



SERIOUS CASE REVIEW

Under Chapter VIII

‘Working Together to Safeguard Children’

In respect of the Death of a Child

Case Number 14

What is a Serious Case Review?

Serious Case Reviews shed light on whether lessons can be learned about the way local professionals and agencies work together in the light of a child death where abuse or neglect are suspected.

Serious Case Reviews are not inquiries into how a child dies or who is to blame. These are matters for coroners and for criminal courts.

Serious Case Reviews focus on improving practices that safeguard and promote the welfare of children.

Please note; That the report has been subject of redaction to protect the identity and privacy of family members and professionals involved in this case.

Report by:

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Independent Overview Report Writer
Monday 26th April 2010**

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Serious Case Review Executive Summary

INTRODUCTION

The purpose of a Serious Case Review is as outlined in Chapter 8 (8.3) of the Working Together to Safeguard Children 2006 Guidance, namely to:

- 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.

Serious Case Reviews are not inquiries into how a child dies or who is to blame. These are matters for coroners and for criminal courts. In production of this report, agencies have collated sensitive and personal information under conditions of strict confidentiality. Birmingham Safeguarding Children Board (BSCB) has balanced the need to maintain the privacy of the child and family with the need for agencies to learn lessons relating to practice identified by the case and has authorised the publication of sufficient information to enable this to take place.

A decision to undertake a Serious Case Review was made on 23 May 2008. The BSCB identified those agencies that had significant engagement with the child and family. Agencies were required to secure and review files for the previous 15 years and compile an Individual Management Review. These reports provided an independent open and critical analysis of individual and organisational practice. The BSCB appointed an Independent Overview Author to chair a panel of independent safeguarding experts to prepare an Overview Report that brings together and analyses the findings from the IMRs.

In addition to the general questions to be asked and analysed by individual agencies. The

most important issues to address in trying to learn from this case were identified in the Terms of Reference in four priority areas. These were:

1. Rights of a Child:
 - Rights of a Child to an Education
 - Rights of a Child to appropriate health care,
 - Rights of a Child to appropriate food,
 - Rights of a Child to appropriate to accommodation and safety.
2. Role of and barriers to individual agencies working together to ensure that these rights are upheld.
3. To identify the barriers that prevents the public from fulfilling their responsibility to safeguard children.
4. The role of BSCB in enabling communities to fulfil their responsibilities.

SYNOPSIS

On 17th May 2008, the child's mother made a 999 telephone call requesting an ambulance due to serious concerns over this child's health. An ambulance crew arrived at the family home at 05.50am and found the child lying on a mattress in an upstairs bedroom. The child did not have a cardiac or respiratory output, and was transferred via ambulance to a hospital emergency department arriving at 06.05am. Resuscitation was continued by emergency department staff, this proved unsuccessful and death was pronounced at 06.25am.

The cause of death is recorded as bronchial pneumonia and septicaemia with focal bacterial meningitis. The child's weight at death had fallen below the 0.4th centile; with a body mass index of 10.7 k/m², which was so low that it could not be plotted on a body mass index chart. The child was described as extremely malnourished with severe wasting. Evidence clearly indicates that severe malnutrition was entirely due to an inadequate intake of food and that there was significant starvation over a period of several

months. All of the surviving siblings were malnourished to a greater or lesser extent and all had specific nutrient deficiencies. Some of the children became ill, one of them seriously, when they were fed, following their admission to hospital for assessment and treatment after the child death.

Mother and the adult male residing in the household were convicted of manslaughter, causing/allowing the death of a child and five other offences of cruelty in relation to the other children. The criminal trial initially commenced on 3rd June 2009, but the trial collapsed and the re-trial started in January 2010, concluding on the 12th March 2010.

The family members within this review are of Black Caribbean, African, and British heritage and all follow the Islamic faith. About 66% of Birmingham residents are White/British, compared with the national average in England of 87%. The average household size of the Black African community is 2.4 and Black Caribbean community is 2.0. Of Black African households with children: 39% were married couples in comparison with 24.2% of Black Caribbean couples.

The child was the second youngest child in a family of six children, all born to the same parents. Some of the children were subject to statements of special educational need; including this child, whose specific needs related to cognitive skills, expressive and receptive language, fine motor skills and independence.

The child's mother described the relationship with the child's father as exploitative and fraught with arguments. However, it was only following separation around 2004 that she alleged domestic violence from the father towards her, when visiting the family home. During some of these alleged violent and abusive incidents injuries to the children were sustained. There is a variance of view relating to domestic abuse, as the children's natural father vehemently denies this ever occurred, or that injuries to the children were sustained, however other independent witnesses corroborated the concerns. The natural father believes he departed from the family home some two years later than suggested by the mother, during the Autumn of 2006. What is known is that the father formed a relationship with another partner, with whom he fathered additional children, whilst still maintaining an intermittent relationship with the child's mother.

An adult male, mother's partner, was living in the family household at the time of the child's

death. Available evidence suggests he moved into the household around September 2007. He had developed a friendship with the child's father during 2000. It is thought that in 2002 when the father went abroad for a period of time, this man provided assistance to the child's mother during father's absence. The mother describes a developing friendship during this period, in which the adult male offered her advice and assistance with the children. The natural father has stated he was unaware of any relationship between the mother and this man and was not aware that he had moved into the family home.

The adult male's (mother's partner) childhood is regarded traumatic. When three, a sibling aged six months, died as a result of cot death. Two years later another three year old sibling, died following significant trauma, after being hit by their father in the stomach as a form of "discipline" whilst being toilet trained. His father was convicted of manslaughter and imprisoned for seven years. He was seen as a strict disciplinarian with rigidity and high, unrealistic expectations. The impact upon this man's development, from these early traumas and his views on discipline and parenting, were unknown prior to criminal proceedings. He was briefly in receipt of adult mental health services during 2001. Whilst he did not provide a full diagnosable history, he did give the Psychiatrist sufficient evidence to strongly suspect a low grade psychotic illness. He was not compliant with attempts to provide medication and this was communicated to his GP.

From information provided by the mother and evidence supplied within the criminal trial, changes in attitudes and routines became noticeable from September 2007 placing the adult male in a position to exercise considerable influence on the family, including, diet, feeding routines and discipline of the children. Prior to the adult male's links with the mother, she had been seen by professionals who knew her, as an engaged and protective mother of the children.

There were a number of early missed opportunities for intervention by professionals. Three incidents during March 2006 were not progressed, either by failures of paperwork to reach the correct departments, failure to follow safeguarding procedures, or to conduct thorough checks prior to case closure, resulting in any knowledge and intervention remaining purely single agency at that stage.

This was clearly a challenging time within the household. Adult relationships present as extremely fragile, domestic abuse was alleged and reported to the police and also to the

family GP, who despite evidence provided by the mother, that the father presented a safeguarding risk to the children, did not follow prescribed procedures by informing Children's Social Care, instead encouraging the mother to do this herself.

The issue of food first appears on professional records during March 2007, following a handwritten letter from the mother to one school and a face to face meeting at another, to discuss the children's eating habits, including a suggestion from the mother that the child was stealing food from other children whilst in school, a situation of which the school at that time were unaware.

Between October and December 2007 several school appointments were missed by both parents. Although they were living separately at this time, their previous commitment to engaging with schools to discuss their children's progress had existed. Failure to attend presented a change of behaviour.

It is not until some nine months later, during December 2007, that professionals again began to record issues around food. Clear evidence of the child stealing food from other children existed and other siblings within the family were indicating obsessive traits towards food and feeding. What we now know, is that the mother was struggling to address her own weight at that time, which was causing her health problems. Evidence from legal proceedings indicate that a regime to enable her to lose weight, was also applied inappropriately to the children's food intake.

Following changes to the mother's behaviour, deteriorating relationships with schools, increased aggression to and reduced co-operation with all professionals, the child and some siblings, were removed from state education during December 2007 and a clear statement issued by the mother, of her intention to educate them at home.

The responsibility for a child's education rests with parents. In England, education is compulsory, but school is not. The legislation that enabled the mother's action is contained within S7 of the Education Act 1996, supported by additional guidance within the Elective Home Education Guidelines for Local Authorities 2007. On this occasion, the legislative framework contributed to the unintended outcome of isolating some children within a home environment and restricted access to those children by professional agencies, effectively removing any oversight of their welfare or development.

This is not to suggest, that many parents undertaking home education, do not provide their children with excellent learning and development opportunities. However, within current legislation, the assessment requirement for home education is weak and there is no mandate to monitor, assess or inspect the quality of home education provision, once approval to home educate has occurred. Consequently, there is no effective method to ensure that home education remains suitable, developmentally appropriate and safe, without the explicit consent and active participation of parents, or carers.

The lack of any prescribed opportunities for children to formally express their views, or to actively participate within the assessment or decision making process of home education, or to have any independent access to external processes, represents a direct contradiction to the aspirations of safeguarding and human rights legislation and guidance. Given the tragic outcomes identified within this review, it also represents a major safeguarding flaw.

Education Otherwise (EO) provides advice, support and assessment to parents who have elected to educate their children at home. The lack of a robust and rigorous process by EO, during February 2008, to assess the capability of adults within this household to provide effective home education, coupled with the absence of any risk assessment process to address safeguarding concerns previously communicated by education welfare, must be viewed as a significant failure. Where safeguarding concerns are identified and professionals do not possess the necessary skills to undertake these tasks, then a joint assessment process with a suitably qualified and experienced worker should be conducted, as a minimum standard.

School staff attempted to communicate professional concerns on several occasions to Children's Social Care, but were not properly heard. Concerns were inaccurately recorded initially and the focus placed upon attendance issues, as opposed to mother's changed behaviour, increased aggression to professionals and the children's obsession with food. Recommendations by Children's Social Care for school to conduct an assessment using the agreed Common Assessment Framework and to request a police safe & well check were inappropriate given the information provided.

The initial assessment by Children's Social Care in February 2008 was not completed. As a result, Children's Social Care failed to accurately assess the risks posed to children

within the family. Adult resistance to professional intervention, doorstep conversations, the mother's sound knowledge of home education legislation and a hostile and aggressive approach, influenced and affected professional actions, preventing a full understanding of conditions within the home and seemed to render professionals impotent, thereby directing the focus away from the welfare of the children. Adults within the household fully controlled, monitored and limited access to the children and through their behaviours and attitudes frustrated a thorough analysis and assessment of the issues. These actions reinforced a power imbalance that undermined the rights, welfare and protection of the children who were at that time educated at home.

The complaint raised by the mother in February 2008, within the Children's Social Care complaints process, following the initial assessment visit above, appeared to impact upon the Children's Social Care manager and practitioner. This action appears to have generated a reluctance to follow through on plans with a partner agency to effectively pursue assessment processes, for fear of wider repercussions within the complaints process.

It is clear that other agencies placed great store on the outcome of the Education Otherwise (EO) assessment process. Ignorance of home education legislation and assumptions surrounding the depth and sufficiency of the safeguarding and welfare component of the EO assessment process, clouded professional assessment and decision making processes and obscured vital objectivity. Had Children's Social Care staff gained an understanding of the constraints within home education legislation and challenged assumptions surrounding the role and remit of EO processes, this may have influenced the initial assessment actions and decision making.

Information relating to concerns for the children's welfare was known to several agencies; opportunities for wider information sharing existed, but were either not recognised, not shared, or delayed. On one occasion, information on alleged domestic abuse within the household did not reach the school for approximately two months. This information could have alerted the school to alternative explanations for the mother's changed behaviour and may have triggered different interventions, or approaches. On other occasions, information was shared, but professional responsibility was not maintained; a Health Visitor referred concerns of domestic abuse to Children's Social Care during February 2007, but did not maintain any contact or support to the family following the referral.

School medical staff did not adequately address concerns raised by school staff, that one of the child's siblings who remained within the state education system may be obsessed with food. Successive school medical appointments failed to monitor this effectively. Records of weight changes were not fully plotted and therefore the full impacts of fluctuations to one sibling's weight were not adequately understood. Despite further issues raised by school staff during April 2008 and evidence that the sibling's weight had dropped, further action was not conducted by school medical staff. Mother's resistance to an appropriate dietician referral did not appear to raise alarm bells for medical staff, generate concern, or professional curiosity. Instead, the situation encouraged further prevarication, in the form of another review some four months hence. Neither did this situation prompt medical staff to undertake safeguarding checks with other agencies, to establish if wider concerns existed.

The safe and well check conducted by the police, December 2007, in response to a professional request from the school, appears to have hardened the mother's resistance to further professional intervention. When Children's Social Care agreed to conduct an initial assessment the mother's attitude and behaviour were immovable, frustrating all professional attempts to intervene and including the mother's use of the complaints process during February 2008, to further destabilise and deter appropriate intervention, enquiry and assessment.

Two attempts were made by members of the public to share their concerns, one by a telephone call, the second by a referral in person at a Children's Social Care office in March 2006. This information was not acted upon. It is perhaps not surprising that no further concerns were identified, as the mother and partner moved towards a position of systematically isolating themselves and the children from wider family members and the local community.

Between 1998 and 2008 the children missed a minimum of 129 professional appointments. Undoubtedly, with a family of six children, some of whom had statements of special educational need, there are particular pressures and stresses for parents and a degree of failed appointments would be expected, particularly, when the mother was operating as a single parent for periods of time. However, the pattern of failed appointments escalated dramatically during 2007 as relationships with professionals

deteriorated. The response to these failures within the agencies was not always actively addressed, or the significance fully understood and therefore not communicated with partner agencies.

Whilst a number of agencies and individuals sought to deliver effective services to the child and her family, there were others who lost sight of the child and focussed instead upon the rights of the adults, the adult's behaviours and the potential impact for themselves as professionals.

LEARNING POINTS

Practitioners across agencies were not in full possession of all the facts, because communication was delayed, mislaid, or simply not undertaken. Decision making often rested upon what was known in individual services. The role of information sharing, assessment and decision making were all important factors and impacted upon the delivery of effective service provision

Had the special school nursing service known about the home education of some of the siblings, domestic abuse to the mother and injuries caused to the children as a consequence; and had details of all previous weight recordings from the Child Development Centre been fully plotted, providing a visual representation of the child's weight pattern, it is unlikely the school doctor and nurse would have delayed a further medical follow up by four months.

It is estimated nationally that at least 200,000 children live in households where there is a known high risk case of domestic abuse and violence. These issues are a consistent feature of Serious Case Reviews, demonstrating how seriously they put children at risk of significant harm. Communication of this knowledge by agencies was not effectively understood or efficiently shared and without doubt the delay in communicating this information to the school impacted upon the way school staff understood and responded to mother's aggressive and challenging behaviour.

Evidence demonstrates that assessments were not of sufficient rigour and poorly focussed. Family and environmental factors and the parenting capacity elements of the Framework for the Assessment of Children in Need and Their Families structure received

scant or no regard. Had these areas been sufficiently explored, this may have led to a more integrated multi-professional service for this family and specifically the children.

Whilst Common Assessment Framework (CAF) processes were inappropriately proposed during referrals of child protection concern to Children's Social Care, families in need should not be excluded from other face to face information sharing between professionals. A child, who is subject to a statement of educational needs which lies outside the CAF process, can and should benefit from a multi disciplinary face to face case review at key points.

A large number of professional appointments were missed which escalated as relationships with professionals deteriorated. It is now generally acknowledged that patterns of missed appointments are one associated factor in identifying struggling families. By reviewing expectations for responding to such appointments, agencies will support and enable staff to respond to families who have difficulties in meeting the development and health care needs of their children, offering support and early intervention as required.

The mother demonstrated resistance to school medical appointments and would not give permission for an appropriate dietician referral to enable a full assessment of another of her children's weight loss. Access to school health services are an important opportunity for young people to have their health, development and welfare independently assessed. The removal or refusal of parental consent for this, or recommended additional services, should include a process of follow up, to establish if safeguarding concerns exist.

Dealing with safeguarding enquiries and assessments can be a stressful process for workers, particularly when attempting to undertake work with aggressive and highly resistant adults. On this occasion the added complexity of a complaint raised by the mother created additional confusion and impacted upon planning and decision making. Mechanisms must be put in place to prevent use of the complaints process by adults adversely affecting the actions of staff when pursuing safeguarding matters, or the welfare of children. In addition, the availability of quality supervision and support are paramount to ensure an objective and child focussed response are maintained.

Some professionals appeared unaware of their responsibilities to communicate safeguarding concerns that arose as part of their interaction with children and families, in

line with existing safeguarding procedures. It is imperative that all professional workers understand the expectation to share professional safeguarding concerns directly, without any assumptions about the roles or actions of other parties.

The responsibility for a child's education rests with parents. In England education is compulsory, but school is not. Some of the children in this family were removed from state education during December 2007. At no point, were any of these children given the right to choose the location, the nature of provision, or any right to consultation to express their views as part of this process. There was no independent access to friends, family, or professional agencies; they were isolated. On this occasion, legislation contributed to an unintended outcome of constricting access to those children by professional agencies and removed any effective oversight of their welfare, or development.

The above highlights a major safeguarding flaw within home education legislation, which focuses upon parental choice and rights at the expense of children's rights, wishes, welfare or protection. There are no mechanisms to ensure that a satisfactory education continues to be received, or that young people's welfare is appropriately safeguarded, except with the express co-operation and participation of parents and carers. This situation is particularly advantageous for parents who may wish to conceal abuse. A review of existing legislation by government would be advantageous, recognising a parent's right to home educate balanced with the Local Authorities duty to safeguard children and the child's right to protection.

CONCLUSION

When considering all of the information presented within this report and specifically, that contained within Section 11 Missed Opportunities, it can only be concluded that the death of the child was preventable. This finding concurs with judgements made within the care proceedings that, the death of the child is the responsibility of the mother and the adult male, but can only conclude that had there been better assessments and effective inter-agency communication over a period of time it could have been prevented.

The death of a child is always a difficult and poignant experience, but when that child has sustained extended punitive brutality and starvation by adults who should have been there to care and protect them, failing in their duty even in the latter stages to seek medical

intervention, it is almost beyond our comprehension. It is the duty of us all to ensure we understand why these tragic events occurred and do everything in our power to prevent such a tragedy from ever occurring again.

RECOMMENDATIONS

Recommendation 1

Birmingham Safeguarding Children Board should commission work to identify how agencies across Birmingham can increase effective professional communication to improve the safeguarding outcomes for children and young people in compliance with policy and procedure.

Recommendation 2

South Birmingham NHS Primary Care Trust should evidence through audit processes that children who are subject to weight and height checks as part of school medicals, have their data fully recorded and plotted on a growth chart in their notes, to provide a complete and readily accessible picture of the child's development.

Recommendation 3

NHS Primary Care Trust's should review processes for obtaining parental consent for child access to the school health service and implement, including a process of follow up action for parental refusal or withdrawal of consent.

Recommendation 4

Where a school has initial concerns the designated senior person should liaise with schools attended by other siblings to ensure an holistic view of the children and family is obtained.

Recommendation 5

Birmingham Children's Social Care must review and demonstrate that staff at all levels understand the appropriate use of the common assessment framework and the application of thresholds for significant harm.

Recommendation 6

Birmingham Children's Social Care and West Midlands Police should review multi agency procedures to ensure that 'Police Safe & Well Checks are not used in place of existing safeguarding policies and procedures.

Recommendation 7

Birmingham Children's Social Care must review and revise their referral and advice screening process to ensure that safe decisions are made based on risk and where the

referrer expresses dissatisfaction this is passed to the Line Manager for resolution.

Recommendation 8

Birmingham Children's Social Care should review the assessment process in the Duty & Referral Service to determine robust management oversight at each stage of the process and ensure robust quality assurance measures are in place which are specific to the 'Framework for the Assessment of Children in Need and their Families.'

Recommendation 9

Birmingham Safeguarding Children Board should commission multi agency guidance and training to equip staff in all agencies to work effectively with aggressive and highly resistant parents and carers.

Recommendation 10

Birmingham Children's Social Care should conduct an evaluation survey to quantify Children's Social Care staff's understanding of the role and responsibility of the Education Otherwise Service following the recent awareness campaign.

Recommendation 11

Birmingham Children's Social Care should review and evidence that mechanisms are put in place to ensure that use of the complaints process by parents or significant adults does not adversely affect the actions of staff when pursuing safeguarding matters, or the welfare of children.

Recommendation 12

Birmingham Children's Social Care to review supervisory expectations and standards, ensuring management and decision making processes contain sufficient rigour when managing risk

Recommendation 13

Education Otherwise should evidence to Birmingham Safeguarding Children Board changes to the recording and assessment process, demonstrating delivery of safe and effective services that contribute to meeting the safeguarding needs of children and young people across Birmingham.

Recommendation 14

The Strategic Director of Children's Services should communicate to the DCSF Secretary of State, the current safeguarding inconsistencies within legislation surrounding children who are educated from home, emphasising that the parents right to home educate does not outweigh the rights of the child.

Recommendation 15

Heart of Birmingham Teaching NHS Primary Care Trust should review and satisfy

themselves that all GP's are aware of their professional responsibilities to communicate safeguarding concerns that arise as part of their interaction with children and families, in line with existing safeguarding procedures.

Recommendation 16

Birmingham Safeguarding Children Board expects all agencies that have completed an IMR to implement any internal recommendations and to take action where management or practice has fallen below expected standards of professional behaviour.

Recommendation 17

Heart of Birmingham Teaching NHS Primary Care Trust and South Birmingham NHS Primary Care Trust, Birmingham Children's Social Care and Education Otherwise agencies should provide evidence to demonstrate an effective response to missed or failed appointments.

Recommendation 18

The Children's Trust in conjunction with the Birmingham Safeguarding Children Board should initiate an education campaign with supporting literature, to build public trust and confidence in ways to effectively safeguard and protect other people's children.

SERIOUS CASE REVIEW PANEL CHAIR AND MEMBERS

John Radford

NSPCC (independent chair and report author)

Clinical Director (Children & Families Division), South Birmingham NHS Primary Care Trust & Designated Doctor (July 2008 to October 2008)

Community Paediatrician & Designated Doctor (from October 2008)

Senior Nurse for Safeguarding & Child Protection
Birmingham East & North Primary Care Trust

Superintendent West Midlands Police

Assistant Head of Safeguarding
Children, Young People & Families Directorate

Principal Officer for BEN Education Welfare Service
Children Young People & Families Directorate

ENSURING LESSONS ARE LEARNT

The report findings were ratified by Hilary Thompson the Independent Chair of the Birmingham Safeguarding Children Board on Monday 26th April 2010. All safeguarding Board Members welcomed the report findings and agreed to ensure that all recommendations would be fully implemented within the agreed timescale. Birmingham Safeguarding Children Board and Government Office for the West Midlands will closely monitor each agencies action to ensure that lessons are learnt from this tragic case.

1. Introduction and Context

- 1.1 On 17th May 2008, mother made a 999 telephone call requesting an ambulance due to serious concerns over the child's health.
- 1.2 An ambulance crew arrived at the family home at 05.50am and found the child lying on a mattress in an upstairs bedroom. The child did not have a cardiac or respiratory output. The child was transferred via ambulance to the emergency department of Birmingham Children's Hospital arriving at 06.05am. Resuscitation was continued by emergency department staff, this proved unsuccessful and death was pronounced at 06.25am.
- 1.3 Cause of death is recorded as bronchial pneumonia and septicaemia with focal bacterial meningitis. At the time of death the child weighed 16.7 kilograms with a height of 125 centimetres; this gave a body mass index of 10.7 kg/m² (the normal range being 18 - 24 kg/m²). The child was described as extremely malnourished with severe wasting, weight for height being less than 70%.

2. Terms of Reference for the Serious Case Review

1. Rights of a Child:
 - Rights of a Child to an Education
 - Rights of a Child to appropriate health care,
 - Rights of a Child to appropriate food,
2. Role of and barriers to individual agencies working together to ensure that these rights are upheld.
3. To identify the barriers that prevents the public from fulfilling their responsibility to safeguard children.
4. The role of BSCB in enabling communities to fulfil their responsibilities.

3. Serious Case Review Panel Members

- 3.1 The author of this report is UK Head of Business Systems with the NSPCC, and is independent of any links to the Birmingham Safeguarding Children's Board, or the Local Authority. He has no responsibility for operational services across Birmingham or the surrounding authorities. Neither does he have links with any agencies or representatives within the ambit of this report. The author was also Chair of the Serious Case Review Panel; this process was agreed prior to an understanding that the two roles should be separated. However, the independent nature of the author's role has ensured impartiality and objectivity throughout this process.
- 3.2 On the 16th December 2008 the DCSF issued national guidance to LSCBs on the future arrangements for completion of Serious Case Reviews that already commenced and not yet finalised. The Board have liaised with OFSTED to ensure compliance with this guidance and the newly appointed Independent Chair has undertaken the "sign off" process.

Panel Members

- John Radford
NSPCC (independent chair and report author)
- Clinical Director (Children & Families Division), South Birmingham NHS Primary Care Trust & Designated Doctor (July 2008 to October 2008)
- Community Paediatrician & Designated Doctor (from October 2008)
- Senior Nurse for Safeguarding & Child Protection
- Birmingham East & North NHS Primary Care Trust
- Superintendent West Midlands Police
- Assistant Head of Safeguarding
Children, Young People & Families Directorate
- Principal Officer for BEN Education Welfare Service
Children Young People & Families Directorate

The panel met on the following dates to consider all the IMR's and to progress the Overview Report:

7th July 2008

18th July 2008

4th September 2008

10th October 2008

12th December 2008

Following the conclusion of the criminal proceedings the Panel were reconvened to review new information to emerge from the criminal and care proceedings, and to undertake a quality assurance review in light of changes made to Chapter 8 of the new Working Together.

22nd March 2010

- 3.3 Whilst the panel does not contain defined specialists in relation to faith, or ethnicity, several members of the panel have significant work experience in these areas gained over a number of years. Throughout the review process the requirement for expert guidance or input was regularly reviewed and evaluated

4. Process and Timeline of Review

- 4.1 The Serious Case Review process began on 23rd May 2008 and was completed in June 2009, with a revision during March 2010, following the outcome of the criminal trial. There are a number of reasons why this review extended beyond the expected four month period:

- A large number of reports were requested from agencies, see Appendix B. Many of these related to complex case histories with completed first drafts not arriving before 20th August 2008.
- The independent author was not commissioned to undertake the work until 12th June 2008.
- Two independent management reviews did not follow the required format, or were of insufficient rigour and clarity and were therefore returned to the respective agencies for revision and resubmission.
- Three further letters seeking clarity over specific issues were also sent, adding further delay to the timeline.

- Subsequent information was identified, requiring letters to agencies on 24th June 2008 and 28th November 2008, the latter relating to an additional alias for mother's partner. Final information on these matters was not received until 24th December 2008.
- Clarification surrounding the child's siblings desire to participate in the review was not received until 14th January 2009.
- IMR Authors were given the opportunity to revisit their IMR on the 12th March 2010 to meet the revised standard template particularly in terms of context. Those that were submitted have been taken into account in the overview report.
- The Review Panel agreed that criminal proceedings should at no time be compromised by publishing any findings. The finalisation of the report was delayed until conclusion of the criminal trial in March 2010.
- OFSTED evaluation feedback has previously focused on the inconsistency and quality of IMR reports and the Panel have ensured that a robust quality assurance process has been undertaken to ensure compliance with the recent guidance within Working Together.

4.2 Within the integrated agency chronology there are issues of concern and learning points that relate to father's second family. Upon consideration of early material, the Panel formed the view that integrating these matters could blur the focus of the main issues leading to the death of the child and the health and welfare of the siblings. This action was taken in recognition that there were no immediate child protection concerns relating to the children of father and his second partner. Therefore this family were excluded from the scope of this review.

4.3 **Schedule of Serious Case Sub Group Meetings**

Discussed at Serious Cases Sub Group on the following dates

23rd May 2008, 6th June 2008, 4th July 2008, 25th July 2008, 12th September 2008, 3rd October 2008, 7th November 2008, 5th December 2008, 9th January 2009, 6th February 2009, 6th March 2009, 3rd April 2009, 1st May 2009, 5th June 2009, 12th June 2009, 8th January 2010, 12th February 2010, 19th March 2010 and 23rd April 2010.

4.4 **Key milestones in the completion of the report**

27th May 2008 – Independent Chair, author and panel members appointed

23rd May 2008 – Discussion at Extraordinary Meeting

23rd May 2008 – Request for IMR

3rd June 2009 – Initial criminal trial terminated.

12th June 2009 – Draft report submitted to Serious Cases sub committee

19th June 2009 – Draft Overview Report presented to BSCB

17th July 2009 – Contact from natural father, wishing to participate in the review

27th August 2009 – Meeting with Natural father to enable comments to be incorporated within this review

1st December 2009 – IMR training delivered to Authors and Senior Managers – new guidance issued.

January 2010 – Re-trial concluding on the 12th March 2010.

12th March 2010 – Post trial review and revision of IMRs.

22nd March 2010 – Serious Case Review Panel reconvened.

23rd April 2010 – Serious Cases Review Sub Group – reviewed final report.

