# 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.