

Executive Summary

Children concerned:
Child A & Child B

**Local Safeguarding Children's Board
London Borough of Brent
July 2008**

Callanan Leslie Ltd

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Agencies Involved:

Social Care Services Brent Borough Council

Education and Learning Brent Borough Council

Brent Primary Care Trust

Metropolitan Police

Local Primary School

CNWL Foundation NHS Trust

Brent Youth Offending Team

Membership of the Review Panel

Donald McPhail	Chair of Brent LSCB
Dr Arlene Boroda	Brent PCT Designated Doctor
Mrs Bernadette Halford	Brent PCT Designated Nurse
DI Louise Cherrington	Met Police CAIT
Janet Palmer	Assistant Director Children & Families LBB
Jean Cooper	Education and Learning Brent Borough Council
Euston Copeland	LSCB Coordinator

The Author

Annie Callanan has a background in social services and has worked in front line social work service delivery and senior management. Annie holds a CQSW and Dip Social Sciences as well as an MBA. She has worked as a service inspector and performance inspector of social services at the Department of Health, and is now a Director of Callanan Leslie Ltd, an independent agency that carries out Serious Case Reviews and other social care consultancy. Annie Callanan works in the capacity of an independent consultant and interim manager in social care.

Reason for the Report

1. This report provides a summary of an Overview Report which was commissioned by Brent Local Children Safeguarding Board (the LSCB) Serious Case Review (SCR) Sub-Committee under the requirements of 'Working Together to Safeguard Children' (HMSO 2006). It followed concerns regarding the service the children concerned received.
2. The report is based upon information provided, via the Serious Case Review Panel, from individual management reviews carried out by agencies that provided services to the children and their family. Any opinions expressed are personal opinions based on the information available. Any conclusions and recommendations are based on analysis of the information provided, with the benefit of hindsight. They are intended to assist in the application of 'best practices' for the future and should not be considered as a judicial opinion based on the rigorous level of investigation required in the Civil Courts.

Purpose of a Serious Case Review

- It is stated at 8.2 within the Department of Health document 'Working Together to Safeguard Children' (HMSO 2006) that the purpose of a Serious Case Review is to:
 - establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
 - identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence, and
 - improve inter-agency working and better safeguard children.
- This report examines the actions of the agencies that were involved with the children and the adults associated with them. The report provides recommendations that are intended to improve services and help to better protect children in the future.

Summary of the Case and Background of the Report

3. The Overview Report was requested by the Local Safeguarding Children's Board (the LSCB) Serious Case Review (SCR) Sub-Committee.
4. The Overview Report is based on and limited to the information available from the individual agencies Internal Management Reviews, (IMR's); and an Integrated Chronology provided to the author by the SCR sub committee.
5. The LSCB SCR Sub Committee was concerned that the service Child A and Child B received was below the standards set out in the Pan London Child Protection Procedures; required by the LSCB and required by the individual agencies involved. The Chair of the Sub Committee asked each agency to undertake an IMR and commissioned an Overview Report.
6. The children concerned are part of a group of six siblings, having the same parents. Their three elder siblings are now adults. The first recorded referral in respect of Family C, was received by Social Care Services on 02-09-1991 and concerned their mother's arrangements for the elder children should she receive a custodial sentence for offences of theft.
7. The first referral to Social Care Services regarding the then three youngest Family C children, (including Child A), was received on 28-07-1995. That referral raised concern about 'three children under the age of 10 years' being left at home alone. The 'baby' (Child A) was reported to be 'crying all the time'. Child A would have been two years old.
8. The first reference raising concerns about Child B was made by the School Health Service on 24-02-04 and refers to Child B's difficulty walking.
9. Between the time of these first recorded episodes and referrals and the end of the timeframe on the Integrated Chronology 20-10-2007, Family C were seen, discussed or written about on 432 occasions.
10. The children were recorded as being seen on approximately 51 occasions with members of the family and/or professionals. The children are recorded as being seen on approximately 46 occasions, where there is no reference to a family member. These are times when the integrated chronology makes reference to visits by the different agencies and the children being seen in their own right. They do not include the children's attendance at school.
11. It is not clear, from the recorded information available to this review, whether the children were ever seen alone, without the adults in their lives for the purposes of assessment, or whether their wishes and feelings were sought and listened to, taken into account and acted on or whether, when the children did express feelings and wishes, what outcomes and improvements were planned or made as a result.

12. Child A and Child B were removed from their parent's home and taken into local authority care in April 2007, following visits to their respective homes by social services. The children were living in squalid conditions. Child A was described as being 'highly distressed' and 'despondent'. Child B was described as being of 'poor physical appearance'.
13. Care Proceedings were initiated and the children were each made subject to interim care Orders.

Lessons to be learned

14. The overview report concluded that social care services to the family lacked co ordination and management overview and did not comply with the London Child Protection Procedures.
15. The referrals received and assessments undertaken were not responded to according to the procedure guidance. Opportunities to gain accurate information and establish the children's needs at an early stage were missed. A core assessment was begun in July 05 and became an s47 investigation in October 05, however the procedures were not followed and a Case Conference which could have identified the children's needs did not take place.
16. In November 05, the children's mother attended a professionals meeting and an inaccurate conclusion was drawn that there had been considerable improvement in the children's care. Unfortunately the evidence for this was not tested by assessment. It would seem the mother's self reported improvements were simply accepted.
17. Brent PCT records show that both Child A and Child B were seen for a range of issues. They attended GP Appointments for minor illnesses; had some attendance at A&E for accidents which appear to correspond with the description of the reported events and were in contact with the school nursing and CAMHS services.
18. CAHMS tried on a number of occasions to engage the children and their parents, but no response was received and the case was closed.
19. The Metropolitan Police had contact with the family on 34 occasions and have recorded seeing Child A on 21 and Child B on one of those occasions.
20. Domestic Violence was the subject of eight calls to the Police with disputes between the parents; between Child A and Child B and between the adults and the children.
21. The Primary School identified Child B as a child in need of support from his arrival at the school in September 2003.