26th April 2010 – Final report presented to BSCB

5. **Government Office West Midlands (GOWM)**

5.1 Serious Cases Sub Group work closely with Government Office providing regular reports on progress and ensure compliance with local and national guidance. This case has been high profile receiving national and local media coverage. The Board have provided Government Office with weekly progress reports at each stage of the finalisation process. They have provided performance updates detailing agencies progress on implementing both IMR recommendations and the emerging findings from this Serious Case Review. The priority has been to ensure that robust and prompt action has been undertaken to implement the early learning from this case.

5.2 Government Office for West Midlands have reviewed progress and granted extensions throughout the process. An extension has been granted up until the 30th April 2010.

6. Individual Management Reviews

- 6.1 An IMR request letter was sent to agencies on the 23rd May 2008 with the details of the case, the scoping information and Terms of Reference. Agencies were required to look critically and openly at individual and organisational practice to ascertain whether changes could and should be made and, if so how this should be achieved. It was a requirement that a designated senior manager who had no previous involvement or line management with the case, should complete the review and Serious Cases Sub Group are satisfied that this was the case. Guidance notes with a template were provided to all agencies including the requirement for agencies to implement their own recommendations in a timely way. In a number of IMRs staff were not interviewed. This was not a practice requirement at the time the IMRs were initially commissioned. Agencies were required to sent a nil return if they could find no trace of involvement with the family.
- 6.2 The Panel were aware of OFSTED evaluation feedback that had previously highlighted inconsistencies in the quality of IMR reports. The Board together with Government Office to deliver IMR training for Authors and Senior Managers in December 2009. The training launched new IMR guidance, IMR template and instructions on the interviewing of staff, together with exemplars of good practice aimed at enhancing the quality of reports. A further quality assurance process has been incorporated within the Serious Case Review process with all agencies receiving evaluation feedback on the quality of IMRs and areas for further clarification and analysis.
- 6.3 Each agency that have submitted an IMR are shown below with the date of their original submission and following a post trial review the revised date of the final IMR submission. The revision of Working Together requires the preparation of an integrated health chronology, however this case was first commissioned prior to this requirement. The panel felt that at this stage it would not aid the analysis or understanding.
- 6.4 **IMR's were received from the following agencies on the dates shown:**
West Midlands Police – original; 01.08.2008 – final; 12.04.2010
West Midlands Probation Service – original; 24.06.2008 – final; 21.04.10
Children's Social Care – original; 31.07.2008 – final; 21.04.10

Children, Young People & Families Directorate Early Years – original; 20.08.2008 – final; 12.04.2010

Children, Young People & Families Directorate Education Welfare Service – original; 31.07.2008 – final; 21.04.2010

Children, Young People & Families Directorate Schools – original; 20.08.2008 – final; 22.04.2010

Birmingham Children’s Hospital – original; 23.06.2008 – final; 12.04.2010

Birmingham & Solihull Mental Health Foundation Trust – original; 6.02.2009 – final; 12.04.2010

Sandwell & West Birmingham NHS Hospital Trust (Midwifery) – original; 01.08.2008 – final; 13.04.2010

Sandwell & West Birmingham NHS Hospital Trust (Paediatrics) – original; 01.08.2008 – final; 15.04.2010

Children, Young People & Families Directorate Education Psychology – original; 20.06.2008 – final; 12.04.2010

Children, Young People & Families Directorate Portage Service – original; 24.06.2008 – final; 12.04.2010

Children, Young People & Families Directorate SENAS – original; 07.11.2008 – final; 19.04.2010

Heart of Birmingham Teaching Primary Care Trust (Health Visitors) – original; 17.08.2008 – final; 16.04.2010

Heart of Birmingham Teaching Primary Care Trust (GP) – original; 17.08.2008 – final; 16.04.2010

South Birmingham Primary Care Trust (Health Visitors) – original; 17.07.2008 – final; 12.04.2010

6.5 **Information Reports:**

University Hospital Birmingham – 14.04.2010

Birmingham City Council Housing Department – 22.04.2010

Birmingham Civic Housing Association – 22.04.2010

NHS Direct – original; 13.06.2008 – 12.04.2010

South Birmingham NHS PCT Named GP – 01.09.2008

The Honourable Mrs Justice King judgement for the Care Proceedings – 06.03.2009

Confidential Victim Impact Statement – Criminal Proceedings – 25.02.2010

6.6 Nil Returns were received from the following agencies on the dates shown:

Heart of England NHS Trust Midwifery Services – 02.06.2008

Birmingham Women's Hospital NHS Foundation Trust – 03.06.2008

NSPCC – 01.07.2008

CAMHS Service – 16.06.2008

Heart of England NHS Trust – Good Hope Hospital Midwifery – 28.05.2008

Royal Orthopaedic Hospital – 05.06.2008

CAFCASS – 30.05.2008

Drug Action Team – 12.06.2008

The initial scoping exercise required agencies to examine records in relation to half siblings and the mother's partner. Nil returns in relation to this aspect are not included in the above list.

6.7 Quality and Timeliness IMR's

The Panel have considered 21 reports, 5 agencies have had minimal engagement with the family and their submissions are considered as information reports only. 16 agencies submitted an IMR in relation to this case, of these 12 made a total of 52 recommendations focused on enhancing their agencies safeguarding arrangements. Where agencies have not made recommendations within their IMR report the panel felt this was appropriate in the circumstances.

6.8 The Serious Case Review Sub Group have undertaken a quality assurance review of all IMRs and information reports providing detailed feedback to IMR Authors and Senior Managers responsible for ratifying their agencies IMR report indicating issues which required further clarification. The IMR process for some organisations did not incorporate interviewing staff involved in this case. At that time it was not mandatory to undertake interviews. BSCB have issued new guidance which specifically addresses interviewing of personnel to aid learning. Additional information provided by agencies has been incorporated into the revised IMR.

7. Parental and Extended Family Involvement

- 7.1 In order to inform this review, the child's siblings were offered through Children's Social Care the opportunity to participate in the review process. This approach was conducted with great sensitivity, recognising the significant trauma the siblings have suffered, the variability in their respective capabilities to contribute, based upon age, levels of understanding and degrees of learning disability as identified within the statements of special educational need for some of the surviving siblings. Whilst the oldest siblings clearly understood the process of the review and its wider objectives, those of sufficient age and understanding declined to participate in this process, leaving nothing further to add from their perspective, save that released as part of the criminal trial evidence. The confidential victim impact statement presented to the judge in the criminal proceedings provided further insight to the tragic circumstances in this case.
- 7.2 Methods to effectively engage the extended family within the report were considered. In recognition of the fractures within family relationships following the child's death, it was assessed that convening a family meeting would not prove conducive to effective communication. Therefore, family contributions were gained through their respective individual professional links and feedback was summarised within a single report, the content of which has been incorporated within section 10.6. The natural father did not respond during the early phase, but made contact via Children's Social Care during July 2009, expressing an interest in participating in the review process. He was subsequently seen during August 2009 and his comments have now been incorporated within this report.
- 7.3 Careful consideration was given to how the child's mother and her male partner could contribute to the Serious Case Review process. The criminal prosecution and subsequent diagnosis of mental health illness for both parties has prevented direct participation. However evidence that has emerged from the care proceedings and subsequent criminal trial provided a significant insight into their involvement in this tragic case.
- 7.4 On conclusion of the OFSTED evaluation process the BSCB will liaise with Children's Social Care to assess the feasibility and appropriateness of sharing the

key conclusions with the surviving siblings and family members. The BSCB will make contact with the natural father who has contributed to the review process to share the reports findings.

8. Ethnicity & Diversity

- 8.1 OFSTED evaluation feedback has highlighted the importance of strengthening evidence that practice was sensitive to racial, cultural, disability, linguistic and religious identity of the child and family subject of Serious Case Reviews. The Birmingham Safeguarding Children Board's commissioning arrangements for IMR reports required agencies to consider this specific issue and the impact on service delivery in this case. There are references to the family's ethnicity by a number of agencies, which contain some variances. Overall, the family's ethnicity is described as black, with different members being recorded as black Caribbean, black African, or black British. It is not clear from the records how this information was obtained and whether the variation relates to how the individuals saw themselves and/or their children, or if these were professional interpretations. Beyond this little was known about the cultural environment of this family.
- 8.2 The family members within this review are of Black Caribbean, African, and British heritage and all follow the Islamic faith. About 66% of Birmingham residents are White/British, compared with the national average in England of 87%. The average household size of the Black African community is 2.4 and Black Caribbean community is 2.0.

9. Family Composition

Please note; that the family composition and genogram that formed part of the original Overview Report has been removed to protect the privacy and welfare of vulnerable children and their families.

10. Family Background

10.1 Mother

10.1.1 For clarity, information on mother's background is principally drawn from a position statement she provided as part of care proceedings. Additional attempts were made by Social Workers to gain further clarity and on each occasion met with intervention from mother's Solicitors. Where possible, information has been supplemented by that provided by maternal grandmother, her mother, and any subsequent clarification provided through evidence as part of legal proceedings.

10.1.2 Mother is the oldest child of maternal grandmother, there are four younger siblings and mother is not aware of the identity of her birth father. Mother lived with her maternal grandmother for most of her childhood but had frequent contact with her mother and step father and was included in family trips with her half siblings. Mother's maternal Grandmother and her mother converted to Islam, when mother was approximately eight years of age. This information suggests that mother has spent the vast majority of her life following the Islamic faith. Mother reports happy family relationships. She describes being raised by her grandmother, by exercising her will over her mother. Mother's maternal grandmother died in 1997.

10.1.3 When mother was 18 she was married under Islamic Law to her first husband. The marriage is thought to have lasted only a few weeks, ending by the choice of her husband. No further information is available on this relationship.

10.2 Father

10.2.1 Father was born under a different name, and subsequently changed his name and is the sixth of eight children. It is known that the eldest three siblings live in Jamaica and the remaining five siblings were raised in the United Kingdom.

10.2.2 It was stated by mother that father's brother and father had largely lost contact and had not seen one another over the last five years. During interview father denied this assertion and indicated that any loss of family contact had been due to being too busy. Either way, it would seem that, following the death of the child, father and

his brother re-formed a bond, with brother assuming the spokesperson role for the family in some respects. However, brother has not engaged with Children's Social Care staff, or sought further involvement with the surviving children.

10.2.3 Within records relating to a half sibling, father's mother was named as significant support. However, she is alleged to have stated on 3rd June 2008, that she had infrequent contact with the half sibling and the mother.

10.2.4 Effective information gathering on family background in relation to father has been limited; father spent much of the period following the child's death living abroad. When interviewed in August 2009, father provided only limited information, with repetition of mainly superficial level information.

10.2.5 He confirmed that contact with the children had become increasingly difficult, last seeing them within the home setting around September \ October 2007. Subsequent phone calls and visits to the family home had met with no response. Following this he had attempted to have contact with the children in the school playground at the end of the school day before they went home. Having not seen the children for some time, he eventually entered the school on the 7 May 2008 and was informed by a teacher that his children had not been at school for approximately six months. He was on his way to the family home following this information when he met one of his children, they sat on a wall and talked and on asking if everything was OK at home was told yes, following this information he did not attempt entry to the home. In hindsight father acknowledged that something was nagging him about that child's condition, but at the time he did not recognise the loss of weight or other traits to trigger him taking any action. Father did state that he now recognised had he taken some action at the time the fate of the child may have been different.

10.3 Adult Relationships

10.3.1 Following mother's separation from her first husband, she did not wish to remarry, but it is stated that her Muslim adviser, her Wakeel (a male protector to represent her interests, responsible for finding out everything he can about a potential groom) and brothers in the faith, had advised her to remarry swiftly. Subsequently, an

arrangement was made for her to meet father, the couple met on three occasions before marrying. It is said that mother's parents were concerned over her re-marrying so soon, but following encouragement from her Wakeel, the marriage took place sometime between 1994 and 1995. There was no subsequent Civil Ceremony.

10.3.2 Mother disclosed that she and father were married under Islamic Law. She explained that she and father had been together for 9 years and had a number of children together. At the time of the marriage she was living with her grandmother and the couple did not live together until 1997. Following the death of her grandmother, mother moved to the home of father's mother. Father agreed when mother was pregnant with a child, that they could move to their own tenancy and this occurred in June 1998.

10.3.3 Mother describes the relationship with father as exploitative and fraught with arguments. Mother has a recognised arthritic disability of the knee and was entitled to a car through the mobility scheme. Mother states that father regularly used this vehicle to meet his own needs and it was frequently not available for mother or the children's use.

10.3.4 It has been difficult to pinpoint exactly when father moved out of the family home, principally because mother states he was frequently absent, but she believes it to be around 2004, whilst father believes it to be the autumn of 2006. Mother states that the early years of their relationship were argumentative it was only latterly, following separation, that domestic violence from father began when visiting the family home. Mother reported domestic violence to both Children's Social Care and West Midlands Police. West Midlands Police call logs support these statements. Father categorically refutes any violence, but suggests he became frustrated as he was not able to see his children and subsequent arguments between himself and mother then ensued.

10.3.5 Mother believes that the couple are divorced and that Talaqs were issued. She believes this had occurred by the time she was pregnant with a child. Father stated on 25th May 2008 that he and mother had not divorced and that she was in breach of the law of Islam in speaking to another man (e.g. the adult male - her partner).

During interview on the 27 August 2009 he now believes the couple were divorced during March 2007. What is irrefutable is that father, during his absences from the family home, had formed a relationship with his second partner and the ages of father and his second partner's children coupled with the birth of mother's last child demonstrates that father was having a concurrent relationship with both women.

10.4 The Partner

10.4.1 The adult male mother's partner, is the eldest of five children. When he was three, his brother, aged six months at that time, died as a result of cot death. The post mortem report indicated death occurred as a result of asphyxia due to the inhalation of vomit.

10.4.2 Two years later when he was five, his sister who was then aged three died as a result of significant trauma after being hit by their father in the stomach, as a form of "discipline" whilst being toilet trained, for not pulling the chain.

10.4.3 On 8th May 1984 his father was convicted of manslaughter and imprisoned for seven years. Psychiatric tests were undertaken on his father and issues identified in respect of his personality and guardedness. He was seen as a strict disciplinarian with rigidity and high, unrealistic expectations.

10.4.4 The partner and his remaining brothers were made Wards of Court and remained in the care of their mother whilst his father was imprisoned. It would appear that his father continued to have some influence and control over the family whilst in prison. The children were made Subjects of Supervision Orders and were offered support from psychologists.

10.4.5 It is pertinent to consider, at this point, the impact on his personal development and views on parenting as a result of his father's strict disciplinarian approach and male role modelling, incorporated with the trauma of losing some of his siblings whilst extremely young. During 2001, he had two contacts with adult mental health services. Whilst he did not provide a full diagnosable history, he did give the Psychiatrist sufficient evidence to strongly suspect a low grade psychotic illness.

The Psychiatrist offered appropriate treatment, but from the information available, the partner declined to follow the advice given. This was communicated to the GP.

- 10.4.6 It is believed that the partner had developed a friendship with father during 2000 and that they spent considerable time together outside of the family home. Further, in 2002 when father went abroad the partner provided assistance to mother during his absence. Mother describes a developing friendship during this period in which he offered her advice and assistance with the children before moving into the family home during September 2007. It is noted mother withheld this information from her mother as she believed she would disapprove of this given that he was a friend of father. It is stated, that all three were all worshippers at the same Mosque.
- 10.4.7 The mother has stated that her partner's mother and brothers were visitors to the family home. Mother describes him as an involved father figure; although he had no children of his own, nor any prior parenting experience. The mother states he advised her on the children's diet replacing "junk" foods with more healthy options such as vegetables. The mother describes a routine from January 2008 which included prayers from 6am, taking the children to school, home tuition commencing from 9am and within this context she states that her partner exercised "light" discipline on the children. The mother denies knowledge of other disciplinary measures. The adults lived downstairs in the front room, on the ground floor.
- 10.4.8 Evidence from legal proceedings suggests that the mother, whilst able and independent in many respects was reliant on the men in her life and duly observant to the role of women within the Islamic religion. This seems to have extended to accepting the partner's interpretation of how the family should live and behave in order to be good Muslims. This change of behaviour is an extremely important feature, requiring the mother's and the children's deference and obedience to his requests, which as his health and impaired state of mind deteriorated, became an unstoppable force. His belief that evil spirits inhabited at least the child, led to a tirade of severe physical chastisements, beatings and humiliating punishments for all of the children, including the withdrawal of food.

10.4.9 Saddest of all is that the partner stated the desire to become a different father to the one he had experienced as a child, but operated in an almost identical pattern, inflicting horrendous abuse on these children, leading to the death of the child.

10.4.10 The panel re- considered in light of disclosures during the criminal trial, whether more could have been known about the partner's strict religious beliefs and his mental health. The panel concluded the answer was no to both matters, because of the following:

- His interpretation of Islam was completely self directed, he did not seek external input either to check, or shape his own understanding or behaviours, including his belief in and the actions required to address possession by Djinn spirits. This is supported by evidence supplied to the criminal trial by a G.P. and cultural expert, who clarified that "anyone who was thought to be possessed by Djinn should be treated by a specialist exorcist called a Sufi and not by a lay person."
- Identification of concerns relating to mental health occurred whilst he was a single man with no links to families or young children, as such, there were no additional concerns raised that required the engagement of other professional groups.
- As his identity was not provided to professionals visiting the house, therefore, lateral checks could not be undertaken on him.
- Due to the level of withdrawal from all external contact, no one outside of the household witnessed his mental health deterioration.

10.5 Known Children's Perspective

10.5.1 The children state positive memories of care by their mother, but note unhappiness that they had witnessed domestic violence by their father towards her.

Please note; that paragraphs 10.5,1 to 10.5.9 that formed part of the original Overview Report has been removed to protect the privacy and welfare of vulnerable children and their families. Some of the children had statements of special educational need.

10.5.10 All of the siblings were living with their natural mother and partner at the family home. It is known that close bonds existed with maternal grandparents and from accounts provided by the children to Children's Social Care, there was relatively frequent contact with them until approximately Christmas 2007.

Please note; that paragraphs 10.5,11 that formed part of the original Overview Report has been removed to protect the privacy and welfare of vulnerable children and their families.

10.5.12 Through video evidence the children described the changes within the household regime following partner's introduction including the range of punishments used, many for what most parents would be regarded as at most, minor infringements, normal child development, or expected behaviours, due to the restricted learning and physical abilities of the children. These included, being made to sleep in the back room for wetting the bed, being "whacked with a stick" for many reasons, one being caught turning on the heating, because you were lying on a cold floor with no mattress and no bedding, having your mattress removed for wetting the bed, being made to stand in the corner with your hands on your head for being cheeky (this was defined as asking questions), sometimes in front of a cold fan only in underwear, standing outside in underwear, being made to spend time in the dark garden shed, having cold water poured over you, or a cold shower, or sit in a cold bath, having meals denied. In addition to these punishments we also now know that the children spent an increasing amount of time confined to a single upstairs bedroom where all of the children slept sharing a single mattress with no bedding, we also know the children had all toys removed, had no access to external contacts with other children, save for those who continued to attend school, had limited clothing and were required to wash this themselves by hand.

10.6 Extended Family Perspective

10.6.1 As indicated previously, there had been no contact between the mother, father and his brother for a considerable period of time, at least five years.

10.6.2 The sister of the father indicates she was close to the mother "like a sister" and wished to maintain contact with her. She had visited the family home once or twice a month until sometime (unspecified) during 2007, when visits ended due to the birth of her own child. She visited the family home three further times during March and April 2008, but had been unable on each occasion to receive a reply. She asked friends who lived nearby if any had seen the mother but all replied negatively.

- 10.6.3 The paternal grandmother described a visit to the family home in January 2007 following a telephone call from the mother. On arrival, she found father in the home in a heated dispute with the mother, she indicated that partner was in the home at the same time. She described the situation where one of the siblings had stood between warring parents and it appears became very distressed.
- 10.6.4 Paternal grandmother had last visited and been able to see the children during January 2008 and had only received a response after knocking for some considerable time. On this occasion she spent approximately one and a half hours and attempted to visit again the following month but had been unable to gain entry. Her visits had become less frequent due to serious health problems; she died in November 2008.
- 10.6.5 Maternal grandmother stated her belief that there had been episodes of violence in the relationship between mother and father and noted that she had encouraged her daughter to end the relationship with him. She stated that mother had lost weight from a size 24 to 14 in a short period (unable to establish the specific time period for this).
- 10.6.6 Maternal grandmother's last contact with her daughter was in January 2008 when mother and partner had visited with the children, seeking advice about his computer. Following this point mother had discouraged visits, saying in telephone conversations and text messages that they were working on the house and it was not fit for visitors. Despite this message, no attempts were made by mother or partner to take themselves or the children on visits to extended family members.

10.7 Changes in the Family Household

- 10.7.1 It is not possible to pinpoint with accuracy when situations in the household changed. We know that mother began to institute some dietary changes during 2007 to address her own weight and health concerns and from information provided that partner moved into the family home around September 2007, it is also clear that by January 2008 there was a changed routine in operation which placed partner in a position to exercise considerable influence on the family including discipline of the children.

10.8 Wider Medical Information

10.8.1 Further investigation of the child's body at post-mortem highlighted bruising to the body that showed a pattern of injury that was subsequently linked to a thin cane found by police on the first floor of the home after the child's death. Histology indicated that the injuries were not all inflicted at the same time, some inflicted between 48 and 72 hours prior to death. A Professor, emeritus professor of Paediatric Gastroenterology and Nutrition, UCL Institute of Child Health, states in his report that the child's weight at death had fallen from between the 50th and 75th centile to below the 0.4th centile, the lowest measurable point on centile charts. He notes the child's height had fallen from between the 91st to 98th centile to the 75th centile. The Professor noted that a body mass index of 10.7 kg/m₂ is so low that it could not be plotted on a body mass index chart. The child was classified by the Professor as extremely wasted and at grade three on the Waterlow classification for weight.

10.8.2 The Waterlow classification is a means of assessing and grading protein energy malnutrition, and when used for acute malnutrition grading is based on actual weight compared to normal weight for height as a percentage. Grade zero relates to a percentage over 90%, grade one between 90% - 80%, grade two 80% - 70% and grade three, the most severe form, below 70%.

10.8.3 The Professor noted that whilst the child was not obviously stunted, the height had fallen from between the 90th and 98th centile to the 75th centile, showing that growth rate had slowed. This might be expected either where there is an inadequate supply of food, or there is clinical disorder. Post-mortem investigations provide no evidence to suggest the child was suffering from a clinical disorder that may have resulted in this state. Therefore, the evidence in the child's case indicates that severe malnutrition was entirely due to an inadequate intake of food.

10.8.4 The Professor concluded that at death the child showed marked evidence of wasting and linear growth rate had slowed. In order for this to occur food intake must have been inadequate for a number of months and it is most likely that it was already inadequate when the child was withdrawn from school. Using research from

the Northern Ireland fasters suggests that survival time for adults with total starvation is between 57 and 73 days. The Professor does not believe that the child suffered total starvation, but in recognition of the faster oxidation rate of young children, it is likely that in the child's case there was significant starvation for a minimum of three months and most likely over a period of seven to nine months.

10.9 Health of Remaining Children

10.9.1 All of the surviving siblings were described as malnourished and suffering from specific nutrient deficiencies, particularly Vitamin D deficiency. Of all the children, only one sibling showed no evidence of wasting or stunting at initial assessment. Longer term follow-up demonstrated an early and significant gain in weight and then height, independent of puberty, giving evidence that the child too had been significantly deprived of nourishment.

Please note; that information contained in paragraph 10.9.1 that formed part of the original Overview Report has been removed to protect the privacy and welfare of vulnerable children and their families. Some children suffered from re-feeding syndrome in hospital after child's death.

10.9.2 "Re-feeding syndrome was first described in Far East prisoner of war camps after the Second World War. In starvation, insulin levels are reduced because there is reduced intake of carbohydrates (starchy foods). Fat and protein stores are broken down to produce energy. This leads to changes in the levels of some of the salts in the body, in particular phosphate. When feeding resumes, the body switches back to using carbohydrate to provide energy, causing an increase in insulin levels and a flow of phosphate into cells, causing profoundly low blood phosphate levels. Low phosphate levels can produce the clinical features of re-feeding syndrome, including muscle breakdown, increased risk of infection, respiratory failure and heart failure".

10.9.3 The surviving children were graded on the Waterlow classification as between grade one and grade two. Subsequently, all the surviving siblings have made good progress and gained weights to within normal limits. A sibling was seriously ill with re-feeding syndrome, to the degree that life was endangered requiring intravenous phosphate infusions to recover.

11. Chronological Sequence of Events

- 11.1 The following extracts from the integrated chronology are the independent author's view of the significant events which occurred prior to the death of the child. The child was one of a number of children born to mother and father.
- 11.2 **19th January 2001** – some children attended A&E department at City Hospital following ingestion of mouse poison, both children were seen and discharged on the same day.
- 11.3 **22nd February 2001** – one of these children was referred to Consultant Community Paediatrician following concerns about development.
- 11.4 **2nd May 2001** – the child was born at City Hospital, normal delivery at 39 weeks gestation, ethnic origin recorded as Black, or Black British Caribbean.
- 11.5 **18th August 2001** - A report was filed with West Midlands Police following a call reporting that the brother and mother's partner had punched a woman repeatedly causing lacerations to her head and face, bruising to her face and a fractured cheekbone. The allegations were later retracted, maintaining the incident had occurred, but not wishing to pursue her complaint. This is the first indication of violent tendencies in relation to partner.
- 11.6 **19th November 2001** - Heart of Birmingham Teaching NHS Primary Care Trust named GP recorded that one child's ethnicity was Black African, religion Islam.
- 11.7 **22nd May 2002** – the child was seen by a GP from the Heart of Birmingham Teaching NHS Primary Care Trust, noted as not walking, appeared to have gross motor delay, not vocalising, a reference was made to a sibling's history and a referral to the same Consultant Community Paediatrician is made.
- 11.8 **2nd May 2003** – mother reported to Worker 1 Portage Service that her husband had left her.

- 11.9 **Comment:** It is clear from earlier references within the Chronology and father's relationship with his second partner and the birth of their child in 2002 that father had been in an ongoing relationship with both women.
- 11.10 **14th May 2003** - A letter from the South Birmingham NHS Primary Care Trust to the Birmingham Midland Eye Centre sought a repeat appointment for a sibling, acknowledged that there has been defaulted appointments but explained the difficulties mother had with the children some of which have learning difficulties. The letter went on to state that mother is currently on her own as her husband was out of the country.
- 11.11 **6th June 2003** - It was reported by the Portage Service Workers 1 and 2 during a home visit that father was back in the family home.
- 11.12 **26th June 2003** - It was recorded by Speech & Language Therapist (SALT) 6 within the records for the child and a sibling when that sibling had climbed on the table the mother said a few times "I will put you in detention".
- 11.13 **28th July 2003** - Heart of Birmingham Teaching NHS Primary Care Trust GP confirmed a positive pregnancy test at home and whilst this was an unplanned pregnancy mother was said to be happy and confirmed this pregnancy was by the same father as the previous children.
- 11.14 **12th August 2003** – the child attended for a 21 to 24 month developmental assessment and health promotion, vision and hearing recorded as fine with gross motor, speech and squint recorded as satisfactory. The child was referred to the GP but the reason for this referral is not recorded and no record of any 12 week follow-up as indicated appears to have occurred.
- 11.15 **5th September 2003** - Worker 2 Portage Service recorded mother noting that father had gone abroad.
- 11.16 **26th September 2003** - Portage Service Worker 1 records note mother now 15 weeks pregnant and father had returned home.

- 11.17 **3rd March 2004** – the child was seen by South Birmingham NHS Primary Care Trust for a medical assessment as part of an educational statement. No medical concerns were identified the main concerns related to speech and language delay
- 11.18 **14th July 2004** - At an annual review regarding a sibling conducted by Children, Young People and Families Education Welfare Service mother's written comments raised concerns that the sibling had trust issues regarding both teachers and Asian pupils resulting from being racially bullied whilst attending School 3.
- 11.19 Mother did not feel school had dealt with the matter so she removed the child before getting a place at School 4. Mother stated "I tried to show the child that not every human being is a racist bully".
- 11.20 **31st August 2004** - Telephone call to police from mother stating that the father of her children was at the family address trying to take the children away. The log notes children could be heard crying in the background. Mother called back ten minutes later requesting the police cancel their attendance as father had left the address and there were no further problems. Police arrived at the time of the second call and confirmed in the log that all was in order at the address. Both parties were still there but no offences were reported. The log records all of the children were present at the time.
- 11.21 **1st September 2004** –Telephone call from mother to West Midlands Police reporting a domestic incident in progress. The call operator could hear a female shouting at a male to stop hitting the children, the log records 'lots of disorder in the background' and log further reports that the female was trying to get the children to go upstairs out of the way of the male. Upon attendance police found and established that there were no injuries or damage. This was the second incident in two days, but no further action was taken.
- 11.22 **26th June 2005** - 999 call to West Midlands Police reporting a male 'giving a female a good beating' at the back of Rackham's in Birmingham City Centre. The caller also stated that there was a small child present. When officers attended they established there had been a verbal altercation between father and his second partner, but there was no evidence of assault, it was a verbal argument only. A child

was present who at the time would have been 2 years 8 months, a domestic abuse form completed for the domestic abuse officer's attention.

