

# **SANDWELL SAFEGUARDING CHILDREN BOARD**

## **SERIOUS CASE REVIEW**

**(under Chapter 8, Working Together to Safeguard Children 2010)**

**In respect of the death of a child (AS)**

## **EXECUTIVE SUMMARY**

**Report by: Alan Ferguson, Independent Author**

**Presented to Sandwell Safeguarding Children Board on 27<sup>th</sup> June 2011**

## **Author's Details**

**I am a qualified Social Worker and registered with the General Social Care Council.**

**I have recently retired from the post of Service Development Manager (Safeguarding & Quality Assurance) within Worcestershire County Council after a career in child care stretching back 35 years.**

**Within that role I have written numerous management reviews on behalf of Children's Services as well as overview reports on behalf of the Local Safeguarding Children Board.**

**I have served on numerous Serious Case Review Panels as both Panel member and Chair and, in recent months, have taken advantage of Regional and National events to further extend my knowledge in this area and to keep abreast of recent developments.**

**Alan Ferguson  
Independent Author**

## **Serious Case Review – Executive Summary**

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## 1. Introduction

### Circumstances leading to Serious Case Review

- 1.1. In the early hours of a morning in summer 2009, an ambulance was called to the home of a child who, for purposes of anonymity, will be referred to throughout this report as AS.
- 1.2. Upon arrival the child was found to be in cardiac arrest and described as ' moribund in appearance'.
- 1.3. AS was transferred quickly to the Emergency Department at a local Hospital where it was established that he needed care in a centre with a paediatric neurological service. However, as no bed was available in the West Midlands Regional resource for this service, AS was accepted at a Hospital in the North West Region and transferred there the same day.
- 1.4. Despite intensive treatment, AS did not respond and discussions were held between medical staff and the parents regarding the withdrawal of treatment.
- 1.5. Six days after his admission, the life support system was switched off and AS died at approximately 15: 50 on that day. He was not quite four months old.
- 1.6. The need for a Serious Case Review was immediately considered by the Chair of Sandwell Safeguarding Children Board (SSCB) having regard to the criteria set out in Chapter 8 of Working Together to Safeguard Children, 2010:

**"Serious Case Reviews must always be undertaken where a child dies (including death by suicide) and abuse or neglect are known or suspected to be a factor in the death."**

1.7. In addition, consideration will always be given to undertaking a Serious Case Review where:

- *a child sustains a potentially life threatening injury or serious and permanent impairment of health and development through abuse or neglect; or*
- *a child has been subjected to particularly serious sexual abuse; or*
- *a parent has been murdered and a homicide review is being initiated; or*
- *a child has been killed by a parent with a mental illness; or*
- *the case gives rise to concerns about inter-agency working to protect children from harm".*

1.8. In this particular case there were a number of concerning features e.g.,

- *a CT scan showed a high attenuation area in the left frontal area which was thought to be blood and which the parents could not explain;*
- *the Consultant Paediatrician "could not rule out non-accidental injury" as a cause of AS's condition;*
- *a month earlier AS (then aged 3 months) had an emergency admission to a local Hospital for apnoea and sepsis. Records show that this was as a result of co-sleeping with Adult 2 (his father) and an older sibling (Child 2 aged 17 months at the time) who is said to have rolled onto his brother; and*
- *In January 2009, Sandwell Children's Services had completed a core assessment to address the potential risk to Child 2 as a consequence of their father's history of sexual offending.*

1.9. In light of this, it was the decision of the Chair of the SSCB that the criteria for holding a Serious Case Review were met on the primary ground, i.e. "a child dies (including death by suicide) and abuse or

neglect are known or suspected to be a factor in the death". **The Serious Case Review Panel (see 1.22 below) entirely endorses this decision.**

1.10. 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.

1.11. Serious Case Reviews are not enquiries as to how a child dies or who is to blame. These are matters for Coroners and Criminal Courts to determine. In production of this report, agencies have collated sensitive and personal information under conditions of strict confidentiality. Sandwell Safeguarding Children Board has balanced the need to maintain the privacy of the child and family with the need for agencies to learn lessons in relation to practice identified by the case and has authorised the publication of sufficient information to enable this to take place.

