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