- 11.23 **1st September 2005** – the father appeared in Court for criminal damage and assault by beating, the victim was mother's partner following an argument outside a public house over a car loaned to mother. Damage was sustained to the public house window and father was sentenced to 160 hours of community punishment.
- 11.24 **15th December 2005** – the child and a sibling failed to attend child development appointment, there had been several defaulted and cancelled appointments prior to this point. A letter was sent to the family offering a further appointment and urging contact if attendance was proving difficult. This information was not shared with other professionals.
- 11.25 **1st March 2006** – the same sibling did not attend for a school medical. There was now a pattern of defaulted appointments emerging. Health professionals did not liaise with one another and there are no documented discussions with the family regarding their needs, circumstances, or support requirements.
- 11.26 **3rd March 2006** – that sibling was brought to the Emergency Department by mother after falling down 5 to 10 steps and injuring their nose on the stair gate. It is noted by Birmingham Children's Hospital NHS Foundation Trust that mother noted that parents were separated.
- 11.27 **6th March 2006** - Telephone call to West Midlands Police from mother reporting the children's father was at the home address threatening to remove the children. Police attended and found it was a verbal as opposed to physical altercation, with no assaults or damage reported.
- 11.28 **7th March 2006** 16.07 hours - Telephone call to West Midlands Police from mother reporting father picked up some of the children from school twenty minutes early without her permission. Mother was concerned as she did not have any contact numbers for him other than his home address.

- 11.29 **7th March 2006** 16.12 hours – the mother called West Midlands Police to say that the children were now back and there was no further need for police attendance.
- 11.30 **7th March 2006** 16.23 hours – Telephone call to West Midlands Police from a neighbour of the mother, reporting a domestic incident occurring outside the family home. West Midlands Police contacted the mother on her mobile at which point she stated her ex partner had now left but had punched her in the face and strangled one of the children. Whilst the father had taken all of the children to the family home on the mother's return there had been an argument as father had attempted to take one of the children. The mother had attempted to stop him by taking a saucepan to hit him with before she had been able to do this he had punched her. Officers saw no marks or bruising to the mother and she stated she was not going to attend hospital. Officers obtained a statement from a witness and the father was arrested for a Section 47 assault on her. The father denied assault stating he was acting in self defence. A WC392 Domestic Abuse form was forwarded by the Domestic Abuse Officers to the Child Abuse Investigation Unit. There is no evidence of this document within the Child Abuse Investigation Unit and no indication that any further action was taken in relation to the safeguarding concern of father strangling one of the children. It is unclear if the document was not actually sent, or subsequently misplaced.
- 11.31 **9th March 2006** – mother visited GP with a sibling stating that father pulled the sibling out of the chair and since then she alleged that the sibling had been complaining of bi-lateral knee pain when walking. GP advised mother to discuss this with Police and Health Visitor. On this occasion the GP did not adhere to safeguarding procedures following allegations that father had injured the sibling, it was insufficient to advise the parent to take safeguarding issues forward individually.
- 11.32 **14th March 2006** - Anonymous caller visited Children, Young People and Families office stating that mother could not control her children and that one of them had fallen down the stairs into a stair gate and hurt their nose. Given that recent domestic violence referral checks were done with the Health Visitor, who had indicated no concerns in respect of the children but agreed to monitor, the referral

was closed. It is unusual for callers to raise concerns directly at an office, but also to be regarded as anonymous during this process.

11.33 **16th March 2006** - Health Visitor 6 Heart of Birmingham NHS Primary Care Trust undertook a home visit – present were mother, and some siblings. Children were observed to be appropriately dressed, one was at home due to falling downstairs and cutting the bridge of their nose on a stair gate. Mother complained of steepness of the stairs and her physical difficulty in using them. Health Visitor observed house to be rather disorganised, and a safety concern in relation to flooring in front room was recorded. Mother disclosed recent and previous domestic violence incidences. The father of the children was reported to have man handled them during a recent incident. Health Visitor 6 failed to record the cause for concerns on the Health Care Needs Analysis, which is a contravention of the record keeping guidelines of the Trust.

11.34 **17th March 2006** - Health Visitor telephoned Children's Social Care and shared the information obtained on 16th March 2006.

11.35 **July 2006** - School Report for a sibling indicates that the sibling prefers to remain silent but had started to speak to the teacher with one word answers. School Report for another sibling states that sibling was very quiet, sometimes speaking only in a whisper. School Report for the child describes a lovely sensitive child who the teacher will miss next year. National expectations for an average child at the end of reception stage are that they will achieve six profile points – the child's school report indicates that the child had achieved five profile points in physical development. To be awarded five points the child would have to move with confidence, imagination and in safety, demonstrate fine motor control and co-ordination such as a good pincer grip, threading, using scissors, pencils, etc. This clearly demonstrated a huge improvement for the child, it is noted that this represented a great single leap forward rather than incremental steps. The report stands out in comparison with reports on some siblings. The child appears to have been more sociable and outgoing, there are examples documented elsewhere which indicate that the child had a strong personality / independence. The Panel wondered whether this was a significant factor latterly and whether the child had a stronger independent streak than the siblings, manifesting itself with a stronger will

and potential defiance resulting in harsher punishments. Clearly the child was a child with significant drive and determination. One potential hypothesis is that within a family with strict behavioural requirements a child who is less conforming and challenging will be viewed negatively and harsher punishments may be deployed to enforce compliance.

11.36 **10th October 2006** – father’s second partner confirmed that she and father had reconciled and were now living together permanently.

11.37 **8th November 2006** – a sibling was seen by the school doctor, South Birmingham NHS Primary Care Trust in the presence of mother for school Medical. It is recorded that the sibling’s general health was good and that the sibling was making good progress. Weight, height and head circumference were recorded and plotted on the 75th centile, demonstrating at this stage the sibling’s physical development is unimpaired.

11.38 **January 2007** - Children, Young People & Families Early Years and Child Care Team recorded that children had stopped attending Breakfast Club due to a drastic change in mother’s personal affairs. This was later clarified as mother’s inability to drop the children at Breakfast Club and take her eldest child to school at the same time.

11.39 **26th February 2007** - During Health Visitor 8’s contact with mother at the Medical Centre the mother informed the Health Visitor she was very frightened of her ex husband who was very abusive and was inflicting emotional abuse on the children which was having a severe impact on their behaviour. He had asked the children to be uncooperative to their mother and has physically abused them by hitting them if they do not obey him. The mother also alleged domestic abuse with his new wife who was also receiving domestic violence within her home environment. Health Visitor was clear given the information provided she would need to make a referral to Children’s Social Care.

11.40 **28th February 2007** - Referral made by Health Visitor 8 to Children’s Social Care letter read ‘I have referred this family because of concerns raised by the children’s mother there is a history of domestic violence in this family the parents are no

longer married or have any intimate relations according to mother however, persistent abuse still occurs when he visits children. The mother also feels threatened and frightened because she feels that he monitors her address frequently. She at present refused the ex spouse any contact with the children as she feels that he is inflicting emotional abuse on the children and has also threatened to harm them and at times been physically abusive to them. The mother has disclosed to me that her ex husband is married to another woman. The letter continues 'mother feels that her ex spouse's behaviour has had a severe impact on her children's behaviour and in my opinion this family needs an urgent assessment and investigation into father's second family'.

- 11.41 **6th March 2007** – School 2 received a handwritten letter from the mother insisting that a sibling was to be given one dinner and no seconds; if there was a snack it was to be one biscuit and a drink. Mother pointed out that they have discussed the food issues before and wanted school to comply with the previous agreement. This is the first notified reference to any issues regarding food and whilst the request is unusual in itself there is nothing in the communication to give further concerns regarding the treatment or safety of the sibling.
- 11.42 **19th March 2007** - Letter from the mother to school 1 complaining that a sibling was not sitting at the front of the class or being given more challenging maths work. Mother alleged that the school was taking away her child's right to progress at school.
- 11.43 Letter from mother to school 1 alleging that a sibling was being bullied and that the class size was small teacher must have witnessed this and was failing to do anything about it. Mother was highly critical of the school's methods of dealing with bullying and threatens to go to court.
- 11.44 **19th March 2007** - On the same day school 2 recorded a discussion with School Nurse regarding a sibling who was said to have put on weight and from a medical view they were satisfied. The sibling presented as bright and chatty. There is an unsigned entry indicating the writer was concerned that the sibling may be obsessed with food because they were always hungry or the child was obsessed with food, could eat and eat and never put on any weight. Given that the sibling

had put on some weight they agreed to see how the sibling was after Easter after being fed at home.

11.45 The two schools did not know about each other's concerns and did not pool their information.

11.46 **20th March 2007** - Meeting between school 1 and mother following a letter found in the child's homework folder saying father was no longer to have contact with the children. Mother informed them that father was unkind, limited treats and supported bombings. She said the Islam he talked about was nothing to do with Islam and she had contacted the Police. Mother was concerned as she had been told that the child was stealing food however the teacher was unaware of this and no incidents had been reported to her. Mother also told the school that her brother had visited her and told her to be firmer with the children and identified the child as being unresponsive and sneaky. Mother felt that the child was finding it difficult to accept that they couldn't see their father and was therefore stealing sweets from the other children. School agreed that the Behaviour Support Manager would observe the child during lunchtimes and a member of staff would talk to the child about personal conduct.

11.47 The school did not share this information with other agencies but concentrated on meeting with mother to discuss her concerns.

11.48 **23rd March 2007** - Teaching Assistant school 1 recorded a session with the child. They discussed taking food from other pupils. The child showed new shoes and said mother bought them for a birthday because the child had been good. The child stated that "I am good now and I do not steal anymore". The child talked about tasting crisps, finding chocolate in the hall and eating someone else's dinner because the child wanted to taste it. But kept stressing that "I was good now".

11.49 The child talked about home cooking and for breakfast having porridge with chocolates and nuts because mum said that the child was good now. "When not good would get horrible porridge". The child went on further to say that mother says "I can stop eating dinner when I am full. It's rude not to eat it all but I can stop when

I am full. The Teaching Assistant asked the child how old they were. The child responded "I am good, I am 100 years old".

- 11.50 **30th March 2007** – mother was seen at Children's Social Care office and gave signed consent for lateral checks as part of initial assessment. Records state individual assessment was completed on all children. It was noted that school were now on Easter holiday so information in detail was not obtained from them, it was agreed that the case would be held on review and monitored until information could be obtained from school.
- 11.51 **18th October 2007** - Parents failed to attend parent's evenings at school for all children. Additionally they did not attend any of the six special needs review meetings held for the child and some siblings during the same period.
- 11.52 **5th December 2007** – school 1 records note concern that a sibling had been filling their pockets with fruit at playtime (seen twice) as fruit was not restricted in school filling the pockets was unusual. Further it is noted that the sibling was seen hanging around the dinner hall as if to get another meal.
- 11.53 **7th December 2007** – the child was absent from school and school telephoned mother who informed them that the child would be educated at home.
- 11.54 **14th December 2007** - Meeting at school 1 between a sibling's class teacher and mother. Teacher was concerned that the sibling repeatedly failed to bring their PE kit to school and so had missed most PE lessons. Mother is recorded as speaking in a very aggressive manner, complained at the way the teachers had spoken to the sibling the day before and stated that PE in school was no good. Teacher invited mother to speak with the PE specialists; Mother dismissed this and stated no one in the school was interested that her children were being racially bullied. Mother was said to have become increasingly aggressive and further would have to pass the matter on if the sibling continued not to bring their PE kit. Mother stated that she had a big file about the things that had been going on in the school and was going to approach the LEA and the Press. Teacher encouraged mother to make an appointment to discuss her concerns with the head teacher.

11.55 The above interchange was witnessed by another member of staff who expressed concern that she thought mother was going to hit the class teacher. Later the same day the class teacher spoke to the sibling for misbehaviour and defiance who called the teacher a liar and indicated that mother said to ignore her. This situation represented a significant change in behaviour for mother there are no previous indications of her presenting aggressively in any fashion and whilst school had described her as a powerful personality she had never previously given cause for concern regarding potential violence

11.56 **17th December 2007** – some siblings attended school 1 for the last time.

11.57 **19th December 2007** - Referral made by Deputy Head Teacher school 1 to Children's Social Care. Concerns related to the child, information suggested the child came from a strict household and had been taking food from other children's bags. Further that a sibling had been cramming food into their mouth; both children were reported to be thin but generally clean and tidy. Information was given that both children had a statement of educational need, they were reported not to socialise well with other children. The child had been out of school following a meeting with mother who had been very hostile towards staff. Information was recorded on the system as initial contact not as a referral. The practitioner stated that the Team Manager had recommended that school education social worker and school nurse should deal with the matter and suggested a CAF was required and that ESW (Educational Social Worker) should be the lead practitioner, despite evidence of a hostile mother who would not be co-operative.

11.58 The Deputy Head rang again later and spoke with a Referral and Advice Officer and informed them of serious concerns regarding some of the children, reiterated the issue of taking food and that in a meeting with mother she had confirmed that the child did the same at home and that the child's behaviour was poor. Information was also shared of mother's intention to educate the child at home. School identified a concern that the child usually had good attendance, but had now not been seen for over a week. Further concerns were raised about a sibling cramming food into their pockets, loitering in the dining room and reported feeling cold. The class teacher had noted that the sibling was hungry and had logged a concern on schools forms. Further concerns from the sibling's class teacher had noted a

sudden change in mother's behaviour and described mother as concerned and agitated. The Deputy Head confirmed that they would fax a written referral. During this conversation, the Referral and Advice Officer informed the Deputy Head that the family were known to Children's Social Care for domestic violence, male against female and if the referral was accepted an Initial Assessment would take place within seven days.

11.59 Whilst it was made clear by the Deputy Head that this was a Child Protection referral a delay occurred as there was no one to take the referral. The school had clearly demonstrated their concerns both by telephone and in a follow-up written referral clarifying mother's intentions to educate the child at home, a sibling was putting food in their pocket stating they were cold, another sibling showing a change in behaviour and attitude towards the teaching staff and becoming confrontational and defiant and the mother's previously unseen aggressive behaviour.

11.60 At 12.30pm the Deputy Head and the Teaching Assistant visited the family home. Children's voices were heard in the house but no reply was received to the front door. After waiting some time the children were quiet and mother answered. The Deputy Head and Teaching Assistant were not invited into the household this was seen as unusual behaviour as it was EID the traditional period of celebration and hospitality. The Deputy Head asked after the children especially the child who had not been in school for some time. Mother indicated she had met in school with two teachers and had not been happy with the messages sent home with a sibling. She said she had been told that the child had been taking food and that she would keep the child at home and sort behaviour out from there. Mother indicated that the child's behaviour was improving and when asked when the child was returning to school mother replied that she was going to educate the child at home. The Deputy Head encouraged mother to discuss the child's needs and the return to school and mother indicated she would contact the school in January.

11.61 Staff returned to school but did not feel reassured and continued to fax their referral to Children's Social Care, needs were identified as emotional and behavioural development, health and basic care. The referral included information that the class teachers for both the child and a sibling had seen them trying to take food from other children's bags, cramming fruit into their pockets and that both children are

very slender. The sibling had been feeling cold; that a teacher had met with mother about food being taken and that the child had not been into school since this point (last attended 10th December 2007). The referral confirmed that Mum had told the school she would teach the child at home.

11.62 **20th December 2007** - Deputy Head of school 1 contacted Children's Social Care seeking an update on the referral. Children's Social Care reported that the referral was not being progressed through to initial assessment, the Deputy Head requested a home visit and was told that Children's Social Care had decided not to proceed with the referral. School staff requested their concerns were taken to the line manager, the practitioner refused, saying the manager would not accept it and suggested a CAF. The Deputy Head was not satisfied with the response and the Referral and Advice Officer, Children's Social Care indicated if the school remained concerned they could contact the Police for a Safe & Well check, and that the school should stress it was urgent and not under play it. Deputy Head again raised concerns that the case was not being progressed and requested written confirmation that the matter would not go to initial assessment. The Referral and Advice Officer replied that this was not standard practice and indicated that they would write to the family to say that a referral had been made but not taken up.

11.63 Deputy Head Teacher of school 1 contacted West Midlands Police requesting the Police to undertake a Safe & Well check on the child, as the Deputy Head noted the child had not attended school since 6th December 2007.

11.64 West Midlands Police attended the family home to undertake Safe and Well check. Mother did not allow Police into the household. Police officers asked to see the child and a child was brought to the door, the child was described as fine and well and mother had confirmed to Police that she would self tutor the children because they were being treated differently because they were Muslims.

11.65 **21st December 2007** – mother rang Special Education Needs Assessment Service to say that she had removed the child from school 1 along with some siblings and wanted them educated at school 4. The reasons given were bullying by children and teachers, a lack of progress/ improvement, failure to challenge the children sufficiently and for calling the Police in relation to the child the previous week for

non school attendance. Mother confirmed that she would not be attending any further planned meetings with schools and wanted the contact number for schools management in order to lodge a complaint.

11.66 Later, mother contacted EWS duty helpline speaking to an administrator who recorded mother had decided to remove the child and some siblings from school 1 because of their behaviour towards her children and that she was going to teach the children at home until a suitable school place was found.

11.67 Prior to this point there may have been some opportunity to encourage mother to return her children to a school setting, but it appears that the request for a Safe and Well check and the subsequent Police visit at the family home hardened mother's attitudes and it is one of the stated reasons why the children would not be returning to school. This is a key turning point, as previously with the children in school, there was an excellent opportunity to maintain an overview of children's well being, development and behaviours and to foster links with parents. From this point on, contact with parents and access to children became extremely difficult.

11.68 **8th January 2008** - Letter received by Special Educational Needs Assessment Service (SENAS) from mother to say that she now intended to tutor the child and some siblings at home because of the perfidious conduct of some of the staff members at school 1. One example given by mother was that no changes had been made to their statements due to the incompetence of tutors. She indicated her intention to return her children to school at Secondary transfer age.

11.69 School Nurse from South Birmingham NHS Primary Care Trust was asked to see a sibling by class staff who were concerned with the child's weight. During this weigh-in, the weight was between the 25th and the 50th centile (previously the child had been on the 75th centile). Staff reported that mother was restricting the diet in school and was not allowing snacks like the child's peers. School staff were unaware of the reasoning behind this behaviour and reported that the sibling was asking for food saying it was hungry. There was a record to note they will ask mother to see the school doctor on 16th January in school at 2pm.

- 11.70 Also on 8th January, Education Welfare Service received a copy of the letter sent to SENAS written by mother on 3rd January announcing her intention to educate at home. The letter is typewritten and uses very formal language which is described as having a religious undertone. This is different from the forms of communication previously used by mother she referred to several of the children being statemented whereas a sibling did not have a statement of which mother was fully aware. She was also extremely aware of the education and special needs system. In addition to this she gave an incorrect date of birth for the child. In the school's experience it was unlike mother to be factually inaccurate.
- 11.71 **16th January 2008** - Duty Social Worker from Education Welfare Service telephoned mother who had decided to opt for Education Otherwise. The EO referral form was completed in respect of the child and some siblings. Ethnicity is recorded as Black British on this occasion.
- 11.72 **21st January 2008** – another sibling failed to attend Ophthalmic Surgeon appointment at City Hospital. There is no record of any active liaison with the School Nurse.
- 11.73 **22nd January 2008** - School doctor saw a sibling in school mother felt that the child was getting too much food as having snacks and lunch in school. Mother stated that the child suffered from eczema if they have chocolate and milk. Weight and height were slowing down, mother was reluctant for a dietician referral. Proposal was for a weight check in three months time, the issue of the child's weight was not explored further at this time.
- 11.74 **25th January 2008** - SENAS telephoned mother to follow up on a letter sent and to offer help mother communicate with the school or find different placements. Mother informed the Review Officer that she had “no legal leg to stand on” was unhappy with the letter from SENAS and did not want any home visits. As SENAS attempted to explain their requirements to ensure the children's needs were being met mother hung up the phone. The response represents a detailed knowledge of home education legislation and an escalation of mother's non co-operation with professionals.

- 11.75 **28th January 2008** - ESW attended a liaison meeting at school 1 and received a referral regarding the child and some siblings. ESW recorded that the school had concerns regarding the welfare of the children and described them being at risk but could not specify what the risk was. School had previously made a referral to Children's Social Care but this had not been accepted. School informed the ESW that a safe and well check had been conducted before Christmas by the Police at their request. Subsequently mother had informed school of her intention to teach the children at home.
- 11.76 ESW1 attempted a home visit but received no reply and left a note requesting mother to contact.
- 11.77 A letter from the Head Teacher with the same date is on file asking ESW1 to advise regarding de-registration of the pupils and querying whether a CAF or multi agency meeting might be appropriate.
- 11.78 Deputy Head Teacher contacted Children's Social Care and advised that mother had applied to educate some of her children at home, that some of the children were statemented so that the SENAS service would need to be involved. This was the third contact from the Deputy Head teacher to Children's Social Care.
- 11.79 Head Teacher of school 1 referred to ESW as mother had requested home education for children. ESW was briefed about the children's special educational needs and the school's concerns. ESW was advised of referrals by school to Children's Social Care on 18th December as the school had concerns about the children stealing food from other children's bags. It is clarified that this has not been followed up with a formal assessment by Children's Social Care and that school were still concerned. The agreed actions were that the school would write to the ESW to request advice about the status of the children and that the ESW would liaise with agencies to support the family.
- 11.80 **30th January 2008** - ESW1 made a telephone call to mother who was not happy that the ESW had visited the family home without a prior appointment. She informed the ESW1 that they were in breach of European law and could be taken to court.

ESW1 records that mother was very angry and would not listen as she attempted to explain role and concerns.

- 11.81 ESW1 made a telephone call to SENAS Review Officer RO1 and confirmed conversation with mother and that prior to hanging up had been quoting the law. It was confirmed that all paperwork had been sent to the EO Adviser.
- 11.82 **30th January 2008** - ESW1 made a telephone call to EO Adviser to inform them of the circumstances leading to mother's withdrawal of the children from the school. This was a significant call, and clarified that the EO Adviser was made fully aware of the home situation and wider concerns, prior to any home visit, or assessment.
- 11.83 ESW1 made a telephone call to Children's Social Care and discussed the family. Children's Social Care worker suggested that a CAF should be undertaken and that the ESW should lead. The ESW1 clearly recorded that a CAF is not appropriate as mother was not co-operating or engaging with professionals. ESW1 recorded that Children's Social Care worker had agreed to make some checks with some other agencies and ESW1 was asked to make some checks to establish if the other children were still attending their schools. Children's Social Care worker was to discuss the case with line manager and call ESW1 back.
- 11.84 **30th January 2008** – ESW1 made contact with Referral and Advice Officer, Children's Social Care following a home visit to the family but was prevented from access to the house by the mother who was hostile and quoting her human rights. The ESW1 was concerned that the children had not been seen by a professional since before Christmas and had not allowed entry by Police in December 2007 during their safe and well check. Further concerns were raised that the children had changed schools in the past and that no professionals had seen these children since 3rd December 2007.
- 11.85 Referral and Advice Officer, Children's Social Care contacted the Health Visitor who stated she had had no contact with the family since her referral in 2007 despite her own concerns. Health Visitor was requested to check whether a sibling had received the correct immunisations and discussed issues in relation to mother's mental health.

11.86 Referral and Advice Officer, Children's Social Care contacted Police to check call-outs. The last one was noted as February 2007. Referral and Advice Officer recommended to line manager that an initial assessment should be conducted on the basis of the following:

- Reported history of domestic violence in the family
- Concerns regarding the child and a sibling were being adequately fed
- The hostility of mother to professionals
- The fact that some of the children had been removed from school 1 to be home educated
- That ESW and Police had both been denied access to the house

Manager signed off recommendations for initial assessment.

11.87 **31st January 2008** - ESW1 received telephone call from Referral and Advice Officer confirming that Children's Social Care would conduct an initial assessment and that ESW would be updated.

11.88 **February 2008** (no specific date) - A telephone call was made by the project 1 to the mother, who stated she had been away and was "busy trying to sort herself out". No explanation was recorded to clarify the mother's comments, several further conversations occurred with her were also not recorded.

11.89 **1st February 2008** - Appointment letter was sent from Education Otherwise Adviser to the mother arranging a home visit on 8th February 2008 to be accompanied by ESW EO.

11.90 **7th February 2008** - ESW1 had now left the department and the case had been allocated to ESW2. There was a telephone call from Children's Social Care to ESW2, and during the course of the day several telephone calls were made to ESW2 but on each occasion no answer was received. Children's Social Care records indicate that a message was finally left stating that Senior Practitioner would be making a visit to the family home on 18th February at 3pm on return from annual leave. There is no corresponding record on the ESW file.

- 11.91 **8th February 2008** - Visit by EO Adviser and ESW EO to the family home to conduct EO assessment. Form EO3 was used for this process and indicated that literacy and numeracy would be taught every day, science on most days and history and geography as projects. Furthermore D&T would be cookery, MFL would be Arabic and French, PE would be sport, PSHE would be health education and RE and moral issues. Under recommendations it is recorded that plans would be sent to the EO Adviser by the family by the end of February 2008. On this occasion the box asking whether or not education was suitable was left blank.
- 11.92 The contact log indicates that the case was originally allocated to the ESW EO and that he visited the family with the EO Adviser; there are no notes on file from the ESW EO.
- 11.93 The ESW log shows that the case was allocated to the ESW EO; in fact, it was passed directly to the EO Adviser as the children were statemented. The usual process is for ESW EO to undertake an initial home visit, advise parents on their rights, responsibilities and to conduct an assessment. The EO Adviser would visit once education has been established, to give educational advice and assess whether the children were receiving appropriate education. As the children were statemented, an immediate educational assessment was warranted and therefore the case was not brought to the attention of the ESW EO, until they were requested to accompany the Adviser on a visit. The ESW EO would not normally do so, but concerns had been raised previously regarding the behaviour of mother and so a joint visit was undertaken.
- 11.94 At no point during the visit, did the ESW EO or the EO Adviser ask to see the children; there was no enquiry of where the children would sit. On the basis of the information received it could be inferred that the purpose of the joint visit was for personal safety of the professionals in response to the increased aggression demonstrated by mother towards other professionals, as opposed to an opportunity for two professionals to make a wider assessment of safeguarding risk and home education potential. This is particularly pertinent given information provided to the EO Adviser expressly by ESW1 on 30th January 2008.

- 11.95 It is concerning to note, that the ESW EO whilst not undertaking any assessment, also did not make any record of events and reinforces the view that the home visit was both poorly planned, conducted and that a lack of child focus and professional curiosity was evident throughout.
- 11.96 **18th February 2008** - ESW2 attended a liaison meeting in school 1. Head Teacher raised concerns as the children had not been seen since the Police safe and well check in December 2007.
- 11.97 ESW2 received a phone call from a Social Worker and the plan was made to conduct a joint visit to the household on 18th February at 3pm. ESW later returned call and rearranged for 3.30pm on 21st.
- 11.98 **19th February 2008** - E-mail was sent from EO Adviser to ESW2 informing that a visit had taken place to the family home and parents had been seen but the children had not.
- 11.99 **20th February 2008** - A fax was received by Children's Social Care from school 1 detailing the attendance records of the child and some siblings. This recorded the child's attendance between 4th September 2007 and 8th February 2008 as 100% up until the point the mother withdrew the child from school. There is no additional information on the fax regarding any other concerns for the children.
- 11.100 **21st February 2008** - ESW2 and Social Worker Children's Social Care visited the family home and saw mother and an unknown male. The adult male was recorded as aggressive and neither worker was allowed entry to the house. ESW2 was refused a request to see the children but pursued this and eventually some of the school aged children were brought to the door. Workers believed these children were the child and some siblings. The mother stated that EO Adviser had visited the previous week and had not suggested he had any concerns about the children. The Senior Practitioner explained the process of an initial assessment but the mother continued to state that she did not want assessments to be carried out.

- 11.101 Whilst the children were described as clean and appropriately dressed they were also assessed as being confused and shy with the only one showing any facial expression being the child. Access was refused to see the younger child who was said to be asleep in bed. Following further discussion it was agreed that the Senior Practitioner from Children's Social Care would return the following day at 4pm to see the siblings who were currently in school.
- 11.102 By the time the Senior Practitioner returned to the office a complaint had already been made by mother against the Social Worker of harassment. Following a discussion with Team Manager 3 the worker's assessment was that although the children were slim and very shy there were no obvious concerns from the brief encounter with the children. The Manager subsequently agreed that because some of the children of whom there were concerns had been seen that the planned follow-up visit the following day to see the remaining children would not go ahead because of the complaint. Instead, the outcome of the assessment for the children to become educated at home by the EO would be awaited.
- 11.103 A significant weight was placed upon the outcome of the EO assessment and this alone demonstrated assumptions and ignorance of the EO assessment process. There is no evidence to suggest that contact was undertaken by Children's Social Care with the EO to advise of the concerns raised, to further explore the views of the EO and to confirm the content of the EO assessment process. The failure to conduct wider checks with other agencies expressly the current schools attended by the siblings or to establish wider welfare concerns would have been proportionate in this case and represent poor practice and a missed opportunity.
- 11.104 **22nd February 2008** - Telephone call was undertaken by ESW2 to EAO Adviser, ESW2 learns that EO visited the family home with the ESW EO and recorded that the classroom had been set up in the house but that not much had been done regarding teaching the children and learning perspectives. No plans existed therefore ESW EO would visit again to obtain the plans.
- 11.105 **28th February 2008** - SENAS were informed by EO Adviser of a visit to the family on 8th February 2008 and at this visit children were not seen but a room in the house was set up as a classroom and parents were able to talk about teaching

plans. The EO had been satisfied that they were sufficiently set up for home teaching and agreed to confirm in writing.