## **Process**

1.12. The death of AS was referred to SSCB in the early summer of 2009 where upon the circumstances were considered at a special meeting of the Board on 10<sup>th</sup> July 2009.

1.13. As stated above, the Chair of SSCB agreed that the threshold for holding a Serious Case Review was met and all partner agencies were

asked to complete an Individual Management Review (IMR) detailing their involvement with the family in the specified period.

- 1.14. The purpose of an IMR is for agencies to 'look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so to identify how those changes will be brought about' (Working Together to Safeguard Children 2010).
- 1.15. To oversee the process of the Serious Case Review, a Panel of local safeguarding professionals was established by the SSCB. The Serious Case Review Panel see below met on four occasions to fulfil this function.
- 1.16. A provisional report of their findings was made to SSCB in January 2010, but final completion of the process was not achieved until June 2011. SSCB had agreed that the Review could not be considered complete without understanding and taking into account information held by the family, but family members could not be interviewed until the criminal proceedings were over. Due to the complexity of the forensic evidence, the trial of AS's father did not take place until early 2011.
- 1.17. The final Review Report, Executive Summary and Action Plan were approved and adopted by SSCB at an extraordinary meeting on 27<sup>th</sup> June 2011.

### **Terms of Reference**

- 1.18. All Serious Case Reviews commence with the Local Safeguarding Children Board (in this case SSCB) 'scoping' the work to be undertaken i.e., drawing up clear Terms of Reference that identify the most important issues to be addressed by partner agencies as they consider their work with the family concerned.

- 1.19. The scoping also sets out the timeframe that agencies will be asked to address when examining their case records. With this Serious Case Review, the timeframe was set as May 2000 (when the father of AS reached 16 years of age) to July 2009 (one month after the death of AS).
- 1.20. The Working Together guidance lists a number of areas that must be addressed in all Serious Case Reviews by each agency submitting an Individual Management Review (IMR). These form the generic Terms of Reference for this Review and are listed below numbered 1 to 10:

**TOR 1** *Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect and about what to do if they had concerns about a child?*

**TOR 2** *Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?*

**TOR 3** *What were the key points/opportunities for assessment and decision making in this case in relation to the child and family?*

**TOR 4** *Do assessments and decisions appear to have been reached in an informed and professional way?*

**TOR 5** *Did actions accord with assessments and decisions made?*

**TOR 6** *Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?*

**TOR 7** *Was information recorded?*

**TOR 8** *Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?*

**TOR 9** *Were more senior managers or other organisations and professionals involved at points where they should have been?*

**TOR 10** *Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children and with wider professional standards?*

1.21. In addition to the above, Sandwell Safeguarding Children Board have asked agencies to consider issues that are specific to this case, i.e.,

**TOR 11** *The nature and dynamics of the parental relationship and evidence of this on the impact of the care of their children;*

**TOR 12** *The presence of any indicators of stress and/or factors that would impact on parenting capacity;*

**TOR 13** *The role of Children's Social Care in the families' lives and nature of support provided;*

**TOR 14** *The quality of the Children's Social Care Core Assessment, with specific focus on the aspect of parenting capacity and the level of involvement of family and partner agencies;*

**TOR 15** *The exchange of information between health services and Children's Social Care;*

**TOR 16** *How professionals respond to information requests and sharing of information within and outside their agencies and consider if appropriate support and advice is available to enable them to make informed decisions;*

**TOR 17** *Was it noted that any specific advice had been given to parents regarding safer sleeping arrangements for children/babies and adults?*

**TOR 18** *Is there any particular significance regarding issues of neglect noted by any agency involved in relation to AS and Child 2 or any historical information which may impact on parenting capacity.*

### **Serious Case Review Panel**

1.22. SSCB have taken a number of steps to ensure that this Serious Case Review meets the standards expected by Ofsted and the Department for Children, Schools and Education, i.e.,

- *Individual Management Reviews are written by Senior Managers or Designated Safeguarding Professionals who have not been directly concerned with the child or his family and who do not line manage any officers who were so involved;*
- ***the Board has established a Serious Case Review Panel composed of safeguarding professionals (again independent of all operational staff involved in the case) to quality assure the IMRs and oversee the Review;***
- *the Board has appointed an Independent Chair for the Serious Case Review Panel (i.e., someone not employed by any of the constituent agencies of the Board) in order to further enhance the independence of this Review; and*
- *the Board has also appointed an Independent Author to draft the Overview Report as required in paragraph 8.28 of Working Together 2006).*

