having a temper, displays sexualised behaviour, although attendance at Coxlease believed to have reduced this, but if the placement were to break down then the risk would be increased, as well as the periods that M is at home this risk would be increased. Coxlease assessed as the best provider to assist M with his problems.

8.3.7 This is the one report that identifies the high risk nature of M's behaviour
towards others. It also indicates that the risk is greater when he is at home. The full extent of this assessment of the risks he posed do not appear to have been carried forward to guide or inform the manner of the arrangements to be put in place for M's periods at home.

8.4 What risk assessment was made of M's situation prior to the sexual assault?

8.4.1 There was no formal risk assessment exercise undertaken by any of the professionals involved with M in spite of the concerns that applied in the summer of 2006 before M had his contact periods at home. There did not seem to be the knowledge or the expertise among the staff involved to inform or alert them to the need for a formal risk assessment to be conducted. It is possible that the lack of a Care Order meant that the social worker considered that she had to continue to work in partnership with Mother and when told by her that M was staying with Ms P felt she could only respond by saying that she did not approve. On a visit to Mother on 04.10.02 the social worker was told that all the friends knew about M's behaviour and ensured their children were supervised. But given the sense of the unreliability of Mother that was present on the home visit on 11.08.06 a telephone call would have been desirable to have been made to Ms P to ensure she was still aware of the risks.

9.0 INDIVIDUAL AGENCY RECOMMENDATIONS

9.1 Tower Hamlets Children's Social Care

9.1.1 Children's Social Care need to develop a unified approach to the issue of training and support of Social Workers in the complex area of

working with Children and Young People who exhibit sexual harmful behaviour.

9.1.2 Children's Social Care need to consider a revision to the recording policy to include advice about the frequency of updating a core assessment, guidelines about chronologies and transfer summaries.

9.2 **Barts and the London Health Trust**.

9.2.1 BLT to undertake an audit within Paediatric Outpatients Department to: Ascertain current practice as to whether information/action on DNA's (did not attend) is routinely shared with other professionals and action taken when appropriate.

Assess in relation to record keeping whether changes in appointment reflect the reasons for change/cancellation of appointment.

9.3 Tower Hamlets Primary Care Trust.

9.3.1 Tower Hamlets PCT revisits the process of identifying mothers who are suffering from postnatal depression and the appropriate range of tools to assist in this screening. All populations should be included in this protocol and all key staff should receive training in applying this process.

9.3.2 Where mitigating factors exist in relation to a child's emotional well-being; the possibility of attachment disorder problems should be included in the assessment/re-assessment of the child, and the child/parent relationship.

9.3.3 Information and training on attachment theory should be provided to all key staff working with children and families to remind practitioners of the impact of dysfunctional adult relationships on the child's well-being and sense of attachment.

9.3.4 When a partner, father or other carer returns to the household following separation which was a result of relationship difficulties; the impact of this return on the child/children should be assessed.

9.3.5 A full assessment of any adult who will be a carer of the child should be undertaken; this assessment should include a focus on their experiences as children and identify their ability to parent. Where the carer changes within a family i.e. informally by a grand parent or other close relative an assessment of their parenting should be undertaken by the health visitor along with a reassessment of the home environment.

9.4 Educational Psychology Service.

9.4.1 No specific recommendations highlighted.

9.5 Metropolitan Police Service.

9.5.1 No specific recommendations highlighted.

9.6 East London and the City Mental Health NHS Trust.

9.6.1 Moderate to high-risk cases involving children or young people with complex needs that are being seen in Tier 3 CAMHS should within CAMHS be jointly held by at least two clinicians with one clinician as the identified and documented key worker. Reasons for any variance from this recommendation must be clearly documented on the case file and agreed with line managers.

9.6.2 There should be a local review of the role of local CAMHS in supporting and consulting to Children's Social Care services and / or education for children and young people who are placed out of borough for educational / therapeutic purposes.

9.7 Tower Hamlets Youth Offending Team

9.7.1 No specific recommendations highlighted

9.8 Educational Psychology Service

9.8.1 No specific recommendations highlighted/

9.9 Special Educational Needs Service

9.9.1 No specific recommendations highlighted

10. LSCB RECOMMENDATIONS

10.1 The review process and reports have shown that there are lessons to be learnt from the case. The individual agencies involved have drawn up a series of recommendations for practice and procedures that are aimed at making improvements to the services provided.

10.2 The LSCB has undertaken to monitor the progress associated with the implementation of recommendations, to clarify the responses to be made by staff to the issues identified for improvement and to ensure that the necessary training and learning is provided to staff.

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