- 11.106 Telephone call was made by ESW2 to Children's Social Care querying whether the siblings had been seen following the previous home visit (21st February 2008). ESW was informed that EO assessment had been positive for the children to be educated at home. ESW were contemplating closing the file.
- 11.107 **29th February 2008** - ESW2 reported that following a conversation with EO Adviser who was satisfied with the teaching and learning the children were to be recorded as home educated. ESW2 requested this to be confirmed by e-mail.
- 11.108 **7th March 2008** - SALT meets with SENCO in school 1 to discuss children. SALT was informed that the child had left school and was being home educated.
- 11.109 A copy of the EO Adviser report was received by SENAS confirming a visit on 8th February and further that educational plans promised by the end of February had not been received to date.
- 11.110 **10th March 2008** - ESW2 contacted Social Worker Children's Social Care to establish if contact had been made with a Health Visitor about concerns for the youngest child. ESW2 learnt that Social Worker did not see the other children as agreed as mother had called to cancel the visit with emphasis on the word CANCEL in capitals. Further ESW2 recorded that Social Worker had no further concerns regarding the welfare of the children.
- 11.111 **13th March 2008** - ESW2 telephoned SENAS and confirmed that the children have now been recorded as Educated Otherwise.
- 11.112 **17th March 2008** - ESW liaison meeting notes indicated SENAS had agreed children could be removed from the school roll. EO was still awaiting a written plan from parents.

- 11.113 **19th March 2008** - Education Psychology Service recorded consultation notes from school 5 concerning a sibling not knowing how to use the card facility in the dining room, and saying that the child is buying food on the way to school.
- 11.114 South Birmingham NHS Primary Care Trust School Doctor recorded the sibling's weight as going up, therefore, no further action was taken.
- 11.115 **20th March 2008** - Second EO Adviser report was received by SENAS. On this occasion the EO Adviser was raising a question mark as to whether home education was suitable as plans had still not been received from parents in relation to the home education of the child and some siblings. EO Adviser indicated the intention to write to parents.
- 11.116 **9th April 2008** - Appointment letter sent by EO Adviser arranging a home visit on 16th April 2008
- 11.117 **10th April 2008** - EO Adviser contacted SENAS to inform that education plans have still not been received and an intention to carry out a further home visit with ESW EO on 16th April 2008.
- 11.118 **16th April 2008** - Home visit by EO Adviser and ESW EO as arranged by letter. No reply was received at the family address.
- 11.119 **21st April 2008** - Children's Social Care Team Manager discussed case with Social Worker in Supervision and agreed case could be closed because home tutoring had been approved. It was understood by Children's Social Care that a review would be undertaken and the family would be monitored by the EO Service.
- 11.120 The case was not written up and closed so therefore remained open up to the point of the child's death. It is unclear whether this was a capacity or competence issue for the individual Social Worker, but failed to meet the standards expected by Children's Social Care.

- 11.121 **Undated event in April 08** - Information from a sibling's class teacher for medical due **7th May 2008** that child was described as thin, weak, tired easily, felt the cold easily, skin was a little better at present. Academically was making some progress, but slow, keen to participate in activities except swimming, said mother did not want this child to swim. Behaviourally whenever food was available would constantly ask for more, did not seem to chew food and had a limited social circle.
- 11.122 **7th May 2008** – the mother did not attend for a sibling's medical appointment, when seen, the child weight was described as down slightly, height was recorded as static, and a further review is planned for September 2008. Given the concerns raised by the school staff and the fact that the child's weight was down it is surprising that a review was set for September some four months hence. Additionally, no plans were made to undertake follow-up home visits by the school nurse or to inform other agencies.
- 11.123 **7th May 2008** – the father having not seen the children for some time, visited the school on the 7 May 2008 and was informed that the children had not been at school for approximately six months. He was on his way to the family home following this information when he met one of his children they discussed whether everything was OK at home. Following this conversation the father did not visit the family home.
- 11.124 **17th May 2008** – the child was brought by ambulance to the emergency department of Birmingham Children's Hospital. Despite cardio pulmonary resuscitation the child was certified dead at 06.25am.

12. Themed Analysis of Agencies Involvement

12.1 Food

- 12.1.1 The provision and withholding of food and nutrition plays a major part in this review. March 2007 marked the first reference to issues of food by the mother. There were handwritten letters to school 2 in relation to a sibling having one dinner and no seconds, concerns about that child's weight fluctuation, references to the child stealing food in school and intervention by mother's brother, whom we now

believe was in fact her partner. Information provided as part of the care proceedings, indicated that she was encouraged to be firmer with the children and specifically identified the child as being unresponsive and sneaky. At this point, school had no indications or evidence to suggest that the child was stealing food and at this stage was clearly an issue driven by mother. In contrast, when a sibling's weight and height were checked at school on 14th March there was no recorded change from November 2006. There was also an unsigned record dated 19th March 2007 concerned that the sibling may be obsessed with food, presenting as always hungry and able to eat and eat without putting on weight.

12.1.2 What is now known is that mother was struggling with her own weight during this period, exacerbating her own health related issues and began to institute a healthy eating regime for herself and probably the children. It is further referenced that the child was struggling to accept they couldn't see their father. The mother was effectively operating as a single parent of six children ranging in age at that time from 10 years 11 months to 3 years 11 months some of whom were subject to statements of special educational need.

12.1.3 With hindsight it is possible to see the child's fixation on food during a conversation between the child and a Teaching Assistant on 23rd March 2007, but it is also understandable why at this stage the school did not have specific evidence that the child was stealing food from other children. At the time, there were no wider changes in the children's or the mother's behaviour, relationships with schools remained positive and the child in particular was making significant progress in school and continuing to thrive.

12.1.4 What is clear is that during March 2007 schools did not share their information with other schools, or agencies, but focused on meetings with the mother to discuss her concerns. **Recommendation 1 - Birmingham Safeguarding Children Board should commission work to identify how agencies across Birmingham can increase effective professional communication to improve the safeguarding outcomes for children and young people in compliance with policy and procedure.**

- 12.1.5 It is some nine months later during December 2007 when professionals again begin to record issues around food. School 1 recorded that a sibling was filling pockets with fruit at playtime, hanging around the dinner halls at lunch periods. During January 2008 the school nurse was asked to see another sibling by class staff, who are concerned with the child's weight which had dropped between the 25th and 50th centile, where previously it had always been on the 75th. Staff were aware that mother was restricting the child's diet and referenced that child asking for food stating that child was hungry. Had the medical professionals chosen to do so three further weights were available in the school nurse records which if plotted on the centile chart would have clearly indicated a significant change to height and weight. **Recommendation 2 – South Birmingham NHS Primary Care Trust should evidence through audit processes that children who are subject to weight and height checks as part of school medicals, have their data fully recorded and plotted on a growth chart in their notes, to provide a complete and readily accessible picture of the child's development.**
- 12.1.6 Of most concern, is when a recommendation for a dietician referral for a sibling was made. Mother was reluctant to allow this to go ahead. The professionals involved do not appear to have challenged, nor been concerned with mother's resistance to a referral addressing her child's dietary requirements. Instead medical staff propose a weight check some three months hence and the response is incongruous and inappropriate. **Recommendation 3 – NHS Primary Care Trust's should review processes for obtaining parental consent for child access to the school health service and implement, including a process of follow up action for parental refusal or withdrawal of consent.**
- 12.1.7 At this time, some of the children had been removed from school and were being home educated, mother was rapidly withdrawing co-operation with all professionals and had demonstrated a significant change in behaviour, including aggression to a number of professionals.
- 12.1.8 The lack of information sharing between professionals clearly impacted upon their awareness and assessment processes. Had wider professional communication been undertaken at this point, it is likely that a different intervention strategy would have occurred.

- 12.1.9 The above is compounded on 19th March 2008 where the school doctor recorded a sibling's weight as increasing; therefore no further action was taken. The failure to fully assess that sibling on this occasion presents as a missed opportunity. It is concerning that the weight indicator alone prevented further assessment. Of great concern is during April 2008 that child's class teacher in preparation for a medical due in May 2008 raised concerns over the child's general health and described that child as thin, weak, tiring easily and feeling the cold. This occurred less than a month after that child's last medical appointment and presents a significantly different picture. Despite these concerns which suggest evidence of a child in need of further investigation and intervention these wider health concerns did not prompt any wider sharing of information or further intervention. At eight years of age that child's weight was virtually the same as it had been at just under six years of age.
- 12.1.10 That sibling did not participate in swimming activities, as mother did not want it and another child persistently failed to bring in their PE kit again supported by mother. It became apparent during care proceedings that one member of teaching staff at a sibling's school became concerned about this behaviour and asked staff to look for injuries during sporting activities. It is highly likely that there were injuries on some of the sibling's bodies that would have been visible had they participated in these activities.
- 12.1.11 The children home educated were the most severely affected by lack of food. The child sadly died and some siblings suffered re-feeding problems following admission to hospital after the child's death. These children presented unusual feeding behaviours within school, one presenting evidence of changes to weight and development. Only the oldest child suffered no wasting or stunting based on the Professor's assessment, but as the oldest, was the one most likely to have developed survival strategies relating to food, both at home and in the school environment. It is clear from school records that child bought food on the way to school to supplement nutritional requirements.

12.2 **Education**

- 12.2.1 March 2007 also marks a significant period for mother's interaction with education writing a number of letters complaining about different aspects of education specifically relating to some siblings, initially challenging the work given to her child and subsequently raising issues of bullying, accusing the school of failing to act. Mother was highly critical of the school's intervention and threatened to take legal action. This occurred at the point that mother was also challenging the school around food related issues for her children.
- 12.2.2 It is likely that wider factors were motivating mother during March 2007 to challenge education settings on a number of different fronts. We now know that her relationship with father was breaking down and that he was absent from the family home leaving mother to operate as a single parent. Evidence suggests that on previous occasions father had asked partner to provide support to mother, specifically during 2002 when he spent some time abroad. What is not clear is whether partner was providing advice and guidance to mother during March 2007. Evidence suggests that partner did not move into the family home until approximately September 2007. We do know from mother's court evidence that around this time she introduced a healthy eating diet, designed to help her lose weight and all indications point to this regime being implemented inappropriately for the children at the same time.
- 12.2.3 It is now known that a referral had been made to Children's Social Care on 28th February 2007 by the Health Visitor regarding possible domestic abuse. It is also clear that the school were not aware of this referral during March 2007 and were not consulted until 30th April 2007. Had the school been aware at an earlier point, this may have altered their view of mother's spate of letter writing and escalating concerns and enabled the school to intervene or communicate in a different way. It is clear that during March 2007 the school did not share information with the other agencies but concentrated on meeting with mother to discuss her concerns.
- 12.2.4 School 1 raised issues during December 2007, when the second spate of concerns in relation to food for several of the children, were identified. On this occasion the school were concerned that one sibling was repeatedly failing to bring PE kit to school and had therefore missed most PE lessons. Concerns had also been raised in relation to another child's failure to undertake swimming

lessons and it is known that mother was resistant for these events to occur. It is known that mother was recorded by the school as speaking in a very aggressive manner with staff concerned that mother would assault a teacher.

- 12.2.5 December 2007 marked a significant change of behaviour for mother. There are no previous indicators of her presenting aggressively and whilst she had been described as a powerful personality had never previously given cause for concern. It is clear from witness testimony that the issues around PE kit and/or swimming lessons represented a wider concern for at least one teacher, beyond the benefits of physical education. Given the changes to mother's behaviour, it would have been appropriate to share these concerns with other professionals, particularly to have checked the experiences of neighbouring schools where siblings were attending. Some staff were clearly concerned about the potential personal threats to their safety, but do not appear to have given any consideration to the factors driving mother's behaviour, or to identify if there was a potential for the school to intervene in a different way to calm mother, or assist her to get further support or services for the family. **Recommendation 4 – Where a school has initial concerns the designated senior person should liaise with schools attended by other siblings to ensure an holistic view of the children and family is obtained.**
- 12.2.6 The lack of engagement with mother was reinforced only three days after this aggressive interchange on 17th December 2007, when some siblings attended school 1 for the last time. The child had been absent from school since 7th December 2007 and mother indicated her intention to home educate the child.
- 12.2.7 The letters sent by mother on 8th January 2008 to the Education Welfare Service also raise concerns. The use of formal language described as having a religious undertone was different from previous communications. There were factual inaccuracies relating to statements and an incorrect date of birth for the child. The school clearly felt this to be unusual and unlike mother the mistakes do raise questions as to the legitimacy of the letter being constructed by mother, or whether she put her name to something constructed by another party. It is known that partner was present in the family home at this point. It is also known that partner had strong beliefs and should be considered that his influences may have

adversely affected mother's behaviour and her decision to remove children from a formalised school setting to one of home education.

- 12.2.8 When mother contacted SENAS on 21st December 2007, to inform them that the child had been removed from school 1 along with some siblings and her intention to educate at home, her reasons given were those of bullying by children and a teacher's lack of progress/improvement and failure to challenge the children sufficiently, alongside calling police in relation to the child's previous removal for non school attendance the previous week. It is pertinent to note that, despite references to racist bullying elsewhere, racism was not identified as a reason for removal from school.

12.3 Referral and communications

- 12.3.1 School 1 refer to Children's Social Care on 19th December 2007 following the removal of the child and some siblings from school and specifically identify concerns relating to food for some of the children, reference educational needs and statements and the hostility and change in behaviour of mother. The schools attempt was frustrated by an inaccurate coding of the request and the referral was marked as an initial contact only. Further, the referral was treated as an education and attendance issue. It is worrying that the school were urged to initiate a CAF, particularly given the hostility of mother and her lack of co-operation, making CAF an inappropriate option. **Recommendation 5 – Birmingham Children's Social Care must review and demonstrate that staff at all levels understand the appropriate use of the common assessment framework and the application of thresholds for significant harm.**
- 12.3.2 A decision by the school 1 to conduct a home visit on the same day is a further indication of their concerns and possibly frustration by a lack of intervention from Children's Social Care. They were not allowed entry to the house by mother, who conducted a doorstep conversation and given that this was EID, an Islamic period of celebration and hospitality this was seen as unusual. Mother clearly communicated her displeasure with the school referencing the child's taking food and intentions to "sort the child's behaviour out from home".

- 12.3.3 The school should be acknowledged for their attempts to act on their concerns and take responsibility to address issues. Whilst they had been unable to see the children during the home visit they clearly attempted to engage with mother, preserve a relationship and encourage her to return children to a school based educational setting. Following this attempt, their continued concerns prompted a faxed referral to Children's Social Care, clearly identifying concerns of emotional and behavioural development, health and basic care for children. It reinforced the issue of both the child and a sibling in relation to taking food, their slender build, the sibling feeling the cold and mother's presentation and sudden change in behaviour, incorporating her then verbal intention to teach the child at home.
- 12.3.4 The school 1 continued to persevere, approaching Children's Social Care on 20th December 2007 seeking an update. Children's Social Care clarified that the referral was not being progressed through to initial assessment. It is particularly concerning that the Referral and Advice Officer refused inappropriately to discuss this with the Line Manager again when requested by the school and, despite the Deputy Head's protestation, was not prepared to provide a response in writing to another agency's request for clarification of action in relation to their referral. Agencies have a right to written information for clarity and completeness of their records and this response demonstrates very poor practice by Children's Social Care, to both working together expectations and best practice outcomes. Instead the school were encouraged to request a Safe & Well Check from Police, which under the circumstances was completely inappropriate. **Recommendation 6 – Birmingham Children's Social Care and West Midlands Police should review multi agency procedures to ensure that 'Police Safe & Well Checks are not used in place of existing safeguarding policies and procedures.**
- 12.3.5 This was a key decision point, information had been provided by the school representing a range of concerns, from mother's behaviour to children's feeding habits, lack of co-operation from adults and threats of violence to school's staff culminating in children being removed from a formal education setting. The decision not to proceed with an initial assessment and respond to appropriate concerns raised by partner agencies was a clear breach of procedures. **Recommendation 7 – Birmingham Children's Social Care must review and revise their referral and advice screening process to ensure that safe**

decisions are made based on risk and where the referrer expresses dissatisfaction this is passed to the Line Manager for resolution.

- 12.3.6 The Police should be recognised for agreeing to undertake a Safe & Well Check based upon the school's information provided on 20th December 2007. Sadly, the Police were unable to gain access to the family home and yet again mother conducted a doorstep conversation, which was to become a standard response to professional attempts to access the family home and undertake effective assessment. With perseverance, the Police were able to see children brought to the doorstep and to undertake an initial analysis of their physical appearance, but were not given the opportunity for detailed conversations with any of the young people, due to location of this interaction and the presence of their carer.
- 12.3.7 The school remained concerned and made a formal referral to the Education Social Worker on 28th January 2008, clarifying their concerns and Children's Social Care position. The ESW was informed of the Safe & Well Check conducted by the police and the school agreed to write to the ESW formally requesting advice re the status of the children. It is somewhat confusing to note that the ESW stated the school were unable to specify the risks to the children. Given the previous referrals made to Children's Social Care the school had clearly specified their concerns incorporating those passed to the police as part of the Safe & Well Check. It is to the school's credit that they were still attempting positive interventions and sharing their concerns with other agencies in an attempt to galvanise some further safeguarding action.
- 12.3.8 On the same day, the Deputy Head Teacher contacted Children's Social Care. This represented the third contact from the Deputy Head to Children's Social Care. At this point it is unclear what the status of the case was and what the respective expectations of each agency had of the other. It is possible that lack of Children's Social Care action to investigate the school's concerns had caused some professional confusion.
- 12.3.9 On 30th January 2008 the ESW made contact with Children's Social Care following a home visit to the family where a further doorstep conversation occurred. On this occasion mother was again hostile and quoting her Human

Rights and the ESW expressed her concern that the children had not been seen by professionals prior to Christmas 2007. This was a positive attempt by the ESW to update Children's Social Care on both actions undertaken and concerns that still existed to these children. The response by Children's Social Care on this occasion was to contact the Health Visitor, as part of conducting lateral checks, who noted that, since her referral in 2007 of her own concerns, there had been no further contact with the family. The health visitor did not maintain any contact or support to the family following the referral, although the health visitor made two unsuccessful attempts to contact mother by telephone following the referral. The health visitor had received a letter from Children's Social Care stating that they had completed an assessment and there were no concerns as the mother was able to protect the children and herself. The father was no longer living with the family at that time

12.3.10 Following further communication with the police, the Referral & Advice Officer made a recommendation to the Line Manager that an initial assessment should be conducted on the basis of the concerns presented by the school on 19th December 2007. Whilst it is positive to see an effective recommendation to address safeguarding concerns at this point that incorporate the issues of both food for the children and a change in behaviour by mother, this action represented a delay of six weeks between the school's initial concerns and a Children's Social Care acceptance of the need for further intervention and assessment.

12.4 **Assessment**

12.4.1 Mother provided a signed consent for lateral checks on 30th March 2007, as part of an Initial Assessment. However, this was at the time schools were closed for the Easter holidays. As such, delays occurred pending the schools return. It is unclear if the children were seen at any point during this initial assessment process and further there does not appear to be any evidence of lateral checks undertaken with the Police. This is concerning given that evidence of domestic abuse was clearly known to Children's Social Care at this time. This process was closed down on 3rd May 2007, without a clear understanding of the findings of the initial assessment process. There would be a benefit in reviewing how assessment services are conducted and monitored within the Duty & Assessment

Services. **Recommendation 8 – Birmingham Children’s Social Care should review the assessment process in the Duty & Referral Service to determine robust management oversight at each stage of the process and ensure robust quality assurance measures are in place which are specific to the ‘Framework for the Assessment of Children in Need and their Families.’**

12.4.2 The Deputy Head contacted Children’s Social Care on 20th December 2007 for clarification of action to the referral made on the 19th December and was concerned to hear that the referral was not being progressed through to an initial assessment. It is concerning to see that the Duty Worker recommended either a CAF or that the school contact the police for a Safe & Well Check. Neither of these responses was appropriate to the concerns raised by the school and represent poor safeguarding practice by Children’s Social Care and a distinct lack of partnership working. It is further concerning that Referral and Advice Officer refused to place in writing confirmation of their response to the school’s referral. Agencies clearly have a right to written information both for clarity of actions and completeness of their own records where safeguarding concerns have been raised. The response by the Referral and Advice Officer from Children’s Social Care on this occasion fell short of an acceptable standard and clearly was a missed opportunity.

12.4.3 On 30th January 2008, following written communication from the school, further follow up and intervention by the ESW, the Referral & Advice Officer recommended to the Line Manager that an initial assessment should be conducted based upon the range of concerns provided. This was an effective response by Children’s Social Care to the information presented and recognised for the first time that the issues relating to feeding of the children was a significant factor. Sadly, this process occurred some six weeks after the schools initial referral. A further week’s delay occurred before Children’s Social Care undertook telephone calls to ESW. By this time, ESW1 has left the department and several failed telephone calls to ESW2 were attempted. Messages were eventually left indicating a home visit would take place on 18th February. The significance of ESW1’s departure at this point cannot be fully assessed. However, it is clear that ESW1 was actively involved in the communication processes and had a full understanding of the safeguarding concerns. What is less clear is the degree to

which ESW2 understood these issues at the point of contact by Children's Social Care. The communication between the Education Welfare Service and Children's Social Care following this is unclear, but on 18th February 2008 when the ESW2 attended a meeting at school 1 the Head Teacher raised concerns, noting that children had not been seen since the Safe & Well Check in December 2007. On the same day the ESW2 received a phone call from Children's Social Care noting that a home visit was planned for 21st February. This was now some nine weeks after the initial concerns were raised by the school and three weeks after the decision was made by Children's Social Care to conduct an initial assessment.

- 12.4.4 A further doorstep conversation was conducted on 21st February when ESW2 and Children's Social Care worker attended the family home. Both mother and an unknown adult male were aggressive towards workers and initially refused to present the children. It is only through persistence by the professionals that the children were eventually presented on the doorstep. Non co-operation was demonstrated by mother at this time and an initial assessment was not adequately completed, due the nature and confidentiality limitations of the location. Additionally, aspects of school attendance, food issues and a change of mother's behaviour and presentation were not discussed.
- 12.4.5 It would appear that the resistance and hostile approach demonstrated by the adults influenced and affected the professional actions. On this occasion it was the adults with parental responsibility who controlled access to the children and frustrated a thorough analysis and assessment of the issues. The approach further reinforced that the power dynamics lay with the parents and not with the rights, welfare and protection of the children. **Recommendation 9 - Birmingham Safeguarding Children Board should commission multi agency guidance and training to equip staff in all agencies to work effectively with aggressive and highly resistant parents and carers.**
- 12.4.6 Following this visit, a significant weight was placed upon the outcome of the Education Otherwise assessment, demonstrating further assumptions and ignorance of the limitations of the EO assessment process. There is no evidence to suggest that contact was undertaken by Children's Social Care with Education Otherwise at any point to substantiate these assumptions. Failure to conduct

wider checks with other agencies, including the schools attended by the some sibling's, would have been proportionate in this case and represent poor practice and missed opportunities.

- 12.4.7 The Education Otherwise assessment home visit had already been conducted by the time of the above visit, and given the weight placed on the EO assessment process, Children's Social Care could have obtained information to inform their assessment prior to the above joint planned home visit. It was ESW2 who contacted the EO Adviser on 22nd February 2008, learning that the EO had already visited the family home and that, although a classroom had been set up, not much else had been done regarding teaching the children and learning perspectives. It would also have been possible to identify that the EO process had not included direct contact with the children and that, as no education plans currently existed, further EO visits would be required.
- 12.4.8 It is clear from the above visits and assumptions made, that Children's Social Care staff did not have a clear understanding of the legislative structure or limitations within the home education environment. Had greater understanding of partners existed, this may have influenced decisions reached by Team Manager 3 as part of the initial assessment process. **Recommendation 10 – Birmingham Children's Social Care should conduct an evaluation survey to quantify Children's Social Care staff's understanding of the role and responsibility of the Education Otherwise Service following the recent awareness campaign.**
- 12.4.9 The EO Adviser contacted SENAS on 28th February 2008 and informed them that a home visit occurred on 8th February. It is confirmed that during this visit the children were not seen, that a basic classroom had been set up, parents were able to give basic information about teaching plans and that the EO had been satisfied that the family were sufficiently set up for home teaching and agreed to confirm this in writing to SENAS. In hindsight, this is a worrying statement presented to SENAS by the EO Adviser. It is clear that form EO3 (the home education assessment form) provides only limited information. There is no requirement to see the children alone. The form represents a one sided, principally tick box approach and there is limited opportunity for additional commentary or assessment. It is also clear that the education statements on the

specific needs of those children, who were statemented, were not discussed throughout this process, or addressed in any way with the parents. The process for home education assessment was extremely minimal and in no way would this process inform to any satisfactory degree, the initial assessment requirements of Children's Social Care.

12.4.10 ESW2 only learnt that Children's Social Care did not return to see some of the children when contacting Children's Social Care on 10th March 2008. The ESW recorded that the Social Worker had no further concerns regarding the welfare of the children.

12.4.11 The initial plan to conduct the assessment had been clear, but due to a number of factors, including a complaint raised by mother, had not been followed through. It is not good practice to enable parents to determine decisions regarding home visits, particularly when potential child protection or safeguarding matters. The Initial Assessment was not completed and written up and it is difficult to understand why the Referral and Advice Officer had no further concerns at this point, given that no new information had been received to suggest that children in this family were safe. **Recommendation 11 – Birmingham Children's Social Care should review and evidence that mechanisms are put in place to ensure that use of the complaints process by parents or significant adults does not adversely affect the actions of staff when pursuing safeguarding matters, or the welfare of children.**

12.4.12 On 21st April 2008 the Team Manager discussed the case with the worker and agreed the case would be closed because home tutoring had been approved. At this time Children's Social Care believed a review would be undertaken and the family would be monitored by the EO service. Once again, assumptions about the role and remit of the EO assessment process and ignorance of legislative provision impacted on both decisions and actions. At this point, a further opportunity to contact the EO Adviser presented itself, but was not taken up. It would have been legitimate to communicate with other professional agencies to ascertain that wider concerns did not exist, but this did not occur. The case was not written up and closed so therefore remained open at the point of the child's death. It is unclear why this was the case but this inaction clearly failed to meet

the standards expected of Children's Social Care employees. **Recommendation 12 – Birmingham Children's Social Care to review supervisory expectations and standards, ensuring management and decision making processes contain sufficient rigour when managing risk.**

12.5 Education Otherwise

12.5.1 In light of the impact of the Education Otherwise process and the weight given to this assessment by other agencies, it is pertinent to review the conduct of the EO assessment process in this case.

12.5.2 ESW1 made a telephone call to the EO Adviser on 30th January 2008 to inform them of the circumstances leading to mother's withdrawal of the children from the school. This was a significant telephone call, as it is clear from this communication that the EO Adviser was made fully aware of the home situation, previous concerns and the rationale for the withdrawal of these children from school.

12.5.3 A home visit to assess suitability for home education was conducted on 8th February 2008 which was a joint visit by the EO Adviser and ESW EO. The standard form EO3 for home education was utilised for this process and initial discussions around teaching plans were undertaken. It was recorded that detailed plans would be sent to the EO Adviser by the family by the end of February 2008. On this occasion the box asking whether or not home education was suitable on Form E03 was left blank. The form utilises a tick box process and does not request details of the hours of education or request that any work is seen or standards are assessed. It presents little opportunity to comment in any meaningful way on the quality and suitability of education provision, nor does the form request any details of discussions with children, or require that their opinion is sought as this is not required within legislation. Nor does it record whether children have been seen during a visit. It is concerning that given the raft of requirements within the State Education System, including Inspection Standards, that an assessment for home education requires such limited process to assess parental capability and suitability for a child's home education and gives paramountcy towards parental choice and rights, giving the child no voice, or focus on their educational needs, or safeguarding requirements.

- 12.5.4 This case was allocated directly to the EO Adviser due to some of the children having statements of special educational need, instead of the usual process where an ESW EO would undertake the initial home visit and conduct the assessment. This change seems to have impacted on the assessment process in this case. The ESW EO was not aware of the family until requested to accompany the Adviser on a visit. Whilst this would not be normal practice, as concerns had been raised regarding the behaviour and aggression of mother, a joint visit was undertaken.
- 12.5.5 It is concerning to note that during this home visit and assessment process the ESW EO did not make any notes or observations. This would suggest that the visit was poorly planned between the EO Adviser and the ESW EO. At no point during the visit was there a request to see the children or seek their views. Subsequently, the ESW EO has indicated this would normally be the case in order to involve young people in the process, respond to any questions they may have and to assist in the assessment of the learning environment. It is therefore unclear why it did not happen on this occasion.
- 12.5.6 On the basis of the information received, it could be inferred that the purpose of the joint visit was for purely personal safety reasons relating to information received from the ESW1 on 30th January 2008 of the mother's increased aggression, as opposed to an opportunity for two professionals to make a wider assessment of risk and parental abilities to meet the children's educational requirements, particularly in relation to some of the children's educational statements and child welfare. **Recommendation 13 - Education Otherwise should evidence to Birmingham Safeguarding Children Board changes to the recording and assessment process, demonstrating delivery of safe and effective services that contribute to meeting the safeguarding needs of children and young people across Birmingham.**
- 12.5.7 On 28th February 2008 the EO Adviser informed SENAS of their satisfaction for home education and agreed to confirm this in writing. This was a worrying statement presented to SENAS. The EO assessment is a limited process. The EO Adviser was provided with information from ESW1 on 30th January 2008 to clarify

the range of concerns held by the school and the referrals that had been made to Children's Social Care in relation to this family. Therefore, given the limited role of the EO3 process and the lack of a detailed assessment conducted by the EO Adviser and the ESW EO, it is concerning that these factors do not feature within the assessment process.