1.23. The composition of the Panel is as follows:

**Independent Chair**

Nicola Pettitt  
Independent Social Work  
Manager/Consultant

**Panel Members**

West Midlands Police	Acting Detective Chief Inspector
Children's Social Care	Service Manager, Children & Young People's Service Sandwell MBC
Education	Lead for Inclusive Learning Sandwell MBC
Primary Care Trust	Lead Nurse Child Death Review Sandwell PCT
Sandwell & West Birmingham Hospital NHS Trust	Named Doctor, Child Protection
NSPCC	Children's Services Manager
Sandwell Safeguarding Children Board	Business Manager
Administrative Support	Child Death Co-ordinator Sandwell MBC

**N.B. Statutory guidance requires that only the names of the Chair of the Serious Case Review Panel, the Independent Author and the Chair of Sandwell Safeguarding Children Board are given in this report. All other personnel on the Panel are referred to by agency and designation only.**

- 1.24. The independent author appointed to write the Overview Report is Alan Ferguson, a Director of Three Towers Consultancy, Worcester.
- 1.25. The Chair of SSCB who authorised the Commissioning of this Serious Case Review was Avriel Reader, but it is understood that she subsequently resigned her post in April 2011.

### **Parallel Processes**

- 1.26. A criminal investigation was held into the circumstances surrounding the death of AS which, due to the need to seek and evaluate extensive forensic evidence, took several months to complete.

1.27. The Crown Prosecution Service subsequently decided that no charges would be brought against Adult 1 (the mother of AS), but that Adult 2 (his father) would be charged with:

- a section 47 assault in respect of an incident on 24<sup>th</sup> May 2009 which resulted in AS receiving life threatening injuries in an apparent 'overlay' situation; and
- manslaughter in respect of the death of AS some four weeks later.

1.28. The matter came to trial early in 2011 when Adult 2 was acquitted of the Section 47 assault, but found guilty of manslaughter. He was sentenced to four and a half years in imprisonment.

1.29. Separately, the local authority commenced Care Proceedings to safeguard the sibling of AS and these proceedings were extended to include a second sibling born several months after his death. Both these children are currently (May 2011) in foster care pending the final outcome of the legal proceedings.

### **Family Involvement**

1.30. SSCB, the Serious Case Review Panel and the author are fully committed to facilitating the participation of relevant family members in this Serious Case Review believing that their knowledge and views can significantly enhance the learning from this process.

1.31. The family members deemed 'relevant' in this Serious Case Review were judged to be:

- the Father of AS
- his Mother
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother

- Paternal Grandfather

1.32. Very early in the process of this Serious Case Review these family members were advised by letter that enquiries were being made and that they would all be invited to participate at the appropriate time i.e., once any criminal proceedings were complete.

1.33. This did not happen until early 2011 and at this time Adult 1 was interviewed in the presence of her parents and the paternal grandparents were seen separately later the same day. With the exception of Adult 2 (now serving a prison sentence), family members contributed significantly to the finding of the Serious Case Review.

1.34. I approached Adult 2 via his Solicitor, advising him of the nature and purpose of my enquiries and inviting him to participate. My request was put to him on 14<sup>th</sup> March 2011, but he declined to be interviewed, or to contribute to this Review in any way.

