

LONDON BOROUGH OF TOWER HAMLETS
Pre-Decision Questions - Overview and Scrutiny Committee – 30 September 2014

Cabinet Report	Question / Comments
<p>Agenda Item 8.1</p> <p>Safeguarding Children's Board Annual Report</p>	<p>Referencing the London Borough of Tower Hamlets Safeguarding Children Board (LSCB) Annual Report 2013/14 appended to the Cabinet report, and in particular the information contained therein relating to the Serious Case Review (SCR) into the death of Child F concluded by the LSCB during 2013/14:-</p> <ol style="list-style-type: none"> 1) What was the learning for the Council arising from the SCR? 2) Why did the Council not alert LBTH Councillors regarding the death of a child in the Council's care given that collectively they have a corporate parenting responsibility. 3) The Corporate Parenting Steering Group has a formal Corporate Parenting role in LBTH, why had it not been alerted to the SCR on Child F? 4) Why had the Overview report and action plans arising from the SCR been published in an obscure part of the LSCB website and not properly press released? 5) Given that the learning from the SCR and associated report had implications for those organisations working with young people, who have mental health problems and are in institutions, sharing the learning would have been helpful for many other organisations across the country and is the whole point of SCRs, so why was the SCR report buried and not properly publicised so that it could be learned from? 6) Will the Corporate Director now write to all members of the Council, in their Corporate Parenting role, setting out the learnings from the case and how the Council has taken action to ensure no other child in the Council's care will be failed in the same way that Child F was?