- 12.5.8 Sadly, it is also clear that other agencies placed a great store on the outcome of the EO assessment process and allowed their ignorance and assumptions about the safeguarding and welfare components to cloud their own professional assessment and decision making processes, obscuring vital objectivity.
- 12.5.9 The EO Adviser reported to SENAS on 20th March 2008 that there are some question marks as to whether home education was suitable. Plans had still not been received from parents as agreed by the end of February. The EO Adviser indicated the intention to write to parents. It is somewhat concerning that, given the EO Advisers concerns around the lack of education plans on 20th March 2008, a letter arranging a home visit was not written until 9th April 2008.
- 12.5.10 A home visit was undertaken as arranged in the letter for 16th April 2008 but no reply was received at the family address. Despite the fact that mother had been pre-warned about a visit from the letter of 9th April, she had taken no opportunity to respond to EO to indicate that the home visit was inconvenient. It can only be assumed that this was a deliberate strategy by mother to avoid contact on this date. By this point it had been over two months since the child and some of the siblings had been seen by any professional.
- 12.5.11 The above process clearly highlights a major flaw in the home education legislation, which is focused upon parental choice and rights as opposed to child focus, welfare or protection. This was compounded by a poor assessment completed by the EO service. There is no safeguard to ensure that a satisfactory education is being received by children and that their welfare is appropriately safeguarded. The current legislative structure enables parents to move their children from state education with minimal reasons and provides an opportunity to render young people virtually invisible. This is a particular advantage for parents who may wish to conceal abuse.

12.5.12 If this position is to be rectified, a change to legislation is required in order to enable access and assessment of young people within a home education setting, including the provision to enable contact with children and young people outside of that observed and controlled by parents.

12.5.13 It is recognised that the current legislative structure that Education Otherwise operate within, represents a significant challenge. Local Authorities can request documentation from parents who are not legally required to respond. This is not to suggest that many parents within a home education setting do not provide their children with excellent learning and development opportunities. However, there is no mandate currently to monitor, assess or inspect the quality of home education provision to ensure it is suitable, developmentally appropriate and safe for all children within the home education environment. Given the tragic outcomes identified within this review this seems to represent a major safeguarding flaw.

Recommendation 14 - The Strategic Director of Children's Services should communicate to the DCSF Secretary of State, the current safeguarding inconsistencies within legislation surrounding children who are educated from home, emphasising that the parents right to home educate does not outweigh the rights of the child.

12.6 Elective Home Education

12.6.1 DCSF Elective Home Education Guidelines for Local Authorities 2007 provides the framework for the Education Otherwise Service across Birmingham. The document provides parent with information and the criteria for educating their children at home instead of sending them to school. This approach to education is significantly different to home tuition, or other education provided by Local Authorities in environments other than at school. In this context, children whose parents elect to educate at home are not registered within mainstream schools, special schools, independent schools, academies, or pupil referral units (PRU's), colleges, children's homes with education facilities or education facilities provided by independent fostering agencies.

- 12.6.2 The responsibility for a child's education rests with parents. In England education is compulsory, but school is not. According to Section 7 of the Education Act 1996, parents have a right to educate their children at home providing that "the parent of every child of compulsory school age shall cause him to receive efficient, full time education suitable – (a) to his age, ability and aptitude, and (b) to any special educational need he may have, either by regular attendance at school or otherwise".
- 12.6.3 The terms 'efficient' and 'suitable' are not defined within the Act, but Case Law has broadly defined 'efficient' as an education that "achieves that which it sets out to achieve" and a 'suitable' education as one that "primarily equips a child for life within the community of which he is a member, rather than the way of life in the country as a whole, as long as it does not foreclose the child's options in later years to adopt some other form of life if he wishes to do so".
- 12.6.4 Local Authorities have a statutory duty under Section 436A of the Education Act 1996, inserted by the Education and Inspection Act 2006, to make arrangements to enable them to establish the identities, so far as it is possible to do so, of children in their area who are not receiving a suitable education. However, guidance makes it clear that the duty does not apply to children who are being educated at home. Furthermore, Local Authorities have no statutory duties in relation to monitoring the quality of home education on a routine basis. Section 437(1) requires Local Authorities to intervene if it appears that parents are not providing a suitable education. This involves serving a notice in writing on the parents requiring them to satisfy within a period not less than 15 days from which the notice is served that the child is receiving such education. This position is further weakened by encouraging Local Authorities to address the situation informally and that parents are under no duty to respond to such enquiries.
- 12.6.5 Within Section 175(1) of the Education Act 2002, Local Authorities have a duty to safeguard and promote the welfare of children. However, Section 175(1) does not give Local Authority powers to enter the homes of, or to see children for the purposes of monitoring the provision of elective home education.

- 12.6.6 The Children Act 2004 Section 10 sets out a statutory framework for co-operation arrangements to be made by Local Authorities with a view to improving the wellbeing of children in their area. Section 11 of the Act sets out the arrangements to safeguard and promote the welfare of children. However, these powers do not enable Local Authorities to see or question children subject to elective home education in order to establish if they are receiving a suitable educational provision. Section 53 of the 2004 Act places a duty on Local Authorities where reasonably practicable to take into account the child's wishes and feelings with regard to the provision of services. This section does not require Local Authorities to ascertain the child's wishes and feelings about elective home education, as it is not a service provided by the Local Authority.
- 12.6.7 Whilst parents seeking to home educate may be encouraged to co-operate with Local Authorities and specific services to assist them in providing effective home education to their children, parents are not legally required to give Local Authorities access to their home. Nor at any meetings they choose to attend is the child required to be present. Further, where parents elect not to allow access to their home, or their child, this currently does not in itself constitute a ground for concern about the education provision being made. Where parents choose not to meet with Local Authorities they may be asked to supply information but are under no legal obligation to comply.
- 12.6.8 Parents of children with special educational needs still have a right to educate their child at home, irrespective of whether the child has a statement of special educational need or not. However, where a child has a statement and is home educated, it remains the Local Authorities duty under Section 7 of the Education Act 1996 to ensure the child's needs are met and to arrange the provision specified within the statement, unless the child's parents have made suitable provision.
- 12.6.9 The new addition of "Working Together to Safeguard Children 2010" highlights that "Everyone shares responsibility for safeguarding and promoting the welfare of children and young people, irrespective of individual roles". Nevertheless, in order that organisations and practitioners collaborate effectively, it is vital that all partners who work with children – including local authorities, the police, the health

service, the courts, professionals, the voluntary sector and individual members of local communities – are aware of, and appreciate, the role that each of them play in this area. This applies to those children who both attend school and those who are educated at home. Both are of paramount concern and remain the responsibility of the whole community.

12.6.10 It is clear from guidance relating to elective home education and the range of legislative requirements referred to above, that a number of expectations and requirements are placed upon Local Authorities in relation to children who are electively home educated. However, alongside these responsibilities it is clear that Local Authorities face a significant number of challenges relating to their ability to fulfil these expectations. Several references above clearly highlight that aspects of guidance and legislation do not apply to children who are being home educated and furthermore, whilst parents are encouraged to co-operate they are under no legal duty to do so.

12.6.11 It is difficult to comprehend how Local Authorities, within the current home education legislative provision, can effectively address a child's right to education, when all of the current rights appear to be conferred on parents. Home educated children are not subject to any independent inspection processes. There appears to be an apparent failure within the current system to address the lack of power to enable Local Authorities to effectively fulfil their safeguarding responsibilities. The current provision appears to take no cognisance of the child's wishes, feelings or welfare and therefore presents as a direct contradiction to the aspirations of the Children Act 2004, Every Child Matters, Section 175 of the Education Act 2002, Working Together 2006 or indeed the UN convention on the rights of the child, principally in this case:

- Article 28 - A Right to Education
- Article 13 - A Right to Receive and Share Information
- Article 12 - Governments to ensure that Children have the Right to Express Freely their Views and to Take Account of Children's Views. Children have the right to be heard in any legal administrative matters that affect them.
- Article 6 - The Right to Life

- Article 24 - Children have a Right to Good Quality Health Care, Clean Water, Nutritious Food and a Clean Environment
- Article 36 - Protection of Activities that Harm their Development.

12.6.12 Within the context of this review the evidence suggests that, following removal from mainstream education, not one of the five outcomes specified within Every Child Matters were met for any of these children whilst they were educated otherwise.

12.6.13 The current legislative structure and guidance allows parents to remove their children from mainstream education and on this occasion enabled the unintended outcome of constricting access to those children by professional agencies and removing any effective oversight of their welfare, or development

12.6.14 Within the current legislative climate it is essential that, when requests are made to educate children otherwise, a full and rigorous assessment of the child's needs and risks associated with home education are conducted at the outset, fully involving children and young people to inform a decision about the appropriateness of Education Otherwise for children and young people's welfare, development and safeguarding requirements.

12.6.15 Given that there were (January 2009) 326 children and young people Educated Otherwise across the Birmingham area it would seem prudent for Birmingham Education Authority and Birmingham Safeguarding Children's Board to satisfy themselves that children educated otherwise are adequately safeguarded and that their educational needs are being met.

12.7 **Missed Opportunities**

12.7.1 The purpose of this section is to collate the occasions where opportunities to intervene further presented themselves, and to analyse the collective impact of this on the tragic outcomes in this case.

12.7.2 Concerns were raised on 7th March 2006 that, during a visit by father to the family home, he assaulted mother and strangled one of the children. This was reported

to police and it was believed that information had been forwarded to the police Child Investigation Unit. There is no evidence that the document was ever received and consequently no further action was taken in relation to the safeguarding concerns identified.

12.7.3 Mother visited her GP on 9th March 2006 with a sibling stating that father had pulled that child out of a chair and since this incident they had been complaining of bilateral knee pain when walking. The GP advised mother to discuss this with the police and the health visitor. The GP failed to follow safeguarding procedures and did not report to other agencies. Had the GP followed the correct procedures, safeguarding processes should have been initiated and the missing police information may have been retrieved, enabling a fuller investigation, and multi agency strategy meeting process to be conducted. **Recommendation 15 – Heart of Birmingham Teaching Primary Care Trust should review and satisfy themselves that all GP’s are aware of their professional responsibilities to communicate safeguarding concerns that arise as part of their interaction with children and families, in line with existing safeguarding procedures.**

12.7.4 An anonymous caller visited Children’s Social Care on 14th March 2006 alleging that mother was unable to control her children and that one of them had fallen down the stairs into a stair gate hurting that child’s nose. As Children’s Social Care were aware of recent domestic violence referrals, checks were undertaken with the health visitor who indicated no concerns. As such the referral was closed. This was the third incident that has occurred during March 2006. It is concerning that, following a single telephone call to a health visitor, this process was closed down. Further, it is unusual for callers to present themselves directly to a Children’s Social Care office to raise concerns. It is somewhat confusing why this caller is recorded as anonymous and it has not been possible to establish if they refused to identify themselves.

12.7.5 Had the above two incidents on the 7th and 9th March been dealt with appropriately it is highly likely that this third intervention by an anonymous caller on 14th March would either have triggered a process, or supported processes already initiated which may have added a wider perspective to the assessment of risk and future intervention strategies.

- 12.7.6 Health Visitor 8 made a referral to Children's Social Care on 28th February 2007 raising concerns of domestic abuse in the family, highlighting that persistent abuse occurred during visits. Information was presented to show that mother was feeling threatened and concerned and there were allegations that the father was inflicting emotional abuse on the children and had threatened to harm them. The school were not notified until April 2007 which followed a period of letter writing by mother to the school around a whole host of issues. The context in which the school responded to mother was not fully informed. Had they been in full possession of the facts, they may have been able to respond to mother differently, offering support and intervention, potentially negating her action to remove children from formalised education.
- 12.7.7 The school referral to Children's Social Care on 20th December 2007 with concerns relating to food, the child being removed from mainstream education, mother's changes in behaviour and becoming aggressive, received a poor response and refusal to progress an initial assessment. Recommendations for a CAF and a Safe & Well Check were insufficient to safeguard the child and inappropriate.
- 12.7.8 It was not until 30th January 2008 when Children's Social Care agreed that an initial assessment should be conducted. This represented a six week delay during which time no professional contact had occurred with the family and the children had not been seen. This time delay may have strengthened mother's feeling of isolation and mistrust of professional organisations, minimising the likelihood for effective engagement. The safe and well check conducted by the police, in response to a professional request from the school as advised by Children's Social Care, appears to have hardened mother's resistance to further professional intervention. By the time Children's Social Care agreed to intervene, mother was immovable, frustrating all professional attempts to intervene, including use of the complaints process to further destabilise appropriate intervention, enquiry and assessment. The outcome was in fact that no effective assessment was completed.

- 12.7.9 8th February 2008 the EO home education assessment process was conducted. The weakness in the EO3 form and the method of conducting this joint home visit were of such poor quality that the outcome of the assessment failed to take into account a number of significant and previously identified safeguarding concerns. In addition to this failure, other agencies placed great store through their ignorance, on the limited value of the EO assessment and failed to liaise directly with EO to evidence their assumptions, making inappropriate safeguarding decisions based upon minimal evidence, resulting in incomplete initial assessments and actions.
- 12.7.10 At the home visit by Education Social Worker and Children's Social Care on 21st February 2008, mother's reluctant and hostile approach to the professionals supported by an unknown male appears to have influenced and affected the professional intervention and assessment process. The parental adult control of the initial assessment through a doorstep conversation, frustrated the thorough analysis and assessment required to conclude this initial assessment effectively. A range of aspects identified within the referral process were not addressed during this assessment and reinforced the power imbalance towards the rights of parents and away from the welfare and protection of children. Without doubt, the legislative armour of the Education Act 1996, supported by the DCSF Elective Home Education Guidelines for Local Authorities 2007, enabled mother to resist the advances of professional intervention and added to the perceived impotence of professionals to intervene.
- 12.7.11 On 7th March 2008 the Speech and Language Therapist (SALT) met with SENCO to discuss a number of the children. On this occasion SALT were informed that the child had been removed from school and was being home educated. This was an ideal opportunity to undertake a professional's meeting to review the child's statement of educational need, given that the child was then being educated at home. The statement would have required a review to ensure that the child's needs were being met in line with the statement of education need and despite being home educated this was still a route open to professional agencies in line with legislation. Given mother's lack of co-operation with professional organisations by this point, and the previous safeguarding concerns that had been

identified, failure to undertake this approach represented a significant missed opportunity.

12.7.12 On 19th March 2008 the school doctor determined that a sibling's weight was going up and therefore further examinations were not conducted. Given the previous fluctuations in weight over a four month period and the concerns identified by school staff, it is incongruous that on the basis of one weight measurement at this meeting that further examinations would not be conducted as a matter of course. Further investigation may have uncovered other injuries or evidence that may have triggered wider safeguarding investigations.

12.7.13 Medical concerns were raised by the sibling's class teacher during April 2008 in relation to that child's general health, where that child was described as thin, weak, tired easily and felt the cold. Reference to that child's behaviour when food is present was flagged, noting that the child was constantly seeking food and seeming not to chew it when it is available. The issue of participation in swimming was identified particularly highlighting the fact that mother did not want that child to participate in this activity. The teacher's information clearly identified a child in need of further investigation and intervention. The issues identified in relation to food had now been around for some considerable time, both for that child and other members of the family. Given the links to the wider health concerns, this should have been a trigger for further intervention.

12.7.14 When the sibling was seen for a school medical on 7th May 2008 mother did not attend for the medical appointment, a pattern now adopted with professionals. The sibling's weight was described as down slightly and the height was recorded as static. Mother was resistant to a dietician referral for that child. As such, a further review was planned for September 2008, despite the information prepared by the school teacher during April 2008 and the issues identified in an earlier medical on 19th March 2008. There can be no justification to action a review some four months hence without reference to any other matters. None of the concerns identified by school staff appear to have registered. No plans were made to undertake follow-up home visits, to pass information to other agencies, or to link the concerns to wider safeguarding information already known to professionals. At

this medical that sibling's weight was almost exactly the same as the weight as a child 2 years younger.

12.7.15 It is concerning to see that medical information on children, collected over a period of time, was not effectively collated and analysed. If undertaken, health staff should have identified worrying trends and intervened differently, by raise safeguarding concerns and triggering investigative processes that themselves may have produced different outcomes.

12.7.16 Failure to act on this occasion represents a significant missed opportunity. This event occurred only ten days prior to the child's death. Whilst this cannot be stated with any degree of certainty, had a more effective intervention occurred at this point and Children's Social Care been involved, some form of wider assessment, or intervention may have taken place. Without doubt, the child would have been in a very fragile state of health, but any trigger for safeguarding action would, at the very least, have presented a final opportunity to intervene prior to the child's ultimate death.

13. Good Practice Examples

13.1 One school made strenuous attempts to act on their concerns and take responsibility to address issues. Whilst they had been unable to see the children during the home visit, they had clearly attempted to engage with mother and to preserve a positive professional relationship with her. The school made several referrals to Children's Social Care and persevered in their attempts to present concerns and to encourage intervention from Children's Social Care. In addition a member of the teaching staff at the sibling's school encouraged colleagues to be vigilant and to look for signs of injuries, whilst the sibling was undertaking sporting activities.

13.2 Similarly, the Police were proactive in responding to the school's concerns for the welfare of those children home educated by agreeing to a request for a safe and well check. In addition, the police, whilst not gaining access to the house, refused to leave until all children had been presented and spoken to.

- 13.3 There is also evidence of individual practitioners across agencies making and receiving appropriate referrals and providing support for these children with their developmental needs.
- 13.4 The Child Development Centre and Speech and Language Therapy recognised the challenges of appointment attendance and worked co-operatively to provide compatible appointments wherever possible, aiming to minimise disruption and improve attendance uptake.
- 13.5 BSCB requires that all agencies implement the internal recommendations contained within their Individual Management Reviews, to evidence that action has been taken prior to the publication of this overview report. Agencies are required to take action where management or practice has fallen below expected standards of professional behaviour. All IMR recommendations have now been fully implemented. **Recommendation 16 – Birmingham Safeguarding Children Board expects all agencies that have completed an IMR to implement any internal recommendations and to take action where management or practice has fallen below expected standards of professional behaviour.**

14. Conclusions

14.1 Racism

- 14.1.1 Although racism was raised by mother in reference to bullying of children on two separate occasions with the school, this was not presented as a reason for eventual school removal, or during interaction with any professionals after this event. Whilst it is imperative that professionals remain open to and challenge the possibility of institutional racism, there did not appear to be any evidence of overt, or covert racism within this case.

14.2 Children's Rights

14.2.1 Right to Education

14.2.2 Some of the children were removed from state education during December 2007. This was an action sanctioned by legislation (S7 Education Act 1996), enabling adult carers, or parents to choose. At no point were any of the children given the right to choose the location of their education, or the nature of that provision. They were given no right to consultation, or to express any views as part of the process. Once removed from state education they were provided with no independent access to friends, family, or professional agencies. They were isolated, effectively removing their rights to be seen, heard, or protected.

14.2.3 The nature and quality of the home education provided within the home is clearer following the criminal trial. No plans were ever presented to Education Otherwise despite requests and although the mother and to some degree partner did initially attempt to deliver a limited degree of education, the judge during the care proceedings most clearly concluded that it was "... apparent that mother was completely unrealistic about the children's learning abilities - had not read their school reports – she admitted that the task of educating the children was beyond her." However, given the degree of nutritional depletion identified within the children home educated, at the time of the child's death it is extremely unlikely, whatever the quality, that they would have had the emotional or physical capacity to benefit from it.

Prior to removal from State Education all the children were making educational progress, and the child specifically had demonstrated in previous education reports that the child had been making great strides to overcome personal challenges.

14.2.4 In this particular family, greater circumspection within the initial EO report would have been appropriate, given the information provided by the ESW, prior to the EO home visit and assessment. This was further highlighted with subsequent concerns raised by the EO Adviser relating to the adult carers failure to provide education plans, as evidenced in communication by the EO to SENAS on 20th March 2008.

14.2.5 The lack of robust and rigorous process to assess the suitability of parents to provide an effective home education, coupled with the absence of any risk

assessment process to address the safeguarding requirements of children, must be viewed as a significant failure.

14.2.6 Whilst some decisions and actions by EO staff must be understood in the context of agreed local processes and requirements that were active at that time, the poor levels of planning, preparation and execution of the assessment process including ineffective note taking and a lack of professional curiosity must fail to address expected professional standards of practice.

14.2.7 Based upon the available evidence, the children home educated were denied the right to an effective education.

14.3 Right to Health and Health Care

14.3.1 Between 1998 and 2008 the children missed a minimum of 129 appointments, 43 (33%) of those relate directly to appointments for the child. A large proportion of these appointments were for health related activities. It must be recognised that in a family of six children, several of whom with statements of special educational need, creates particular pressures and stresses for parents and a degree of failed appointments would be expected. However, the pattern of failed appointments escalated dramatically during 2007, 26 (20%) appointments were missed, as relationships with professionals deteriorated. Between January and May 2008 a further 7 were defaulted. The BSCB identified a similar issue in Serious Case Review Case 9. Significant learning and good practice has been developed in an adjoining PCT which has enhanced the coordination and continuity of care by health professions, particularly for family with multiple siblings.

Recommendation 17 – Heart of Birmingham Teaching Primary Care Trust and South Birmingham NHS Primary Care Trust, Birmingham Children’s Social Care and Education Otherwise agencies should provide evidence to demonstrate an effective response to missed or failed appointments.

14.3.2 It is from October 2007, with failures to attend hospital appointments and school medicals, that the greatest increase is seen. There is also evidence of the mother’s parental resistance to medical intervention for her children, e.g. a dietician referral for a sibling only ten days before the child’s death, on 7 May

2008. Whilst it cannot be proven, indicators strongly suggest that, the increased failure to attend professional (especially medical) appointments was a deliberate strategy to restrict professional access and assessment of the health requirements for the children. This includes those still attending school not participating in physical education and swimming activities, where their bodies would be exposed to wider professional scrutiny.

14.3.3 School medical staff did not adequately address worries in relation to the sibling. Concern had been raised that the child may be obsessed with food. Successive medicals failed to monitor this effectively. Records were not fully plotted and therefore the full impacts of weight changes were not adequately understood. Despite issues raised by school teaching staff and evidence that the child's weight had dropped, a full examination was not conducted. Mother's resistance to an appropriate dietician referral for the sibling did not generate wider concern, but instead encouraged further prevarication, in the form of a further review some four months hence. That child's weight at this time was almost exactly what it had been two years earlier.

14.3.4 There was an absolute failure to seek medical intervention by the child's carers until it was far too late. Given the findings of the Professor and the identified actions of the carers, the children within this family, to varying degrees, were denied the right to health and health care.

14.4 Right to Food

14.4.1 The evidence in this area is incontrovertible. All children, apart from one, who seems to have devised other survival strategies, were found to be suffering from malnutrition following the child's death. The medical evidence clearly evidences this situation had occurred over a period of some months. All non food related medical explanations for this condition have been explored and eradicated. Some children in the family were so severely affected by malnutrition that, upon admission to hospital, they suffered re-feeding syndrome, one developing into a life threatening situation, requiring medical intervention.

14.4.2 Given that adults in the household were not suffering from malnutrition and given the police evidence as part of the criminal trial that the kitchen cupboards were stocked with food, the children's malnutrition cannot be attributed to family economic or resource shortages. What has clearly emerged is that food was not only withheld in the required quantities for good health from these children, but removal of food was also used as a method of punishment. On this basis, it can only be concluded that the children in this family were denied the right to sufficient food in order to maintain a healthy lifestyle.

14.5 Right to Accommodation and Safety

14.5.1 Living conditions within the household deteriorated over a period of months, it is now known that mother wanted to be re-housed to larger premises, but was frustrated in this desire by the registered social landlord due to the state of decoration within the home, this in part due to the fact that children had drawn pictures on the walls. At some point after partner moved in to the household, the couple began a programme of refurbishment. It would appear however, that this was not tackled in a systematic way and new projects were initiated, before the previous ones had been completed. This resulted in a constant reduction of habitable space within the house, eventually leading to only one upstairs bedroom, which all of the children occupied, a downstairs room which mother and partner shared and access to the kitchen, which was secured with a padlock and only accessible by the adults.

14.5.2 The tensions this situation generated as months went by must have been significant, but when coupled with several children in the household, some of whom were supposed to be receiving home education, but in the latter stages were merely confined to a single upstairs room, with no external outlet, or stimulus, would have been literally explosive. As the partner's mental health deteriorated the culmination of events was almost inevitable, particularly without any external support, which both adults had clearly rejected.

14.5.3 In relation to the children's safety, there is evidence from a Professor of bruising and injury to several of the children, we now know these injuries were caused through use of a cane and may have been a key driver in mother's resistance for

some of her children who remained in school to participate in physical education and swimming activities.

14.5.4 The removal of some of the children from state education effectively prevented professional oversight of their welfare and development. Further, professional intervention to these children was frustrated at every turn by the adults. As the Judge concluded within the care proceedings "...had there been a proper investigation it (the child's death) could have been prevented"

14.5.5 The combined impact of the injuries recorded, degree of malnutrition identified, removal of some of the children from professional oversight and adult resistance to and non co-operation with professional agencies and the subsequent death of the child, all point to a single conclusion that the children's right to safety was denied.

15. Role and Barriers to Individual Agencies Working Together to Ensure That Children's Rights Were Upheld

15.1 Information relating to concerns for the children's welfare was known to several agencies. Opportunities for wider information sharing existed, but were either not recognised, shared or delayed. One example relates to information on domestic abuse, which did not reach the school for approximately two months and could have informed and alerted the school to alternative explanations for mother's changed behaviour.

15.2 On other occasions, information was shared but the level of follow up was not consistent with expected standards; a health visitor referred concerns of domestic abuse to Children's Social Care during February 2007, but did not maintain any contact or support to the family following the referral.

15.3 There were attempts by the school to communicate professional concerns that were not properly heard, or accepted, by Children's Social Care. Despite persistence, including a visit to the family home, repeat phone calls and faxed written referrals, initial attempts by the school were miscoded and the focus placed upon attendance and education issues, as opposed to concerns in relation

to mother's changed behaviour, increased aggression and the children's obsession with food, etc.

15.4 During this review, some concerns have been raised by agencies in relation to referral thresholds and resource availability, such as, heavy workloads, or staffing vacancies. It is important to provide context, the current vacancy level for qualified social workers is 14% (June 2009) with vacancies wherever possible covered by agency staff. The social care staffing per capita is 22% lower than the national core city average. The Social Worker involved in this case had an excessive workload of 50 allocated cases. Where agency staff are used to cover vacancies this can create logistical difficulties for training and development. There continue to be shortfalls in health visitors and school nurses. At this time the Education Welfare Service averaged 800 referrals per month. This was a period of peak demand, however in this case initial contact with the family was made within an acceptable timescale. There is no evidence that policing capacity impacted the case, although it is noted that there has been a 33% increase in child protection policing capacity within Public Protection Units. These were established at each of the nine Birmingham operational command units during 2009, but with variability across occupational command units as to the deployment of officers. Despite this, partnership working was hampered by inappropriate responses from Children's Social Care to the issues raised, by suggesting the school should initiate a CAF, or engage the Police to undertake a Safe & Well Check. Neither suggestion was appropriate within the context of information presented, or helpful, and resulted in professional confusion, frustration, delay and a lack of effective intervention. Failure to review decisions with a manager when requested by another agency, or to provide written confirmation of decisions, represented poor standards of practice by Children's Social Care and would benefit from further internal review.

15.5 There are examples of a lack of professional curiosity, or appropriate child focus. The Education Otherwise assessment was brief, poorly planned and executed and the key aspects and concerns notified by the Education Social Worker to EO prior to this appear to have been largely ignored. It would appear that the only concern heard was that of mother's changed and aggressive behaviour, resulting in two members of staff visiting, apparently more for self protection purposes than

enabling an effective assessment with clear child focussed safeguarding outcomes.