22. The school made early continuous and appropriate referrals to Social Care and Health Services on 13 occasions.
23. Child A attended six schools during his school career and was identified as having 'difficulties with his behaviour' from the beginning of that career. He was identified as being 'disobedient and physically fighting other children'.
24. Although the school put a wide and varied number of programmes in place as attempts were made to both contain his behaviour and offer him an education, Child A clearly demonstrated that he was unable to engage for more than a short period of time.
25. Child A was subject to a Referral Order that brought him, and his mother, into contact with Brent YOT in March 2005. Both Child A and his mother engaged with the programme and, on the majority of occasions, kept appointments.
26. There was evidence that, when the courts are involved, the children's mother engaged with the services which may suggest that a more robust approach to working with her could have brought more positive results.
27. The lessons to be learned in this case are that in spite of the amount of contact and efforts made by agencies to try to provide services to the children and their family, where this was not underpinned by accurate assessment and coordinated inter agency service delivery, there was a failure to prevent the children suffering significant harm.
28. The agencies, particularly the school were tenacious in their efforts to refer concerns to the local authority social care service. While information was followed up, the outcomes remained unsatisfactory. Assessments of need that the children were entitled to receive did not take place. As the history of the concerns developed within the social care records, this did not appear to be referred to within an assessment process so that an overview of the level of concerns over a period of time could be addressed. In addition the children's mother resisted intervention by being unavailable and/or unwilling to meet with professionals. While there is no doubt this was a difficult family to engage with, the parental resistance need not have prevented services to the children had a statutory process been followed. Opportunities for agencies to share their concerns and for accurate holistic information of the children's needs to be made known were missed. This was primarily due to the London Child Protection Procedures not having been followed and complied with concerning the receipt of referrals, initial assessment, core assessment and s47 investigation.

Recommendations of the Overview Report

No	Recommendation	Desired Outcome
1	Social Care ensures that the London Child Protection Procedures and Working Together guidance are implemented in every referral received.	The implementation of the procedures in every case will ensure thresholds are within the legal definitions of s17 and s47 that children are seen alone whenever possible, that comprehensive assessment is made, and decision making recorded. Children will be Safeguarded in Brent.
2	The LSCB reviews procedures for responding appropriately when an agency is not compliant or effective and vulnerable children are not being provided with appropriate services.	Where partner agencies are concerned that children may not be adequately safeguarded it is clear what action can be taken
3	The LSCB satisfies itself that the procedures for working with Children in Need are able to identify children in need of protection or suffering significant harm.	Children in Need are specifically reviewed and identified when circumstances change and they are assessed as children suffering or likely to suffer significant harm and action consistent with the Pan London Child Protection Procedures taken.
4	The LSCB ensures that cases involving domestic violence are responded to appropriately, and sibling abuse identified, within the London CP procedures, and staff and managers made aware of the need for a coherent and informed response that protects children and their families.	Children and young people living with domestic violence and sibling abuse are safeguarded
5	The LSCB review policy and procedures on responding to sibling abuse.	Staff are clear that sibling abuse is identified and responded to appropriately.
6	The LSCB ensures that cultural identity and ethnicity are specifically identified so that resources available are deployed to support children and their families.	The cultural identity of children and their families are explicitly identified and appropriately addressed as part of case assessment.
7	Social Care should ensure that case recording and case management demonstrate an understanding of the case history and provide analyses of how that impacts on new information.	Cases are dealt with in the context of the case history and all information available on the family is used to assess risk and monitor progress.

8	Social Care must ensure that all Initial and Core Assessments consider all the dimensions of the Framework for the Assessment of Children and their Families.	The needs of the children within their family context are fully considered.
9	Social Workers are required to speak to the child/young person alone when completing Initial and Core Assessments, unless there are reasons why this is not in the child's best interest. Recording must demonstrate that the child was seen alone, or the reason why not.	Maximise the understanding of the child's situation within the family context.
10	LSCB will establish if the current thresholds for section 17 and section 47 are understood across agencies and are operating effectively to meet the needs of children.	All agencies are empowered to ensure the needs of children are met.
11	All agencies will ensure that the focus remains on meeting the needs of children when an uncooperative parent attempts to limit effective involvement.	Obstacles to meeting the needs of children are addressed.
12	LSCB to establish which external agencies are regularly providing services to Brent children and ensure that Brent agencies establish effective communications to support the needs of children.	Improved understanding and communication with agencies outside of the Borough.
13	That BOCU (Borough Operational Command Unit) ensure their staff are reminded of the requirement for compliance in completing MERLINS for all children who Come to Notice (CTN) of Police.	Improved communication between Police and other agencies in relation to police involvement with vulnerable children.
14	That the recommendations set out in the individual agencies IMR's (Attached at Appendix 3) are adopted as part of this process.	Progress of the implementation of the recommendations is brought back to the LSCB SCR Committee and improvement monitored.

Recommendations on National and Local policy

1. The LSCB raises concern about the impact of the new government initiative, which asks parents and/or patients to take responsibility for initiating contact with health services to make an appointment, on the lives of vulnerable children.