- 15.6 No initial assessment was undertaken by Children's Social Care, due to professional and organisational holiday periods and communication difficulties between agencies agreeing dates for joint visits. The absence of an initial assessment prevented an accurate assessment of the risks posed to children within the family. An assessment would have identified the unknown male residing at the house at that time. Adult family member's resistance to intervention, aggression and doorstep conversations, supported by home education legislation, prevented a full understanding of conditions within the home, seeming to render professionals impotent. The subsequent complaint raised by mother following a joint home visit appears to make the Children's Social Care manager and practitioner reluctant to follow through on plans, for fear of wider repercussions within the complaints process. A robustly concluded initial assessment should give an holistic overview allowing agencies to identify any safeguarding or educational needs and would have identified the need for further significant intervention.
- 15.7 Throughout, a significant focus rests upon the rights of adults and fails to adequately focus upon the needs, wishes, feelings and safeguarding requirements of the children. This would include seeing and talking to a child where appropriate to their age and understanding. This was not exclusively the case. A number of agencies, notably school 1, should be commended for their persistence in raising safeguarding concerns, direct action through a home visit and faxing written concerns to Children's Social Care etc. The Police demonstrated a commitment to partnership working and child focus by agreeing to conduct a Safe & Well Check at the behest of the school.
- 15.8 A degree of ignorance was evident in the role and remit of agencies, specifically related to legislation and the assessment processes conducted by Education Otherwise. Significant weight was placed upon the outcome of this assessment. The inference from Education Otherwise of satisfaction with the home environment for educational purposes was seen by Children's Social Care in particular as an indication that no safeguarding concerns existed. Sadly, at no

point was clarification sought on these inaccurate assumptions. Had it been, it would have been obvious to all that a more rigorous and child focused analysis of the risks was required.

- 15.9 Regardless of the above, a significant barrier to effective intervention lay in the home education legislation (S7 Education Act 1996) and guidance (DCSF Elective Home Education Guidelines for Local Authorities 2007). This enabled adults to effectively remove children from state education and the effective oversight of professionals, empowering adults and enabling them to isolate the children, whilst also limiting the range of opportunities open to professionals to intervene. The lack of any prescribed opportunities for children to express their views, or to undertake active participation in this process, has to represent a significant legislative failure.
- 15.10 On the few occasions where professionals could have intervened, e.g. through school medicals, SEN statements/reviews, etc. they were not effectively addressed.

16. Identification of the Barriers That Prevent The Public From Fulfilling Their Responsibility to Safeguard Children

- 16.1 Two attempts were made by members of the public to share their concerns, one by telephone call, the second by an “anonymous referral” in person at a Children’s Social Care office. It is perhaps not surprising that no further concerns were identified, as the family moved towards a position of systematically isolating themselves from wider family members and the local community.
- 16.2 There is a great diversity of population within the community where the family lived, drawn from many places across the world. It is reported that many residents, particularly those who have arrived recently from other countries, are fearful and mistrusting of engagement with authority figures at any level. It is therefore not surprising that community members would be reluctant to report concerns, even if identified.

16.3 Throughout the criminal trial information was presented to suggest that neighbours, or members of the local community may have had some concerns in relation to this family, particularly one incident during February 2008, when the child was said to have eaten bread thrown out for the birds by the next door neighbours. Unfortunately, as this family had moved and their new location had not been established, it was impossible to fully test their evidence in court, or to establish any specific concerns they may have held.

16.4 The reluctance to engage is in part a comment on society, where individuals do not intrude or intervene in matters outside of their own ambit. Any mechanisms that support and stimulate community or personal engagement should be explored. All efforts to enable members of the community to understand the message that safeguarding children is everyone's responsibility should be considered. **Recommendation 18 - The Children's Trust in conjunction with the Birmingham Safeguarding Children Board should initiate an education campaign with supporting literature, to build public trust and confidence in ways to effectively safeguard and protect other people's children**

17. The Role of Birmingham Safeguarding Board in Enabling Communities to Fulfil Their Responsibilities

17.1 Given the mistrust and fragmentation of the community, engagement at a community level would be the most effective starting point. It will be necessary to build trust, provide opportunities for advice and support and to demonstrate that damaging and frightening memories experienced elsewhere in the world will not be replicated within the current environment.

17.2 Changes within communities are often achieved by building trust through the younger members who by their very nature are more open to new experiences and opportunities. Success at this level will be driven by young people promoting positive outcomes and encouraging participation by older community residents. Nurseries, crèches, playgroups, community health and schools, particularly where extended school provision exists, can all play a major part in building hope, faith and community participation.

- 17.3 In recognition of the diverse communities, the Birmingham Safeguarding Children Board should consider key safeguarding messages that could be appropriately shared with young people, in order to raise their awareness and aid self protection strategies initially. A secondary strategy of producing key community safeguarding messages in a range of languages for adult audiences, which young people could reinforce, may be beneficial.
- 17.4 Given Lord Laming's assertion that "safeguarding children is everybody's responsibility" through pro-active information sharing and increased public awareness, the general public should be encouraged to play a significant part in helping children stay safe and enjoy their childhood. Key to this will be an awareness of how to contact professionals if they are concerned about a child/young person's welfare.

18. Final Conclusion

- 18.1 When considering all of the information presented within this report and specifically, that contained within Section 11 missed opportunities, it can only be concluded that the death of the child was preventable. This finding concurs with judgements made within the care proceedings that the death of the child is the responsibility of the mother and the adult male, but can only conclude that had there been better assessments and effective inter-agency communication over a period of time it could have been prevented.
- 18.2 The death of a child is always a difficult and poignant experience, but when that child has sustained extended punitive brutality and starvation by adults who should have been there to care and protect them, failing in their duty even in the latter stages to seek medical intervention, it is almost beyond our comprehension. It is the duty of us all to ensure we do everything in our power to prevent such a tragedy from ever occurring again.

19. Progressing Recommendations and Dissemination of Learning

- 19.1 At a full meeting of the BSCB on 19th June 2009 members ratified the draft Overview Report and findings. Agencies agreed to ensure that the emerging

recommendations and IMR recommendations would be acted upon promptly and fully implemented by the agreed target date. The Quality Assurance and Audit Sub-Group have closely monitored agencies progress on implementing both IMR and the emerging Serious Case Review recommendations to ensure that early lessons are learnt. Quarterly performance reports to the Board identify completed, pending and outstanding recommendations to ensure that agencies are able to demonstrate that lessons have been learnt.

- 19.2 Although the protracted criminal proceedings have delayed finalisation of the Overview Report, all agencies have taken immediate action to respond to the emerging findings. Agencies are able to demonstrate that significant progress has been made in implementing the initial identified recommendations and will commence implementation of the new recommendations that have emerged from the criminal proceedings. The BSCB have provided GOWM with weekly progress reports and formal performance meetings between the BSCB Business Manager and Safeguarding Advisor GOWM have been held to monitor and scrutinise the implementation of recommendations and audit compliance. Schedule of meetings; 30.01.2009, 23.07.2009, 19.08.2009 and 08.02.2010, with further meetings scheduled for the 11.05.2010, 23.07.2010 and 21.09.2010.
- 19.3 At the conclusion of the criminal trial the Chair of BSCB participated in multi-agency press briefings to reassure the public of the independence of the Serious Case Review process, and to confirm on finalisation of the OFSTED evaluation process the Overview Report, Executive Summary, recommendations and action plan will be published on the BSCB website. This case has attracted intensive national, regional and local media and public interest that will require a press strategy to accompany the publication of the Serious Case Review findings.
- 19.4 Each agency is required to provide feedback from the IMR and the Serious Case Review process to the personnel specifically involved in the case. The broader dissemination of the key learning will be target at the wider children's workforce. The BSCB have an established Training Steering Group which deliver a comprehensive programme of multi-agency interactive briefing on 'Lesson Learnt' from Serious Case Reviews. The Training Steering Group utilise direct feedback from the OFSTED evaluation process and research from national reports

published by the DCSF to inform an enhanced local dissemination of the key learning from Serious Case Reviews. The BSCB also utilises a safeguarding newsletter and website to highlight good practice and key themes from Serious Case Reviews. In addition all agency safeguarding leads are provided with a copy of the Executive Summary, Overview Report, Action Plan and Recommendations together with additional contextual information as an aid to learning lessons.

- 19.5 Lord Laming recommended that OFSTED should share full Serious Case Review reports with HMI Constabulary, the Care Quality Commission and HMI Probation to enable all four inspectorates to assess the implementation of action plans when conducting front line inspections. The Executive Summary will also be shared with the association of Chief Police Officers, Strategic Health Authority and Primary Care Trusts to promote learning. OFSTED will coordinate the dissemination of learning with the above mentioned organisations. On completion of the OFSTED evaluation process the BSCB will forward the final version of the documents for publication to OFSTED to enable the dissemination to the above organisations.



Serious Case Review Action Plan in respect of Case 14

Date commenced 19th June 2009

Red overdue
Green Pending
Black completed

The recommendations have been accepted by the BSCB and agencies will ensure that identified action is implemented by the agreed target date. The BSCB will receive quarterly progress reports from named agencies. BSCB and GOWM will monitor the implementation of recommendations and audit compliance prior to case finalisation.

Recommendation (SMART)	Agreed by Agency Lead	Action Required by Agency	Implementation Lead & Agency	Target date for completion	Summary of Action Taken & Date Received	GOWM. BSCB & Ofsted Monitoring & feedback	QA&A Sub Group. Audit, Progress & Finalisation date
Recommendation 1 Birmingham Safeguarding Children Board should commission work to identify how agencies across Birmingham can increase effective professional communication to improve the safeguarding outcomes for children and young people in compliance with policy and procedure.	Chair Birmingham Safeguarding Children Board	Birmingham Safeguarding Children Board to review its policies and procedures with respect to effective professional communication. Training Steering Sub Group to ensure that module 1 training learning objectives emphasises the importance of effective communication amongst safeguarding professionals.	Chair of Development Policy and Procedures I and Chair of Training Steering Sub Group	1/09/2009	The BSCB Policy and Procedures group have reviewed all sections of core procedures and ensured that effective communication underpins all procedures. The group continue to review each section of guidance with a clear focus on ensuring procedures and guidance is	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009	Consider Evidence for Audit 1) Copy of revised policy 2) Revised training outcomes module 1 Agency action reviewed by QA&A Sub Group. Action Completed. Finalised

					clear and unambiguous regarding professional communication requirements.	8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010	
Recommendation 2 South Birmingham NHS Primary Care Trust should evidence through audit processes that children who are subject to weight and height checks as part of school medicals, have their data fully recorded and plotted on a growth chart in their notes, to provide a complete and readily accessible picture of the child's development.	Chief Executive of South Birmingham NHS PCT	South Birmingham NHS PCT audit processes to provide evidence that School Medical Checks accurately record weight and height to provide a complete and readily accessible picture of the child's development. Audit outcome to be shared with the Birmingham Safeguarding Children Board.	Safeguarding Lead South Birmingham NHS PCT	1/09/ 2009 1/11/ 2009	In 2009, School Health staff, Special School Nurses, Health Visitors and Community Nursery Nurses in South Birmingham Community Health attended best practice workshops in respect of growth measurement and recording in order to standardise the recording of height and weight. A strategy is now in place to ensure training is continued through community practice teachers to ensure new staff receive this training.	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Copy of audit findings. Agency action reviewed by QA&A Sub Group. Further evidence of action undertaken required from South Birmingham PCT of the Audit outcome to be forwarded to QA&A Sub Group by 11 th May 2010 for finalisation. Outcome of audit scheduled for July 2010 to be reviewed by QA&A Sub Group. On 30 th June 2010 QA&A sub Group requested further progress report on audit action for review at QA&A meeting on 13.07.10 QA&A Sub Group reviewed South

					<p>The new version of the Parent held Child Health Record has been circulated, containing growth measurement charts, which the staff have been trained to use.</p> <p>There will be an audit in early 2010 in order to monitor/review the standard of recording following training.</p> <p>From the action plans developed in relation to the audit results, we are still working to ensure 100% compliance on this issue. New centile charts have been delivered to staff in the last 2 months. Further audit plan for July 2010. Audit results will be</p>		<p>Birmingham PCT Audit Outcome. Action finalised.</p>
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					<p>forwarded to QA&A Sub Group.</p> <p>Further training sessions to those unable to attend before will also be provided on an ongoing basis across all universal children's services.</p> <p>The new record keeping guidelines and associated training will support the standardization of practice in relation to centile charts in active records.</p> <p>Ongoing monitoring of practice and reinforcement to staff continues and will also be monitored through supervision.</p> <p>A DNA audit was completed</p>		
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		School Health Service to evidence that policy is being effectively implemented.			<p>extend the opt out consent procedure for weight and height to include school entry vision and hearing tests.</p> <p>Children's Services Protocol for the Management of Non-Attendance at Health Appointments and No Access, which has now been approved, provides clear guidance for follow-up in relation to refusal of service.</p> <p>Opt out consent proforma for reception age height, weight, eye and hearing tests has been agreed and implemented in HOBtPCT.</p> <p>Pan Birmingham PCT group is currently agreeing pan</p>	<p>30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010</p>	
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				<p>Birmingham consent process. Completed.</p> <p>South Birmingham NHS Primary Care Trust – Special School Nursing Service have a standard communication in place, stating that implied consent will be taken after two occasions of failure to respond, unless the parent contacts the practitioner to voice non-consent. A review is currently being conducted around applying this system to mainstream schools. The implementation of this will form part of the organisation's DNA audit programme.</p> <p>Evidence of this audit has now</p>		
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					<p>been provided.</p> <p>Evidence of advice sought from Corporate Affairs in relation to parental consent has now been provided. Completed.</p> <p>Birmingham East & North NHS Primary Care Trust – Birmingham East & North has reviewed the consent process and is utilising the PAS system to record responses to parental consent. PAS system to be used from September 2009. Request for consent will be repeated where there is a nil response.</p> <p>An audit of response rate has been undertaken for</p>		
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					the reception cohort 08/09 and action plan being written to address this. Action Plan will be available from the end of November 2009. Completed.		
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<p>Recommendation 4 Where a school has initial concerns the designated senior person should liaise with schools attended by other siblings to ensure an holistic view of the children and family is obtained.</p>	<p>Strategic Director of Children Young People and Families Directorate</p>	<p>Children Young People and Families Directorate - School Effectiveness to review and re-issue Head Teachers and Designated Senior Persons with guidance on information requirement and process for effective referrals to Children's Social Care.</p> <p>New guidance to be incorporated with DSP training Programme.</p> <p>Post-Implementation Audit of referral to Children's Social Care to evidence effectiveness of new guidance.</p>	<p>Safeguarding Lead – Directorate Director School Effectiveness, Children Young People and Families</p>	<p>31/12/2010</p>	<p>Headteacher and Designated Service Persons guidance is being reviewed and updated to ensure compliance with: information required and processes to be followed to ensure effective referrals to Children's Social Care.</p> <p>The updated/new guidance will be incorporated within the DSP training programme - commencing Autumn term 2010.</p> <p>Processes to enable a full and effective audit of referrals to Children's Social Care will be developed in consultation with Headteachers and DSPs in the Autumn of 2010.</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit</p> <p>1) Copy of Audit findings 2) Copy of DSP Training Programme</p> <p>On 30th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10</p> <p>Reviewed by QA&A Sub Group 13.07.2010.</p> <p>Progress report submitted 23rd July 2010,</p> <p>QA&A Sub Group to review 8th November 2010 copy of : 1) New guidance 2) Training evaluation 3) Audit outcome</p>
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<p>Recommendation 5 Birmingham Children's Social Care must review and demonstrate that staff at all levels understand the appropriate use of the common assessment framework and the application of thresholds for significant harm</p>	<p>Strategic Director of Children Young People and Families Directorate</p>	<p>Children Young People and Families Directorate should conduct an audit of the Common Assessment Framework to identify whether application of thresholds for significant harm are being appropriately and consistently applied.</p>	<p>Safeguarding Lead for Children's Social Care, Service Director</p>	1/09/2009	<p>An audit of children subject to Common Assessment Framework has recently been completed.</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p>	<p>Consider Evidence for Audit 1) Copy of CAF Audit 2) Percentage and number of staff trained.</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence of action undertaken required from Children's Social Care prior to finalisation. Requested 23/4/2010 percentage and number of Children's Social Care staff having completed CAF training to be forwarded to QA&A Sub Group by the 11th May 2010.</p> <p>On 30th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10.</p> <p>7th July 2010, QA&A Sub Group Review. Require further evidence from Children's Social Care . 1) Outcome of training programme</p>
		<p>The audit findings to be utilised to inform development of the Common Assessment Framework training programme.</p>		1/11/2009	<p>The Common Assessment Framework lead manager undertook an audit through a 12 month period May 2009 to February 2010. The findings were used to inform the training for Duty & Assessment Duty Screening staff. Training took place between 16 April to 18th June 2010 and delivered via Learning & Development trainers. A clear threshold criteria document is in place which has been approved by BSCB. All staff have access to the tool which</p>	<p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010</p>	
		<p>Identify the percentage and number of Children's Social Care Staff who have successfully completed Common Assessment Framework training at an appropriate level.</p>		1/09/2009			

				<p>underpins the training received. During the same period briefings took place for Duty & Assessment, Social Workers and Team Managers.</p> <p>A threshold Criteria document for Common Assessment Framework is in place Endorsed by BSCB. Further work is currently underway on thresholds as part of the Family Support Strategy. All Referral and Advice Officers have been trained in the use of Common Assessment Framework.</p> <p>A series of 15 individual day Common Assessment Framework training programmes</p>		
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					<p>are now underway and being attended by all duty and assessment staff.</p> <p>In addition, the ongoing twice monthly Common Assessment Framework training will be made available to Children's Social Care staff. Ten places on these courses have been identified for duty and assessment staff.</p>		
<p>Recommendation 6 Birmingham Children's Social Care and West Midlands Police should review multi agency procedures to ensure that 'Police Safe & Well Checks' are not used in place of existing safeguarding policies and procedures.</p>	<p>Chief Constable West Midlands Police and Strategic Director of Children Young People and Families Directorate</p>	<p>Children Young People and Families Directorate should lead a joint review and issue practice guidance on the use of 'Police Safe & Well Checks'</p> <p>The revised guidance to be effectively disseminated to all relevant staff.</p> <p>Police Public Protection Unit Managers and Social Care Operations</p>	<p>Safeguarding Lead for West Midlands Police and Children's Social Care, Service Director</p>	<p>1/11/2009</p> <p>1/11/2009</p>	<p>West Midlands Police - force policy is currently being revised and is due to be launched in April 2010. The revised policy contains direction in respect of ensuring that 'Police Safe & Well Checks' are not used in</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence</p>	<p>Consider Evidence for Audit</p> <p>1) Copy of revised guidance disseminated to staff 2) Outcome of Dip sampling process</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence of action undertaken required from West Midlands Police and Children's Social</p>

		managers to undertake Dip Sample of cases to ascertain that policy is being effectively implemented.			<p>place of existing safeguarding policies and procedures (pg 42).</p> <p>An email has been sent to all child abuse investigators and managers making them aware of this recommendation and action, reinforcing the need for Public Protection managers to ascertain that policy in respect of police safe and well checks is being effectively implemented.</p> <p>Additionally, all managers were reminded of their responsibility to monitor the use / misuse of police safe and well checks during their audit / dip sample of cases undertaken. This is an</p>	<p>of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010</p>	<p>Care. Outcome of first phase of dip sampling process to be forwarded to QA&A Sub Group by the 11th May 2010 for review and finalisation. Requested 23/4/2010</p> <p>On 30th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10 Completed</p>
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				<p>ongoing process. In December 2009 managers were asked to confirm their compliance with the case audit / dip sampling process. Managers have confirmed that across the Birmingham area, there is compliance with this process.</p> <p>Completed</p> <p>Children's Social Care This practice no longer happens. Managers and staff have been informed across Children's Social Care offices. There is regular auditing of Initial Assessments across the City and this demonstrates that there is no evidence that "safe and well checks" are requested by Social Care</p>		
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					staff. 189 audits have been completed to date. Completed.		
Recommendation 7 Birmingham Children's Social Care must review and revise their referral and advice screening process to ensure that safe decisions are made based on risk and where the referrer expresses dissatisfaction this is passed to the Line Manager for resolution.	Strategic Director of Children Young People and Families Directorate	Children's Social Care must review and revise the advice and referral process to ensure that safe decisions are made based on risk. Audit findings to be shared with BSCB.	Safeguarding Lead for Children's Social Care, Service Director	1/09/2009	Changes have been made to the Referral & Advice screening Process including the expectations of managers to oversee the sign off referrals. This revised system was examined during the Unannounced OFSTED Inspection during November 2009. Price Waterhouse Coopers also reviewed this new system and associated thresholds and produced a report which validated the changes. It has been made clear to staff that any referrer that expresses dissatisfaction	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Copy of revised guidance 2) Outcome of Audit Case Reviews Agency action reviewed by QA&A Sub Group. Further evidence of action undertaken required from Children's Social Care copy of audit findings to be provided to QA&A Sub Group by the 11 th May 2010 for finalisation. Requested 23/4/2010 On 30 th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10 Completed

					with the proposed response must be brought to the attention of the duty manager. This is recorded on the A25 contact & referral form. A general audit of these forms is undertaken on a regular basis to ensure standards are complied with. Completed		
<p>Recommendation 8 Birmingham Children's Social Care should review the assessment process in the Duty & Referral Service to determine robust management oversight at each stage of the process and ensure robust quality assurance measures are in place which are specific to the 'Framework for the Assessment of Children in Need and their Families.'</p>	Strategic Director of Children Young People and Families Directorate	<p>Children's Social Care Quality and Practice Standards Group should take account of the findings from unannounced OFSTED Inspection to develop a robust audit program that complement existing audits aimed at improving quality and consistency of the assessment process.</p> <p>The findings from the first phase of the new audit program to be reported to the BSCB.</p>	Safeguarding Lead for Children's Social Care, Service Director	31/10/2010	<p>The Duty & Referral Service has been reviewed independently by Price Waterhouse Cooper (PWC) and actions taken to improve the process of assessments; which was further validated by the unannounced OFSTED inspection in November 2009.</p> <p>A new Quality</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further</p>	<p>Consider Evidence for Audit 1) Copy of audit findings</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence of action undertaken required from Children's Social Care to provide QA&A Sub Group copy of audit findings by the 9th November 2010 for finalisation.</p> <p>On 30th June 2010 QA&A sub Group requested further progress report for review at QA&A</p>

					and Practice Standards Group has been created within Children's Social Care which will determine a coordinated audit program to build on existing audits and will also identify further actions to improve assessments. The findings will be reported to the BSCB. Pending.	meetings are planned for; 23/07/2010 21/9/2010	meeting on 13.07.10 QA&A Sub Group 13.07.2010 review – CSC need to continue to develop robust quality assurance system, progress report by 31.10.2010.
Recommendation 9 Birmingham Safeguarding Children Board should commission multi agency guidance and training to equip staff in all agencies to work effectively with aggressive and highly resistant parents and carers.	Chair Birmingham Safeguarding Children Board	Training Steering Group to review Core Multi-Agency Child Protection training programme to ensure key learning from this case is included in existing Child Protection Modules. Training Steering Sub-Group to incorporate learning objective within training evaluation report.	Chair Training Steering Sub-Group and Chair of Development Policy and Procedures	1/12/2009 1/12/2009	The Learning from Serious Case Reviews is incorporated within all core multi-agency child protection modules, including the module four drugs and alcohol related programme. Cases 1 to 9 are currently being utilised by training providers. The lessons and learning from Case 14 will be	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010	Consider Evidence for Audit 1) Training Evaluation Report Agency action reviewed by QA&A Sub Group. Key learning from Serious Case Review incorporated in core child protection modular training. BSCB agreed on the 26.04.10 to commission further specific training on effective working with aggressive and resistant parents and

		Training Steering Group to commission specific training module on effective working with aggressive and highly resistant parents and carers.		31/10/2010	incorporated within all future training programmes once the document is in the public domain. Training Steering Group have commissioned a specific training module on effective working with aggressive and highly resistant parents and carers. Ongoing.	11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010	carers. QA&A Sub Group to review evaluation of first phase of training. On 30 th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10. QA&A Sub Group 13.07.2010 review Training Steering Group, progress report by 31.10.2010.
Recommendation 10 Birmingham Children's Social Care should conduct an evaluation survey to quantify Children's Social Care staff's understanding of the role and responsibility of the Education Otherwise Service following the recent awareness campaign.	Strategic Director of Children Young People and Families Directorate	Children's Social Care should conduct an evaluation survey to quantify children's social care staff understanding of the role and responsibility of the Education Otherwise Service following the recent awareness campaign Findings from survey to be presented to the BSCB.	Safeguarding Lead for Children's Social Care, Service Director	31/07/2010	An audit of all the children educated other than at school was undertaken soon after the sad death of child 14; and risk factors were assessed. This resulted in one case having intervention. Procedures have been updated in relation to Education	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009	Consider Evidence for Audit 1) Copy of survey findings Agency action reviewed by QA&A Sub Group. Further evidence of action undertaken required from Children's Social Care to provide QA&A Sub Group copy of survey findings by the 14 th September 2010 for finalisation. Requested 23/4/2010

				<p>Otherwise. Information available on the Council Website in relation to the legal parameters of Education</p> <p>Otherwise. Education</p> <p>Otherwise. Manager gave a detailed presentation on the role of the staff involved in this service to Social Care Managers. This presentation was cascaded to individual teams and staff were required to take note of this information.</p> <p>Integrated Services Assistant Director conducted an evaluation survey following the death of the child. Specific guidance has been drawn up between Social Care and Elective Home</p>	<p>19/8/2009</p> <p>8/2/2010</p> <p>11/05/2010</p> <p>Further meetings are planned for;</p> <p>23/07/2010</p> <p>21/9/2010</p>	<p>On 30th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10.</p> <p>Reviewed by QA&A Sub Group 13.07.2010. Children's Social Care to produce outcome of survey prior to finalisation. Pending.</p>
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					Education Service for joint working practices which has been issued July 2010. Completed		
Recommendation 11 Birmingham Children's Social Care should review and evidence that mechanisms are put in place to ensure that use of the complaints process by parents or significant adults does not adversely affect the actions of staff when pursuing safeguarding matters, or the welfare of children.	Strategic Director of Children Young People and Families Directorate	Children Young People and Families Directorate to provide evidence that where a complaint has been made that there is a system for management oversight to ensure that the complaints process does not adversely impact on the delivery of social care for children. Provide BSCB with an overview of the quality assurance processes to measure the impact and outcome of complaints system.	Safeguarding Lead for Children's Social Care, Service Director	1/09/2009 1/09/2009	All complaints are managed via Representations and Complaints procedure. All Managers ensure complaints process does not interfere with the completion of assessments. Where a complaint arises which threatens the process of assessments operation Managers make a decision to escalate process to Sec 47(Children Act 1989) or seek legal advice. The customer Relation Service which receives complaints from public will not proceed with the complaint	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Copy of complaints system overview report Agency action reviewed by QA&A Sub Group. Action completed. Finalised

					whilst social care staff undertake their assessments. Completed.		
Recommendation 12 Birmingham Children's Social Care to review supervisory expectations and standards, ensuring management and decision making processes contain sufficient rigour when managing risk	Strategic Director of Children Young People and Families Directorate	Children's Social Care should review model for staff supervision to ensure that it is sufficiently robust to adequately assess the rigour of safeguarding practice delivered. Ensure Personal Development Review process focuses on the impact of supervision in delivery of safe practice. Children's Social Care should undertake an audit, to evidence that managers are both supporting staff and challenging any lack of professional curiosity, or action, to ensure delivery of safe practice. Audit findings to be shared with BSCB.	Safeguarding Lead for Children's Social Care, Service Director	1/09/2009 1/12/2009	A City-wide supervision policy is in force and this was updated in September 2009 to include a revised contract specification. Supervision is included in the Children's Social Care staff's Personal Development Review process. An audit tool was established and implemented; and this has two key parts:- a scheduling element and a mechanism for sampling the quality of supervision. A comprehensive training	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Copy of revised guidance 2) Outcome of Supervision Audit Agency action reviewed by QA&A Sub Group. Further evidence of action undertaken required from Children's Social Care to provide QA&A Sub Group with findings from first monthly audit programme by the 11 th May 2010 for finalisation. Requested 23/4/2010 On 30 th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10 Completed

					programme for all Care Management staff was completed by October 2009. This included detailed practice standard guidance and expectations for staff and managers. A further detailed training programme is currently underway for all front-line staff in the Duty & Assessment Service. This includes a major focus on Risk Assessment and analysis. Completed.		
Recommendation 13 Education Otherwise should evidence to Birmingham Safeguarding Children Board changes to the recording and assessment process, demonstrating delivery of safe and effective services that contribute to meeting the safeguarding needs of children and young	Strategic Director of Children Young People and Families Directorate	Education Otherwise should provide evidence of changes to recording and assessment process designed to safeguard children. Education Otherwise Service to provide a report on the effectiveness of the service of safeguarding children.	Safeguarding Lead for Education Otherwise Service.	1/09/2009 09/07/2010	The Education Otherwise Service Team have provided detailed evidence to the Head of Safeguarding on the revised procedures and recording systems established in the light of this	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review	Consider Evidence for Audit 1) Copy of Education Otherwise Report Agency action reviewed by QA&A Sub Group. Action Completed. On 7 th July 2010 the Strategic Lead for Education Otherwise gave a presentation

<p>people across Birmingham</p>				<p>case. The Education Otherwise have improved systems to enhance service delivery of the Education Otherwise Service, and will ensure lateral checks are undertaken with children's services, that the frequency of Education Otherwise officers contact with families (normally on a six monthly basis) must not be considered as an effective monitoring of children's safety and wellbeing. Recommendations of the Badman report may strengthen the role of Education Otherwise Service officers, but the level of regular contact by teachers with children in schools will not</p>	<p>progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010</p>	<p>to the BSCB detailing changes to the Education Otherwise service with specific focus on the effectiveness of arrangements to safeguard children.</p> <p>On 30th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10 Completed</p>
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				<p>be possible through the Education Otherwise Service arrangements.</p> <p>9th July 2010 Strategic Lead for Education Otherwise attended the BSCB and gave overview of changes to the Education Otherwise service with specific focus on the effectiveness of arrangements to safeguard children.</p> <p>The Education Social Work Service have reviewed the guidance concerning children educated at home. The Review Action Plan, revised Guidance and associated referral, recording, assessment and</p>		
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					<p>tracking documents were presented to BSCB on 9th July. Other than minor amendments that documentation is ready for implementation. The revised process will be cross-referenced with the Safeguarding Procedures.</p> <p>The finalised new guidance will be disseminated to all ESWs and schools and will be presented to the Children's Social Care Operations Managers/Team Managers study day in September 2010.</p> <p>Completed.</p>		
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<p>Recommendation 14 The Strategic Director of Children's Services should communicate to the DCSF Secretary of State, the current safeguarding inconsistencies within legislation surrounding children who are educated from home, emphasising that the parents right to home educate does not outweigh the rights of the child.</p>	<p>Strategic Director of Children Young People and Families Directorate</p>	<p>Strategic Director of Children Young People and Families Directorate to write to Secretary of State at Department for Children Schools and Families with regard to the inadequacy of current legislation to safeguard children who are educated otherwise.</p>	<p>Strategic Director of Children Young People and Families Directorate</p>	<p>1/07/2009</p>	<p>The Children Young People and Families Directorate contributed to the Badman Review providing a detailed submission as part of the consultation phase of the review.</p> <p>In September 2009 the Strategic Director of Children Young People and Families Directorate personally wrote to the DSCF Secretary of State. Completed.</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit 1) Review DCSF response following publication of Badman Review.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>
<p>Recommendation 15 Heart of Birmingham Teaching Primary Care Trust should review and satisfy themselves that all GP's are aware of their professional responsibilities to communicate safeguarding concerns that arise as part of their interaction with</p>	<p>Chief Executive of Heart of Birmingham Teaching Primary Care Trust</p>	<p>Heart of Birmingham Teaching Primary Care Trust to incorporate within GP Safeguarding Training Events a Core Module on key lessons from Serious Case Reviews.</p> <p>Heart of Birmingham Teaching Primary Care Trust to Identify the</p>	<p>Safeguarding Lead Heart of Birmingham Teaching Primary Care Trust</p>	<p>1/08/2009</p>	<p>Training delivered to GPs at Practice Learning Time (on 17.03.2009). This included case studies based on Serious Case Reviews including Case 14. A report</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's</p>	<p>Consider Evidence for Audit 1) Copy of GP Training Event Evaluation 2) GP attendance data. 3) Participation evaluation data. 4) Course content.</p> <p>Agency action</p>

<p>children and families, in line with existing safeguarding procedures.</p>		<p>number of GP's who require Child Protection Training.</p> <p>Provide a copy of the training evaluation report detailing the outcome of the programme and the number GP's trained.</p>		<p>1/12/2009</p>	<p>based on participation evaluation is available.</p> <p>An ongoing programme has been agreed for delivery at Practice Learning Time events for all GPs.</p> <p>Heart of Birmingham Teaching Primary Care Trust safeguarding children training strategy and directory identifies mandatory and essential role training for all health professionals, including GPs. Implementation complete.</p>	<p>Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010</p>	<p>reviewed by QA&A Sub Group. Actins completed.</p> <p>Finalised</p>
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<p>Recommendation 16 Birmingham Safeguarding Children Board expects all agencies that have completed an IMR to implement any internal recommendations and to take action where management or practice has fallen below expected standards of professional behaviour.</p>	<p>Chief Executive and Chief Officers from all Agencies Completing IMR's</p>	<p>Safeguarding Lead to provide written confirmation that recommendations have been full implemented within identified agreed timescale.</p> <p>Safeguarding Lead to provide written confirmation that where management or practice has fallen below expected standards of professional behaviour appropriate Management action has been under undertaken.</p>	<p>Safeguarding Lead</p> <p>Children, Young People & Families – Education Welfare Service</p> <p>Children, Young People & Families – Schools</p> <p>Children, Young People & Families – Portage Service</p> <p>Children, Young People & Families Psychologist Service</p> <p>Children, Young People & Families – Early Years & Service Integration</p> <p>South Birmingham NHS PCT – Community Health</p> <p>Children, Young People & Families – SENAS</p>	<p>1/09/2009</p> <p>1/10/2010</p>	<p>The 13 Agencies made recommendations within their IMRs. The BSCB has written to all agencies seeking report on progress.</p> <p>All Agencies have provided confirmation that all recommendations have been fully implemented or evidence that significant progress has been made for target dates for finalisation.</p> <p>Appendix C provides a detail breakdown of each Agencies recommendation s and action taken.</p> <p>The below Agencies have provided confirmation that action has been taken where management or practice has fallen below</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit</p> <p>1) Agency Reports confirming implementation of IMR recommendations</p> <p>BSCB requested progress report from Children's Social Care, 03/02/2010</p> <p>Response received 05/02/2010</p> <p>Further progress report requested by QA&A sub group 11/05/2010</p> <p>Agencies responses reviewed by QA&A Sub Group.</p> <p>All agencies required to provide confirmation of that where management or practice has fallen below expected standards action has been undertaken to QA&A 14th September 2010.</p> <p>On 30th June 2010 QA&A sub Group requested further progress report for</p>
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			<p>West Midlands Police</p> <p>Heart of Birmingham Teaching Primary Care Trust –GP</p> <p>Heart of Birmingham Teaching Primary Care Trust – Health Visitors</p> <p>Birmingham & Solihull Mental Health Foundation Trust</p> <p>Birmingham Children’s Social Care</p>	<p>expected standards of professional behaviour:</p> <ul style="list-style-type: none"> * West Midlands Police * Education Welfare Service * Education Psychology * Portage Service * BSMHFT <p>Responses are still awaited from the following agencies:</p> <ul style="list-style-type: none"> ▪ HOB PCT – GP ▪ HOB PCT – Health Visitor ▪ Birmingham Children’s Social Care ▪ South Birmingham PCT – Community Health ▪ CYPF - Schools ▪ CYPF – Early Years and Service Integration CYPF ▪ SENAS 		<p>review at QA&A meeting on 13.07.10</p>
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<p>Recommendation 17 Heart of Birmingham Teaching Primary Care Trust and South Birmingham NHS Primary Care Trust, Birmingham Children's Social Care and Education Otherwise agencies should provide evidence to demonstrate an effective response to missed or failed appointments.</p>	<p>Chief Executives HOB t PCT and South PCT, Strategic Director Children Young People & Families</p>	<p>Each agency to carry out self Audit of missed or failed appointments to evidence compliance.</p> <p>Audit findings to be presented to Quality Assurance Sub-Group</p>	<p>Safeguarding Lead for Heart of Birmingham Teaching Primary Care Trust, South Birmingham NHS Primary Care Trust, Safeguarding Lead for CYP&F and Children Young People and Families Directorate</p>	<p>1/12/2009</p>	<p>Heart of Birmingham NHS Primary Care Trust – An audit of Children's Services response to DNAs was undertaken in October and the results were collated and analysed on 05/11/09. The results have been shared with all relevant managers, and will provide a baseline to measure compliance with Children's Services Protocol for the Management of Non-Attendance at Health Appointments and No Access, which has now been approved and disseminated to service managers. Completed.</p> <p>South Birmingham</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010 Further meetings are planned for; 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit 1) Copy of audit findings</p> <p>PCT action reviewed by QA&A Sub Group. Action Completed.</p> <p>Further evidence of action undertaken required from Children's Social Care to QA&A Sub Group by the 11th May 2010 for finalisation. Requested 23/4/2010</p> <p>On 30th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10 Completed</p>
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					<p>NHS Primary Care Trust – have a pre-existing DNA policy which was amended in December 2009. All level one and two safeguarding training links the relevance of DNA to safeguarding concerns. Opportunities to work in partnership with parents to improve attendance are contently being reviewed.</p> <p>Evidence of a self-audit of this process has been received. A comprehensive discussion has been held regarding DNAs at Child Development Centres. Further audits are now planned to ensure that implementation of the outcomes has been</p>		
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					<p>successful. Completed.</p> <p>Birmingham Children's Social Care Director Children's Social Care provided written confirmation actions completed on 5th February 2010.</p> <p>Children's Social Care have Practice Standards in place which require staff to record a missed appointment and on home visits to leave a clear message requesting further contact. In the event that this does not happen then further attempts are made within a 7 day period, thereafter the Initial Assessment continues. Compliance with this is monitored through the</p>		
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					Initial Assessment audit process. Completed.		
<p>Recommendation 18 The Children's Trust in conjunction with the Birmingham Safeguarding Children Board should initiate an education campaign with supporting literature, to build public trust and confidence in ways to effectively safeguard and protect other people's children</p>	<p>Chair of the Children and Young People Board</p>	<p>The Children's Trust in conjunction with the Birmingham Safeguarding Children Board should develop and launch a public awareness campaign, to inform and engage communities in safeguarding children. The aim is to build public trust and confidence in ways to effectively safeguard and protect other people's children.</p> <p>Children, Young People & Families Directorate to appoint Project Lead and establish a task and finish group with representation from the Birmingham Safeguarding Children Board to develop and implement public awareness campaign.</p> <p>Campaign evaluation report to be shared with the Children's Trust and Birmingham Safeguarding Children Board.</p>	<p>Chair of the Children and Young People Board</p>	<p>31/12/2010</p>	<p>Chair of BSCB to present overview of findings for SCR to Children's Trust. This Recommendation referred to the Children's Trust meeting 16th July 2010.</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010 11/05/2010</p> <p>Further meetings are planned for; 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit 1) Campaign Evaluation Report</p> <p>On 30th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 09.11.2010 Pending.</p>

Appendix B

Bibliography

CPS Domestic Violence Good practice Guide - November 2005

http://www.caada.org.uk/library_resources/CPS5.pdf

DCSF Elective Home Education Guidelines for Local Authorities 2007

<http://www.dcsf.gov.uk/localauthorities/documents/content/7373-DCSF-Elective%20Home%20Education.pdf>

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http://www.opsi.gov.uk/ACTS/acts1996/ukpga_19960056_en_2#pt1-ch1-pb3-l1g7

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<http://publications.everychildmatters.gov.uk>

A descriptive study of missed appointments: *Journal of Paediatric Health Care*, Volume 13, Issue 4, Pages 178-182

V. Pesata, G. Pallija, A. Webb

The nature and extent of malnutrition in children – Isabel T. Avencena and Geoffrey Cleghom Cambridge University Press

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<p>Red overdue</p> <p>Green Pending</p> <p>Black completed</p>

Implementation of IMR Recommendations in respect of Case 14
Date commenced 19th June 2009

The below recommendations have been ratified by the Strategic Lead for each agency, who will be responsible for ensuring they are fully implemented by the agreed target date. The BSCB will receive quarterly progress reports from named agencies. BSCB and GOWM will monitor the implementation of recommendations and audit compliance prior to case finalisation.

Recommendation (SMART)	Action Required by Agency	Implementation Lead for Agency	Target Date for Completion	Summary of Action Taken & Date Received	GOWM & Ofsted Monitoring & Feedback	QA&A Audit, Progress & Finalisation date of IMR Recommendations
Birmingham & Solihull Mental Health Foundation Trust						
Recommendation One Review and improve Birmingham & Solihull Mental Health NHS Foundation Trust systems for the storage, archiving and subsequent retrieval of care records, including those records transferred from the former Trusts	Urgent review of care record management arrangements across Birmingham & Solihull Mental Health NHS Foundation Trust	Birmingham & Solihull Mental Health NHS Foundation Trust Care Records Manager	01.09.09	Issues logged in the Birmingham & Solihull Mental Health NHS Foundation Trust Risk Register & highlighted in the Assurance Framework - remedial action monitored every quarter via the Risk Management Committee and Trust Board until action completed Care record archive and retrieval arrangements revised	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree	Consider Evidence for Audit 1) Copy of care management guidance. Agency action reviewed by QA&A Sub Group. Action Completed. Finalised

				and improved across all Birmingham & Solihull Mental Health NHS Foundation Trust sites Revised Care records Management Policy agreed at Trust Clinical Governance Committee on 1 st September 2009 Action completed	evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	
Recommendation Two Take account of the learning identified from the Individual Management Review for all Birmingham & Solihull Mental Health NHS Foundation Trust clinical staff	Enhance the child safeguarding training content	Birmingham & Solihull Mental Health NHS Foundation Trust Child Safeguarding Lead Nurse	Immediate	Action completed	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Copy of training programme. Agency action reviewed by QA&A Sub Group. Further evidence to be provided to QA&A Sub Group by the 11 th May 2010. Request evidence QA&A sub-group 13/07/2010 outcome of safeguarding training prior to finalisation

<p>Recommendation 3 Seek further information on the loss of contact between North Birmingham Mental Health Trust and patient's General Practitioner</p>	<p>Request copy records from patient's General Practitioner</p>	<p>Birmingham & Solihull Mental Health NHS Foundation Trust Child Safeguarding Lead Nurse</p>	<p>Immediate</p>	<p>This recommendation relates to the patient being seen by the former North Birmingham Mental Health Trust, following a merger in April 2003 and at the time of the Individual Management Review, the patient's mental health record could not be located.</p> <p>On reviewing this recommendation and in light of the significant action taken by Birmingham & Solihull Mental Health NHS Foundation Trust in relation to ensuring the systems for storage, archiving and retrieval of care records are in place, this course of action will not aid any further learning.</p> <p>Finalised.</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit 1) Review outcome.</p> <p>Agency action reviewed by QA&A Sub Group. Birmingham & Solihull Mental Health NHS Foundation Trust have provided a rationale for why this recommendation is no longer achievable.</p> <p>Finalised</p>
<p>Early Years Service</p>						
<p>Recommendation One The Early Years Community Project to keep more detailed records of children's progress</p>	<p>The setting is registered with OFSTED and bound to follow the Early Years Foundation Stage Framework so are obliged to ensure this is in place</p>	<p>Early Years Community Project Leader</p>	<p>31.12.09</p>	<p>Early Years – Safeguarding Officer - has visited the setting to ensure this process is now in place, further visits will be made by the settings development worker</p> <p>The setting now keeps much more detailed</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with</p>	<p>Consider Evidence for Audit 1) Record keeping guidance.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p>

				records of the children that access the service	GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Finalised
Recommendation Two The Early Years Community project to keep relevant (updated) details of any one authorised to drop off or collect children from the setting.	New templates need to be used by the setting requesting all relevant information	Early Years Community Project Leader	31.12.09	<p>Early Years – Safeguarding Officer - visited for the second time in November 2009 this action had been implemented. The development worker will ensure through an audit process that this action continues to be met.</p> <p>Record keeping is now more consistent and details of all persons who collect children are now kept on record, along with their telephone numbers and relationship with the child.</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010</p>	<p>Consider Evidence for Audit 1) New guidance.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

					Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	
Recommendation Three The Early Years Community project to implement a telephone log to formally record all conversations made and received.	A telephone recording book is to be used in future	Early Years Community Project Leader	31.12.09	This has been evidenced on two occasions by Early Years – Safeguarding Officer -, and will be monitored further by the settings development worker. The telephone log is kept consistently and all calls made and received are recorded. The managers have attended 2-day safeguarding training and also attended various safeguarding briefings.	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children’s Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) New guidance. Agency action reviewed by QA&A Sub Group. Action Completed. Finalised
Education Psychology Service						
Recommendation One Education Psychologists to ensure that where any information is recorded in School Files on named pupils for whom there is a Case File	1. Reminder to be issued to all Education Psychologist’s. 2. Education	Acting Chief Educational Psychologist	1. Immediately 2. 31.07.09 3. 31.07.09	1. Reminder issued 17 th June 2008. Follow-up reminder issued 17 th October 2008. 2. Staff File amended	BSCB provide GOWM with a weekly progress report on current	Consider Evidence for Audit 1) New guidance.

they should transfer the information to that case file as soon as practicable.	Psychology Service Information for Staff file to be amended. 3. Guidance included in Induction Pack			29th July 2008 3. Induction Pack amended 29th July 2008	Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Agency action reviewed by QA&A Sub Group. Action Completed. Finalised
Education Welfare Service						
Recommendation One Duty Social Workers to continue to send out information re Education Otherwise to parents and to give telephone advice but that referrals should be passed immediately to the school Education Social Worker for investigation, action and they will refer, without delay, to the Education Otherwise team.	Revise guidance to Duty Social Worker's	Principal Officer, Education Welfare Service	01.09.08	1. Verbal guidance given July 2008 re specific progression of Education Otherwise cases on duty. 2. Revised duty management guidance "The Management & Allocation of Duty Helpline" published & adopted October 2008. This document deals with the progression, monitoring & prioritisation of all duty cases	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and	Consider Evidence for Audit 1) New guidance. Agency action reviewed by QA&A Sub Group. Further evidence required to be provided to QA&A Sub Group by the 11 th May 2010. QA&A subgroup to review revised guidance prior to

				3. Education Otherwise case requirements for Education Welfare Service area staff written and circulated to Education Welfare Service management team for adoption in December 2008. This Guidance reiterates and expands upon verbal guidance previously given regarding the management of Education Otherwise duty cases and also covers cases referred by schools.	agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	finalisation 09/07/2010
Recommendation Two Education Otherwise referral form to be revised to ensure information is clearly and appropriately recorded including adequate information to safeguard children is passed to the Education Otherwise team	Revise form	Principal Officer, Education Welfare Service	31.10.08	Referral Form revised and agreed with Head of Service November 2008. New guidance distributed in December 2008.	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009	Consider Evidence for Audit 1) New guidance. Agency action reviewed by QA&A Sub Group. Action Completed. Finalised

					8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	
<p>Recommendation Three All Education Welfare Service records to be kept in individual files for each child. IMPULSE record system to be checked to ensure record keeping capability meets required standards. Education Welfare Service record keeping system to be reviewed and amended as appropriate to ensure all aspects of intervention are recorded clearly and appropriately.</p>	<p>Review Education Welfare Service Record keeping systems, processes and procedures. Implement any amendments.</p>	<p>Joint Acting Head of Service</p>	<p>29.02.09</p>	<p>1.IMPULSE records on individual pupil basis. Majority of workers now keeping case records on IMPULSE and remainder are receiving training. 2. Education Welfare Service Referral and Assessment forms revised pre Feb 2009 3. Case recording content reviewed, revised guidance issued and training delivered via Education Welfare Service Network Delivery Team Meetings in February 2008.</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit 1) Record keeping guidance. Agency action reviewed by QA&A Sub Group. Action Completed. Finalised</p>
<p>Recommendation Four That opportunities be sought for Education Welfare Service and</p>	<p>Establish working group with Children's Social Care</p>	<p>Assistant Director – Safeguarding / Assistant Director</p>	<p>31.03.09</p>	<p>Merging of the previously separate safeguarding</p>	<p>BSCB provide GOWM with a weekly</p>	<p>Consider Evidence for Audit 1) Work programme</p>

<p>Children's Social Care to gain insight into each others work and promote effective joint working</p>	<p>managers to devise a plan and programme of training, development. Improve liaison with Children's Social Care managers</p>	<p>– Integrated Youth Support</p>		<p>managements groups in Social Care and Education brought together managers from all children's services from January 2009.</p> <p>Social Care became key members of schools Designated Senior Person Networks and Schools Safeguarding Group from January 2009</p> <p>Nominated Operations Manager to identify need and opportunities e.g. mutual inclusion in Induction programmes, presentations at team meetings, attendance at agency training re relevant issues etc.</p> <p>Briefing to Social Care Managers on role of Elective Home Education Team Feb 2010. Further meeting between Acting Head of EWS and OM March 2010 to build programme of joint activity.</p>	<p>progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>and training programme.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>
<p>Recommendation Five Education Otherwise Team Procedures to be reviewed and revised to ensure rigour in assessment, lateral checks be</p>	<p>Revise procedures. Liaise with Children's Social Care to agree future processes for discussion of</p>	<p>Assistant Director – Integrated Youth Support</p>	<p>Partial revision in place. Full review to be</p>	<p>Procedures revised and published October 2008. Guidance for parents revised and published</p>	<p>BSCB provide GOWM with a weekly progress report on current</p>	<p>Consider Evidence for Audit</p> <p>1) New procedure.</p>

<p>made and liaison with Children's Social Care happens as a matter of course and contact to be made with children and young people in every event</p> <p>Team working within Education Otherwise team to be promoted.</p>	<p>Education Otherwise cases.</p> <p>Supervision and PDR</p>		<p>implemented by February 2009.</p>	<p>November 2008. Job Description and Personal Specification for Education Otherwise Advisors revised November 2008.</p> <p>Team personnel changes in September 2008 and April 2009. Briefing meeting with area Education Welfare Service teams on revised procedures and joint working. Engagement with Education Otherwise groups developed April 2009.</p>	<p>Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>
<p>Recommendation Six Lobbying for legislative change</p>	<p>Education Welfare Service Strategic Leadership Team</p>	<p>Assistant Director – Integrated Youth Support</p>	<p>Ongoing</p>	<p>Every opportunity has been taken to engage with, contribute to and influence legislative change to ensure that children Electively Home Educated are safeguarded and their right to a suitable education protected. This includes direct contact with Badman author of the Badman Report into Elective Home Education, raising issues and concerns with the</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree</p>	<p>Agency action reviewed by QA&A Sub Group. Action Completed. Children, Young People & Families Directorate provided a detailed submission to the Badman enquiry.</p> <p>Finalised</p>

				DCSF and Regional Advisors. Changes sought are that there are: Clearer obligations on parents in respect of evidencing the education they are providing A clear definition of what constitutes an efficient, full time, suitable, education Local Authority to have right of entry to homes and access to children A Registration system and requirement A structured process which includes the right to monitor	evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	
Schools						
Recommendation One All schools effectively keep records, Including information regarding parental engagement.	Provide and update Local Authority school record keeping guidelines in consultation with schools and appropriate agencies.	Principal Officer, Education Welfare Service	Interim guidance issued 2008. Final guidance 30.04.2010	Interim guidance issued to schools in June 2008. Formal consultation with schools and professional associations commenced May 2008. Updated final guidance completed and now ready for issue in May 2010. 2 nd June 2010, copy of Birmingham Pupil record keeping and management guidance forwarded to BSCB	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of	Consider Evidence for Audit 1) Copy of guidance 2) Evidence of audit of compliance. Agency action reviewed by QA&A Sub Group concerns expressed over the delay in the implementation. Schools to evidence compliance with new guidance and a progress report to be provided to QA&A Sub Group by the

				confirming guidance issued to schools.	compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	11 th May 2010. On 30 th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10 Completed Reviewed by QA&A subgroup 13/07/2010. Guidance Reviewed.
Recommendation Two Schools should be reassured that it is appropriate to exercise their professional curiosity, encouraged to make lateral checks and provided with opportunities to share relevant information.	Feedback to be provided for all schools and settings within Children, Young People and Families regarding the findings and recommendations in this IMR	Head of School Effectiveness	30.04.10	Letter from Strategic Director detailing the agreed recommendations from this IMR was sent to Head Teachers and Designated Senior Persons within all schools and settings by 02/06/2010. Circulated to schools in June 2010 Completed	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are	Consider Evidence for Audit 1) Copy of letter issued to schools. Agency action reviewed by QA&A Sub Group concerns expressed over the delay in the implementation progress report to be provided to QA&A Sub Group by the 11 th May 2010. On 30 th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10 Reviewed by QA&A subgroup

					planned for; 11/5/2010 23/07/2010 21/9/2010	13/07/2010. Letter reviewed and finalised.
Recommendation Three Schools and children services awareness and understanding of elective home education (Educating Otherwise) procedures and requirements to be raised.	Schools to be provided with copies of the educating otherwise/elective home education guidance and procedures. Content regarding elective home education to be included in child protection training for schools.	Assistant Director – Integrated Youth Support Assistant Director - Safeguarding	31.05.2010 31.05.2010	Letter of guidance for Head Teachers action in cases of Elective Home Education sent to all schools and settings by May 11 th 2010. Letter included reference to the full LA Guidance on EHE and provided access to this guidance through e-briefing on Birmingham Grid For Learning. Recommendation to be referred to Health Education Unit responsible for all schools child protection training. Content to be included in all training from May 2010 Guidance circulated in May 2010	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Copy of Education Otherwise Guidance and Procedures. 2) Evaluation of Child Protection Training delivered to schools. Agency action reviewed by QA&A Sub Group concerns expressed over the delay in the implementation progress report to be provided to QA&A Sub Group by the 11 th May 2010. On 30 th June 2010 QA&A sub Group requested further progress report for review at QA&A meeting on 13.07.10 Reviewed by QA&A subgroup 13/07/2010. Completed
Heart of Birmingham Teaching Primary Care Trust - GP						
Recommendation One Avoid abbreviations if possible but where used there should be a key to these abbreviations	Clinicians and General Practitioners practice staff to be advised on the use of	Named General practitioner for Child Protection	31.08.08	Implementation complete. Heart of Birmingham	BSCB provide GOWM with a weekly progress report	Consider Evidence for Audit 1) Dissemination process

	abbreviations by letter.			<p>Teaching Primary Care Trust's named General Practitioner for Safeguarding Children communicated this requirement to all General Practitioners on 28th July 2008.</p> <p>All practitioners were provided with guidance from the Royal College – General Practitioners to support implementation</p>	<p>on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>2) Information provided to GP's.</p> <p>Agency action reviewed by QA&A Sub Group. Completed</p> <p>Finalised.</p>
<p>Recommendation Two</p> <p>Have a system in place to record alerts for abuse indicators on parents' and children's notes with a system for cross referencing (if possible)</p> <p>If possible, clinical system should allow all family members to be linked enabling easier identification of at risk family members.</p>	<p>Clinicians and practice staff to be provided with guidance on the appropriate national safeguarding alert read codes to be used.</p>	<p>Named General Practitioners for Child Protection</p>	<p>30.09.08</p>	<p>Implementation complete</p> <p>Heart of Birmingham Teaching Primary Care Trust's named General Practitioner for Safeguarding Children communicated this requirement to all General Practitioners on 28th July 2008.</p> <p>All practitioners were provided with guidance from the Royal College</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and</p>	<p>Consider Evidence for Audit</p> <p>1) Record Audit. 2) GP contract Review</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence required of the audit outcome to be provided to QA&A Sub Group by the 11th May 2010.</p> <p>Details response</p>

				<p>– General Practitioners to support implementation</p> <p>Completed</p>	<p>agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010</p>	<p>received 2nd July 2010. QA&A sub group to review and finalise at the meeting on 13th July 2010.</p> <p>Reviewed by QA&A subgroup 13/07/2010. Finalised</p>
<p>Recommendation Three Avoid hand written records if possible but if practices use paper records then these need to be detailed.</p>	<p>Clinicians and General Practitioner practice staff that are still using hand written records to be advised on the need to write comprehensive contemporaneous records by letter</p> <p>Performance management to identify and support General Practitioners practices still using hand written records to use electronic records.</p>	<p>Named General Practitioner for Child Protection</p>	<p>31.08.08 31.12.08</p>	<p>Implementation complete</p> <p>Heart of Birmingham Teaching Primary Care Trust's named General Practitioner for Safeguarding Children communicated this requirement to all General Practitioners on 28th July 2008.</p> <p>All practices were provided with guidance from the Royal College – General Practitioners to support implementation. Evidence of process for dissemination.</p> <p>Performance management to identify and support General Practitioners practices still using hand written records to use</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010</p>	<p>Consider Evidence for Audit</p> <p>1) Record Audit. 2) Clarification of how GPs still utilising handwritten recording systems. Timetable for change over to electronic record system. 3) GP contract Review 4) List of GP practices</p> <p>Agency action reviewed by QA&A Sub Group. Progress report to be provided to QA&A Sub Group by the 11th May 2010.</p> <p>Details response received 2nd July 2010. QA&A sub group to review and finalise at the meeting on 13th July</p>

				<p>electronic records.</p> <p>The HOG IT team have confirmed that all GP's use electronic record systems.</p>	21/9/2010	<p>2010.</p> <p>Reviewed by QA&A subgroup 13/07/2010. Finalised</p>
<p>Recommendation Four</p> <p>All staff to be aware of requirement to refer to Social services and Health Visitor with any allegation of or suspected abuse</p>	<p>General Practitioner practices to be provided with a copy of Birmingham NHS safeguarding children & Young People policy and procedures and contact numbers of who to contact for advice and support about safeguarding concerns.</p>	<p>Named General Practitioner for Child Protection</p>	30.09.08	<p>Completed.</p> <p>The named GP for child protection has written to all practices on 28/07/08 advising of this recommendation and action. Letter contains links to Birmingham NHS Child Protection procedures and Child Protection Contacts.</p> <p>16/07/08 Manager of Performance management confirmed that compliance with IMR recommendations will be addressed in annual GP audit and review processes.</p> <p>July 2010 Evidence of referrals made to social care following feedback meeting with GP. Internal training provided to GP.</p> <p>GP practice has lead for safeguarding. There are weekly practice meetings to</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit</p> <p>1) Copy of guidance.</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence required to be provided to QA&A Sub Group by the 11th May 2010</p> <p>Details response received 2nd July 2010. QA&A sub group to review and finalise at the meeting on 13th July 2010.</p> <p>Reviewed by QA&A subgroup 13/07/2010. Evidence of compliance to be reviewed prior to finalisation</p> <p>23rd July 2010 documentary evidence provided.</p>

				discuss concerns. GP facilitated implementation of alert system for safeguarding.		Finalised
<p>Recommendation Five Failed hospital appointments should be recorded on clinical system to enable clinician to advice patient/parent at the next consultation.</p> <p>General Practitioner practice should have a system in place to inform the health visitor of failed appointments and any correspondence received from secondary about issues parenting.</p>	<p>Clinicians and General Practitioner practice staff to be advised on the recording of failed appointments and the action to be taken by letter.</p>	<p>Named General Practitioner for Child Protection</p>	<p>31.08.08</p>	<p>Named General Practitioner for Safeguarding Children communicated this requirement to all General practitioners on 28th July 2008.</p> <p>All practices were provided with guidance from the Royal College – General Practitioners to support implementation evidence of process for dissemination.</p> <p>Implementation complete</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit 1) Outcome of record keeping audit to clarify compliance with recommendation.</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence required of the audit outcome to be provided to QA&A Sub Group by the 11th May 2010.</p> <p>Reviewed by QA&A subgroup 13/07/2010. Finalised</p>
Heart of Birmingham Teaching Primary Care Trust - HV						
<p>Recommendation One Health Visitors to reinforce to parents/guardians of a new baby at</p>	<p>To inform Health Visitors to discuss the importance of safe</p>	<p>Safeguarding Children and Young People</p>	<p>30.09.08</p>	<p>Implementation complete.</p>	<p>BSCB provide GOWM with a weekly</p>	<p>Consider Evidence for Audit 1) Relevant section of</p>

<p>the primary visit the importance and relevance of the Personal Child Health Record for their child. If parents and guardians are informed about how the record will be used and its usefulness, this will encourage the safe keeping of the document.</p>	<p>keeping of the Personal Child Health Record, the need for parents to bring the record with them to every contact with a professional and to have it available for use within the home.</p> <p>This should be added to the Primary Care Trust Child Health Promotion and Health Education Policy.</p>	<p>Team</p>		<p>All Health Visiting Team Leaders were informed of the requirement for this recommendation to be implemented by all Health Visiting Teams on 23rd September 2008.</p> <p>This requirement has been incorporated within Pan Birmingham Record Keeping Guidelines which are awaiting final ratification by Pan Birmingham NHS.</p> <p>Finalised</p>	<p>progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 21/9/2010</p>	<p>record keeping guidance. 2) Confirmation draft policy implemented.</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence to be provided to QA&A Sub Group by the 11th May 2010.</p> <p>QA&A subgroup to review a copy of the Pan Birmingham Record Keeping Guidelines by 13/07/2010</p> <p>23rd July 2010 documentary evidence provided.</p> <p>Finalised</p>
<p>Recommendation Two To ensure that all Health Visitors and School Nurses receive Active Intervention Record Keeping Training and that this is updated no fewer than at three yearly intervals</p>	<p>The Audit of Health Visitor and School Nurse service compliance to attend Active Intervention Record Keeping Training.</p>	<p>Safeguarding Children and Young People Team</p>	<p>30.09.08</p>	<p>Implementation complete.</p> <p>A rolling programme of Active Intervention Training is in place.</p> <p>As at June 2009 more than 80% of Health Visiting / School nursing staff were up to date.</p> <p>Staff with training outstanding have been booked on to the next</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and</p>	<p>Consider Evidence for Audit</p> <p>1) Review DCSF response following publication of Badman Review.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

				<p>scheduled training session in June.</p> <p>24 (61%) of Health Visitors are recorded to be up to date with DV training. Additional training has been commissioned.</p> <p>All staff involved with this family who remain in the service are up to date with this training.</p>	<p>agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	
<p>Recommendation Three For the Primary Care Trust to have a minimum standard response that can be applied by practitioners when children do not attend appointments that are relevant to their health and wellbeing.</p>	<p>The development of a Did Not Attend (DNA) policy that can be applied in response, when children do not attend appointments whether they are scheduled or unscheduled.</p>	<p>Safeguarding Children and Young People Team</p>	<p>31.12.08</p>	<p>Implementation complete.</p> <p>Since November 2009 Children's Services' staff have been required to implement a detailed protocol for the Management of Non-Attendance of Health Appointments and 'No Access'.</p> <p>An audit of Children's Services response to DNA's was undertaken in October and the results were collated and analysed on 5th November 2009. The results have been shared with all relevant managers and will provide a baseline to measure compliance with the 'Management of Non-Attendance</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010</p>	<p>Consider Evidence for Audit</p> <p>1) Confirmation of DNA policy implemented. 2) Evidence of effectiveness of DNA policy.</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence to be provided to QA&A Sub Group by the 11th May 2010.</p> <p>QA&A subgroup to review DNA audit outcome prior to finalisation 13.07.2010</p> <p>23rd July 2010 documentary evidence provided.</p>

				Protocol'. Finalised	23/07/2010 21/9/2010	Finalised
Recommendation Four The Primary Care Trust to review the process for obtaining parental consent for children to receive a school health service, and what follow up action would be required to explore the reasons for parents withdrawing their children from this service.	To establish a working group to explore the issues, develop an understanding and identify solutions that would enable children to have equity of opportunity to receive a school health service. It may also be relevant to encourage the working group's membership to include the remaining two Birmingham Primary Care Trusts.	Safeguarding Children and Young People Team	To commence 01.09.08	Implementation complete. As required by the recommendation consent processes were reviewed by a Heart of Birmingham Working group and a final report with recommendations was presented to the Safeguarding Children and Young People group in August 2009. This has resulted in the implementation of the protocol for managing Non Attendance of health Appointments and No Access. An Opt Out consent proforma for hearing, vision and weight checks for school age children is awaiting final ratification. Learning will be shared with Birmingham East & North and South Primary Care Trust's. Opt out consent policy agreed for Hobt PCT	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Outcome of working group. Agency action reviewed by QA&A Sub Group. Further evidence to be provided to QA&A Sub Group by the 11 th May 2010. QA&A subgroup reviewed 13/07/2010 Finalised.
Portage Service						
Recommendation One Ensure all team members continue to work holistically and provide	Review Safeguarding Policies for both the	Team Co-ordinators	31.07.08	July 2008: Policy completed	BSCB provide GOWM with a	Consider Evidence for Audit

<p>detailed evidence in all records how their assessment of need and planned intervention with each child and family fully reflects this.</p> <p>(ECM Outcomes: Stay Safe, Be Healthy, Enjoy and Achieve)</p>	<p>Portage Service and the Learning Support team and update for the newly integrated Early Support Service, incorporating recent Children's Centre guidance</p> <p>Establish supervision arrangements for the newly integrated Early Support Service and continue to monitor home visit data via supervision to identify emerging patterns of 'no answer' visits</p>		<p>31.12.08</p> <p>31.03.09</p>	<p>November 2008: Service Day INSET</p> <ol style="list-style-type: none"> 1. Safeguarding policy 2. Supervision framework for Early Support Service <p>March 2009: Supervision arrangements in place for the newly integrated Early Support Service evidenced by 1:1 rotas and supervision notes</p>	<p>weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for; 11/5/2010 21/9/2010</p>	<p>1) Copy of Safeguarding Policy.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>
<p>Recommendation Two Continue the implementation of service plan objectives to develop integrated working through Team Around the Child and Team Around Schools approaches</p> <p>(ECM outcomes Stay Safe, Be Healthy, Enjoy and Achieve)</p>	<p>Ensure all team members have CAF and Early Support training.</p> <p>Support, develop and challenge individual and team practice on an ongoing basis, monitored through supervision, PDR, Continuous Professional Development .</p>	<p>Team Co-ordinators</p>	<p>31.07.09</p>	<p>March 2009: Service INSET: Working in Partnership using Early Support module (delivered by ES trainers)</p> <p>Common Assessment Framework training in place</p> <p>July 2009: PDR and Continuous Professionals Development</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review</p>	<p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

				arrangements in place in accordance with Birmingham City Council Excellence in People Management	progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	
<p>Recommendation Three To reduce waiting times for support and improve transition processes for children and their parents/carers</p> <p>(ECM outcomes: Stay Safe, Be Healthy, Enjoy and Achieve, Make a positive contribution)</p>	<p>Continue to use reporting lines to Senior managers re capacity/waiting times for children and families and ensure these are addressed through objectives in Service Development Plan.</p> <p>Use demand/needs analysis to provide evidence of capacity issues and inform developments within Early Support Service</p> <p>Develop frameworks of support to ensure fair and flexible service delivery to children and families according to need</p>	Team Co-ordinators with Leadership team	31.03.10	<p>Demand/needs analysis completed for referrals in academic year 2008-9. To continue on an ongoing basis for subsequent years.</p> <p>Service Development Plan in place for 2008-2010</p> <p>Referral and caseload data presented at Early Support Service Advisory Group on a termly basis and at Children's Centres Leadership Team.</p> <p>Frameworks of support introduced to caseload management and monitored through supervision</p> <p>February 2010 –</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010</p>	<p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

				recruitment to Children's Centre funded Early Support Worker post	23/07/2010 21/9/2010	
Special Educational Needs Assessment Service						
Recommendation One New procedure for escalation of cases to Assistant Education Officer within 6 weeks where parents not co-operating with school placement	Internal Procedure to be agreed at staff meeting	Assistant Education Officer	30.06.08	Agreed June 2008 and included in revised Education Otherwise procedure	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Education Otherwise procedure. Agency action reviewed by QA&A Sub Group. Action Completed. Finalised
Recommendation Two New procedure for responding to requests for Education Otherwise than at school for children with statements in liaison with Education Otherwise colleagues	Guidance including timescales, multi-agency meetings and liaison with legal services, to be issued to all staff	Assistant Education Officer	31.12.08	Guidance Issued December 2008 and procedure to be further updated in April 2010	BSCB provide GOWM with a weekly progress report on current Serious Case	Consider Evidence for Audit 1) Guidance Agency action

					<p>Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>
<p>Recommendation Three New SENAS Child Protection policy</p>	<p>Policy written and issued to staff</p>	<p>Assistant Education Officer</p>	<p>31.12.08</p>	<p>Issued October 08</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of</p>	<p>Consider Evidence for Audit</p> <p>1) Copy of SENAS Child Protection Policy.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

					compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	
Recommendation Four Delivery of Safeguarding Training	Training for all staff 2 day training for designated persons Head of Service attends Serious Case Review Training	Assistant Education Officer	31.03.09	Delivered December 08 Delivered January 09 Attended October 08	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Training evaluation. Agency action reviewed by QA&A Sub Group. Action Completed. Finalised
Recommendation Five	SENAS	Assistant	31.12.08	Represented since	BSCB provide	

<p>SENAS representation on Safeguarding Children, Education Sub-Group</p>	<p>representation</p>	<p>Education Officer</p>		<p>December 2008</p>	<p>GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>
<p>Recommendation Six Termly meetings with Education Otherwise to review current cases and operation of procedures</p>	<p>Meetings to be arranged</p>	<p>Assistant Education Officer</p>	<p>31.05.10</p>	<p>To commence in May 2010</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's</p>	<p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

					<p>Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010</p>	
Children's Social Care						
<p>Recommendation One Review and amend the current policy and procedures for the management of domestic abuse referrals</p>	<p>The current review of the Domestic Abuse Referrals to including the learning from this Serious Case Review. Joint screening process to be introduced</p>	<p>Assistant Director - Safeguarding Head of Service Operations Manager</p>	<p>31.10.08</p>	<p>Domestic Abuse Review undertaken in partnership with West Midlands Police and Health has been completed. Birmingham using the new screening tool for Domestic Abuse referrals. Joint screening with West Midlands Police and Health now taking place for 392's across the city.</p> <p>New Policy & Procedure in place</p> <p>Report by Consultant Practitioner December 2009</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further</p>	<p>Consider Evidence for Audit 1) Joint Screening guidance.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

					meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	
Recommendation Two Action not being undertaken in relation to an anonymous referral when it has been identified that a child may have been harmed	Review current guidelines for the management of referrals and amend if required Disseminate lesson and amendments to all front line staff	Head of Service Procedures Writer	30.09.08	Procedures have been reviewed and amended to include specifically the issue of anonymous referrals. Information disseminated to all front line staff.	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Copy of guidance. Agency action reviewed by QA&A Sub Group. Action Completed. Finalised
Recommendation Three Staff to be reminded of undertaking an assessment of all children when a referral of concern is received.	Memo to all frontline staff	Head Of Service - Duty and Assessment Head of Service - Care Management	31.07.08	A practice standard is in place and this is being incorporated within procedures. It requires individual assessments to be undertaken with	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews	Consider Evidence for Audit 1) Audit of compliance of assessment process.

				<p>siblings or half siblings within the family. The Team Manager's decision making sign off process for the Initial Assessment ensures compliance with this requirement.</p> <p>Finalised</p>	<p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>Agency action reviewed by QA&A Sub Group. Further evidence to be provided to QA&A by the 11th May 2010 for finalisation.</p> <p>QA&A subgroup 13.07.2010 reviewed a copy of memorandum. Finalised</p>
<p>Recommendation Four To review current practice of the requesting West Midlands Police to undertake "safe and well checks"</p>	<p>All Screening and Duty and Assessment team managers to review use of safe and well checks To ascertain the extent of use with West Midlands Police To cease practice</p>	<p>Head Of Service - Duty and Assessment</p> <p>Operations Manager Screening and Duty and Assessment</p>	31.07.08	<p>This practice no longer happens. Managers and staff have been informed across Children's Social Care offices. There is regular auditing of Initial Assessments across the City and this demonstrates that there is no evidence that safe and well checks are requested by Social Care staff. 189 audits have been completed to date. West Midlands Police have also agreed to inform the Assistant Director,</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p>	<p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

				Safeguarding of any circumstances of contravention to this directive.	30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	
Recommendation Five Review processes in screening and duty and assessment to ascertain whether there are any capacity or compliance issues, and if they are fit for purpose	Commission Independent review of all screening and duty assessment systems across the city Action recommendations	Strategic Director Social care Director	30.06.08	Independent reviews of Duty Screening and assessment thresholds which included Duty Screening systems have been undertaken by Independent Consultants in Autumn 2008 and the Safeguarding Service in December 2008. Further review was completed by Price Waterhouse Cooper in Spring of 2009. Integrated Children's System team including external providers OLM with Duty & Assessment staff and chaired by the interim Assistant Director undertook a review of Duty & Assessment systems, recommendations for changes implemented. Further refinement has been put in place following the Rapid	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Price Waterhouse Cooper's findings. Agency action reviewed by QA&A Sub Group. Action Completed. Finalised

				Improvement workshops completed with relevant Managers There was a further Duty Review Report by Consultant Practitioner December 2009		
Recommendation Six Review current practice and understanding of ascertaining parental consent in screening and duty assessment processes	Review current practice through sampling of cases Amend policy and procedure where appropriate Disseminate findings	Head of Service - Duty and Assessment Operations Manager Screening and Duty Assessment	31.07.08	Practice guidance to staff provided for parents refusal of consent to Initial Assessment and escalation process to S47 in place. Policy & procedure amendment	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Copy of practice guidance. Agency action reviewed by QA&A Sub Group. Action Completed. Finalised
Recommendation Seven Review of the roles and responsibilities of Social Workers from Specialist Services and Social	Ensure staff understanding of respective roles. Commission review	Service Directors for social care and Inclusion Services	30.09.08	An audit of all the children educated other than at school was undertaken soon after	BSCB provide GOWM with a weekly progress report	Consider Evidence for Audit 1) Outcome of review of roles and

workers from Education Welfare Service	of the respective roles and responsibilities across the city Action recommendations			<p>the sad death of child 14; and risk factors were assessed. This resulted in one case having intervention.</p> <p>Procedures have been updated in relation to Education Otherwise. Information available on the Council Website in relation to the legal parameters of Education Otherwise.</p> <p>The Assistant Director Integrated Youth Support and the Education Otherwise Manager gave a detailed presentation on the role of the staff involved in this service to Social Care managers on the 5th February 2010. This presentation was cascaded to individual teams and staff were required to take note of this information.</p> <p>Work is nearing completion on re-defining the respective roles of Social Care and Education Welfare Service staff in assessing children. New guidance will be issued during May</p>	<p>on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>responsibilities Specialist Services and Education Welfare Services.</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence of compliance with the recommendation to be provided to QA&A Sub Group by the 11th May 2010.</p> <p>QA&A subgroup reviewed on 13/07/2010 Finalised</p>
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				2010. An evaluation to assess the awareness amongst Children's Social Care staff of the role of the Education Otherwise Service will be undertaken by the end of June 2010 and this follows the awareness raising activity already completed. The findings from this action will be reported to the Board.		
Recommendation Eight Review the performance issues of all staff involved.	Review to be undertaken in conjunction with Human Resources	Service Director Children's Social Care	30.09.2008	Children's Social Care has a system for close oversight of implementation of IMR recommendations and regular reporting on this is undertaken to the Board. Decisions regarding any action taken in response to individual staff, whose practice has fallen below expected standards, are made on a case by case basis and within the City Council's procedures. In addition, where appropriate, the General Social Care Council will be informed of potential action that could be taken, and	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010	Consider Evidence for Audit 1) Evidence of staff performance addressed Agency action reviewed by QA&A Sub Group. Further evidence of compliance with the recommendation to be provided to QA&A Sub Group by the 11 th May 2010. QA&A Subgroup 13/07/2010 reviewed. Confirmation action completed.

				<p>action that is taken, against particular staff who are social work qualified.</p> <p>Disciplinary action has been undertaken for those staff whose performance fell below the required standard.</p> <p>Completed</p>	<p>Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010</p>	
<p>Recommendation Nine Review of recording process on CareFirst for all staff including all managers Team Managers and above</p>	<p>Review current procedure Review capability of Carefirst6 Amend procedure where appropriate and disseminate</p>	<p>Head of Service & Operational Managers Assistant Head of Safeguarding</p>	<p>31.10.08</p>	<p>Carefirst6 is compliant with Integrated Children's Service. Staff have been trained re recording on the system. System now has the facility for all managers to input where appropriate on the case notes.</p> <p>Integrated Children's System Team confirmed on 11th March 2010 that standard is in place</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit 1) Copy of procedure.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

South Birmingham Primary Care Trust						
<p>Recommendation One Special School Nursing, Community Paediatricians and Therapy Services to access level 2 safeguarding children Training which includes Framework for the Assessment of Children in Need and their Families guidance which consider all 3 domains of a child's wellbeing and needs.</p>	<p>Re-Issue explicit guidance for accessing Level Two Training to all Children's Directorate staff. Circulate Framework for the Assessment of Children in Need and their Families guidance to all staff groups in The Children & Young People & Families Division</p>	<p>Lead Nurse Safeguarding Children in conjunction with the Heads of Service in the Children and Families Division</p>	<p>31.01.09</p>	<p>Level 2 training is mandatory for all Children Directorate staff. The Primary Care Trust level 2 training syllabus reflects the use of the FACIN. The trust training data base monitors all training and staff attendance, and a report of the same is submitted to the corporate leads for safeguarding. Monthly assurance is given to indicate that Level 2 training is being delivered in accordance with the strategy, and percentage of staff trained is reported on a yearly basis. Individual staff appraisals are used to ensure compliance with appropriate levels of training. This is further monitored via supervision.</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit 1) Copy of new guidance.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>
<p>Recommendation Two The Children & Families Division within South Birmingham NHS Primary Care Trust should access the DNA (Did not Attend) procedure and ensure that their service wherever possible ascertains reasons for continually defaulted or sporadically attended appointments,</p>	<p>DNA policy made available to all staff via heads of service and available on trust intranet</p> <p>Special School Nursing Service, Child Development</p>	<p>Lead Nurse Safeguarding Children in conjunction with the Heads of Service in the Children and Families Division</p>	<p>31.01.09</p>	<p>The Children & Families Division has a DNA Policy.</p> <p>The introduction of the chronology sheet into school health active intervention records requires staff to record</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular</p>	<p>Consider Evidence for Audit 1) Copy of DNA Policy.</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence of</p>

<p>and shares the information with all professionals involved.</p>	<p>Centre services (including community paediatricians) and Therapy Services within the Children and Families Division South Birmingham NHS Primary Care Trust should make use of the chronology sheet (attached) to record significant events and family changes. E.g. Defaulted appointments across all services when information received. Copies of sheets already in use in other services are attached and should be either used as they are or developed to be more service specific.</p>			<p>on the chronology sheet when that child has failed to attend an appointment and address that issue as part of their assessment, care planning and liaison. Active records include records for children requiring an enhanced service because of additional needs, cause for concern and child protection care plans.</p> <p>Non-attendance is followed up initially by a letter and then dependant on needs assessment further communication and contact to facilitate the child receiving the health care required</p> <p>All level one and two safeguarding training links the relevance of DNA to safeguarding concerns in particular neglect, and discusses the role of the whole teams including admin personnel in playing their part to flag up concerns and recognise pictures of non-engagement.</p> <p>An audit of Special</p>	<p>meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2010 23/7/2010 19/8/2010 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010</p>	<p>compliance with the recommendation to be provided to QA&A Sub Group by the 14th September 2010.</p>
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				<p>School Nurse records has been completed and the results were shared with the team leaders. This audit included the recording of failed appointments and use of the chronology sheet.</p> <p>Further audit of non-attendance follow up is planned for July 2010 with front line teams. The results will be reported into the Quality and Assurance sub-group.</p>		
<p>Recommendation Three All records for children receiving a service from South Birmingham NHS Primary Care Trust specialist services for children (Special School Nursing Service, Community Paediatricians, Child Development Centres, Therapy Services) should include</p> <p>a) A Multi –agency involvement sheet to highlight all professionals involved and should be kept up to date and provide contact details.</p> <p>b) A Family Profile sheet to ensure that the child is seen as part of his/her family and not as an individual in isolation.</p>	<p>Copies of sheets already in use in other services are attached and should be either used as they are or developed to be more service specific</p>	<p>Lead Nurse Safeguarding Children in conjunction with the Heads of Service in the Children and Families Division</p>	<p>31.01.09</p>	<p>Special school nurses have in 2009 commenced using separate nursing files that match the Active Intervention Records utilised by health visitors and school nurses. An audit is presently being carried out to assess the new process and training.</p> <p>Registration sheets are now available in all records for the Child Development Centre.</p> <p>Work will continue in order to standardise of family profile sheets</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children’s Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009</p>	<p>Consider Evidence for Audit 1) Copy of record keeping guidance</p> <p>Agency action reviewed by QA&A Sub Group. Further evidence of compliance with recommendation required to QA&A by the 14th September 2010.</p>

				required to provide assurance that require Common Assessment Framework training have completed a recognised update.	23/07/2010 21/9/2010	
Recommendation Five South Birmingham NHS Primary Care Trust should evidence through audit processes that children who are subject to weight and height checks as part of school medicals, have their data fully recorded and plotted on a growth chart in their notes, to provide a complete and readily accessible picture of the child's development	South Birmingham NHS Primary Care Trust should evidence through audit processes to provide evidence that School Medical Checks accurately record weight and height to provide a complete and readily accessible picture of the child's development. Audit outcome to be shared with BSCB.	Lead Nurse Safeguarding Children	31.01.09	As of November 2009 The School Health staff in South Birmingham Community Health attended workshops with in respect of best practice regarding growth measurement and recording in order to standardise the recording of height and weight. Special school nurses attended in July 2009. Ongoing training is available for new starters and staff who were unable to access previous sessions. The new version of the Parent held Child Health Record (red book) has just been circulated and all new babies and child contacts will be issued with the new version. It contains new growth measurement charts which the staff have been trained to use and also contains	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	Consider Evidence for Audit 1) Audit outcome. Agency action reviewed by QA&A Sub Group. Further evidence required with target date for completion of Audit. Progress report to be provided to QA&A Sub Group by the 14th September 2010 for finalisation.

				<p>instruction on how these should be completed.</p> <p>The newly issued centile charts according to the World Health Organisation guidelines have been made available for use in all universal services nursing records.</p> <p>Initial Audit completed. Further audit will be completed in July 2010 to demonstrate compliance with 100% standard and to monitor / review the standards of recording following training.</p>		
West Midlands Police						
<p>Recommendation One Review of force training currently provided to probationary officers, Police Community Support Officer's and new police employees with responsibility for call taking / incident handling.</p>	Training review	Detective Inspector – Public Protection Unit	31.12.08	Review completed, training revised. December 2008	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and</p>	<p>Consider Evidence for Audit</p> <p>1) Copy of training programme.</p> <p>Agency action reviewed by QA&A Sub Group. Action Completed.</p> <p>Finalised</p>

					agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010	
Recommendation Two West Midlands Police to make accessible to all police officers and police staff basic child protection recognition and referral training. Training to include wider safeguarding responsibilities under section 10 and 11 of the Children's Act 2004, additionally single and multi agency responsibilities.	Training package to be developed and delivered	Detective Inspector – Public Protection Unit	31.12.08	Training time approved, training package developed, training programme for all staff commenced December 2009 As of 15 th June 2010, 6559 frontline staff had received the mandatory training, with approximately 3000 staff still requiring training. The deadline date for completion is September 2010. In September phase three training commences, which builds upon the initial child safeguarding training and through the medium of a case study, gives all staff an awareness of lessons learnt from recent serious case reviews (covering past 3 years)	BSCB provide GOWM with a weekly progress report on current Serious Case Reviews Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010	Consider Evidence for Audit 1) Update on role out of training programme. Number and percentage of staff trained together with target date for completion. Agency action reviewed by QA&A Sub Group. Progress report to be provided to QA&A Sub Group by the 11 th May 2010 for finalisation QA&A subgroup 13/07/2010 reviewed outcome of training Finalised

				across the whole of the West Midlands Police area.	21/9/2010	
<p>Recommendation Three A detailed three tier audit process is being developed for Public Protection Units, which will be rolled out from September 2008. The audits will involve detailed examination of investigations including adherence to force policy.</p>	Audit process completed	Detective Inspector – Public Protection Unit	31.12.08	<p>Audit process completed</p> <p>Copy of three tier audit process received by BSCB and results analysis paper have been added to the folder for reference.</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; 30/1/2009 23/7/2009 19/8/2009 8/2/2010 Further meetings are planned for; 11/5/2010 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit</p> <p>1) Copy of audit process.</p> <p>Agency action reviewed by QA&A Sub Group. Progress report to be provided to QA&A Sub Group by the 11th May 2010 for finalisation</p> <p>QA&A subgroup 13/07/2010 reviewed audit outcome. Finalised</p>

<p>Recommendation Four Develop audit process to include dip sampling of frontline staff responses to child safeguarding issues, when dealing with incidents which are not overtly child protection/child safeguarding matters. Testing the effectiveness of training (recommendations 1 and 2).</p>	<p>Develop and deliver revised audit process</p>	<p>Detective Inspector – Public Protection Unit</p>	<p>30.09.10</p>	<p>Public Protection HQ Staff are in the process of developing the revised audit process, to include dip sampling of frontline staff responses to child safeguarding issues, when dealing with incidents which are not overtly child protection/child safeguarding matters. The aim is that the audit will test the effectiveness of the mandatory training provided to officers.</p> <p>Pending</p>	<p>BSCB provide GOWM with a weekly progress report on current Serious Case Reviews</p> <p>Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance;</p> <p>30/1/2009 23/7/2009 19/8/2009 8/2/2010</p> <p>Further meetings are planned for;</p> <p>11/5/2010 23/07/2010 21/9/2010</p>	<p>Consider Evidence for Audit</p> <p>1) Outcome of first phase of dip sampling process.</p> <p>Agency action reviewed by QA&A Sub Group. Progress report to be provided to QA&A Sub Group by the 9th November 2010 for finalisation</p>
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Appendix D

Guidance to Acronyms

A&E	Accident & Emergency
DSW	Duty Social Worker
EO	Education Otherwise
EP	Educational Psychologist
ESW	Education Social Worker
EWS	Education Welfare Service
GP	General Practitioner
BCC	Birmingham City Council
HV	Health Visitor
LSCB	Local Safeguarding Children Board
PAS	Patient Administration System
PCSO	Police Community Support Officer
PE	Physical Education
PSHE	Physical Sexual Health Education
D&T	Design & Technology
MFL	Modern Foreign Languages
QEPH	Queen Elizabeth Psychiatric Hospital
RE	Religious Education
SC	Social Care
SENAS	Special Educational Needs Assessment Service
SW	Social Worker
CAF	Common Assessment Framework
CAMHS	Child & Adolescent Adult Mental Health Service
DCSF	Department of Children, Schools & Families
GOWM	Government Office for West Midlands
IMR	Individual Management Review
LEA	Local Education Authority
NHS	National Health Service
PCT	Primary Care Trust
PRU	Pupil Referral Unit
SALT	Speech & Language Therapist
DNA	Did Not Attend