## 2. **The Facts/Summary of Events**

- 2.1. AS did not come to the attention of any agencies other than universally available Midwifery and Health Visiting services, until he was admitted to Hospital (aged three months) with serious, and initially, life-threatening injuries. Despite being unable to identify the causes of his condition, AS was discharged home to his parents' care. At this time the composition of the family was identified as father, mother, AS and one sibling.
- 2.2. His elder sibling had come to the attention of Children's Social Care in 2008 when the family were the subject of a Core Assessment following a referral from West Midlands Police. The Police had been called to a domestic incident at the family home and, upon checking their records, discovered that Adult 2 had received a caution for a sexual assault upon his younger brother several years earlier (at the time he was aged 15 years and the brother seven years).
- 2.3. Although the offence could be considered minor by the level of the sanction imposed, the presence of a young child in the household required that an assessment of any risk posed to that child by his father should be undertaken by Children's Social Care.
- 2.4. The outcome of this assessment, which took some five months to complete, was to take no further action. One of the findings of this Review is that this assessment was superficial and failed to address the key issue in respect of his father.
- 2.5. A properly conducted and robust assessment at this time would have revealed a significant level of concerning information about both parents and mother's extended family which could have prompted a very different outcome to AS's first Hospital admission in 2009.
- 2.6. In respect of his mother it would have revealed that she grew up in a family where anti-social behaviour, alcohol abuse and domestic abuse

were characteristics of her parents' behaviour. The family were evicted from at least two tenancies because of their anti-social behaviour (harassment of neighbours, noise, etc) and rent arrears. Maternal grandfather had a significant criminal record linked to anti-social behaviour and maternal grandmother had an acute liver disease as a consequence of alcohol abuse. At the time of this assessment mother, who as 20 years of age, was pregnant for the fifth time (a factor also known to the Social Worker undertaking the assessment) but had only one surviving child. AS, the child she was carrying, was to be her second live birth.

- 2.7. The father of AS had a troubled childhood and adolescence, which led to involvement with Child and Adolescent Mental Services. On two occasions he came to the attention of Children's Social Care for sexual assaults upon younger siblings (one of these is described at 2.2 above). His behaviour put a strain on his mother's relationship with her current partner and he spent a brief period in the care of the local authority and then living with a family member before returning to his mother's care. As a young adult he became involved in the local drug culture and lost the tenancy of a council flat due to anti-social behaviour (linked to drug use) and rent arrears. Agency records do not indicate when he began to co-habit with the mother of AS, but he is known to be the father of both her children.
- 2.8. However, little of this information was uncovered by the Social Worker allocated to this assessment and no protective action was taken in respect of AS's sibling.
- 2.9. AS was born a few weeks after this referral was closed within Children's Social Care, there were no complications or concerns about the birth. He was seen by Health Visitors, Midwives and the GP over the next three months, but again there were no concerning features

about these contacts which were for routine developmental checks or normal childhood illnesses.

- 2.10. His situation changed at age three months when he was admitted to Hospital with a life-threatening apnoea attack. Despite a number of concerning factors, including a failure to find any medical cause for his condition, AS was discharged home to his parents' care three days later.
- 2.11. Unknown to Hospital staff, Police Officers had been called to the family home at approximately 02.30 hours on the same day (i.e., about six hours before AS was admitted to Hospital) following four 999 calls from his mother alleging domestic abuse by her partner. The family had been at a barbeque earlier in the day and had clearly consumed a lot of alcohol.
- 2.12. These two incidents are not linked until after the death of AS and in the course of this Serious Case Review.
- 2.13. Approximately three weeks after being discharged from Hospital after this incident, AS was re-admitted having suffered injuries that were later described in Court as 'catastrophic and irreversible'. His father continued to deny having deliberately harmed his son, but a jury accepted that he was in sole charge of AS in the critical period and was responsible for his injuries.
- 2.14. While AS was in Hospital fighting for his life, his sibling was initially placed in the care of his paternal grandparents. However, at the request of his parents, he moved to live with maternal grandparents a few days later.
- 2.15. This decision was questioned by West Midlands Police Officers based upon their knowledge of maternal grandparents' history of criminal activity, alcohol abuse and anti-social behaviour, but it was some six months before the sibling is removed from their care and placed with foster parents. By this time Care Proceedings had been instigated to

safeguard this child and a new baby who arrived in the period following AS's death.

### **3. Key Issues/Themes Arising From This Review**

#### **Key Issue 1 – Children Missing from Education**

- 3.1. The Serious Case Review Panel were deeply concerned that a ten year old girl could leave primary school and simply not return for her secondary education. Not only has she been deprived of the formal education that was her right, but she has also lost out on other benefits of the educational experience e.g., opportunities for social interaction with her peers, leisure interests, etc.
- 3.2. It is also known that children missing from education are at risk of involvement in criminal activity and of sexual exploitation.
- 3.3. The failure of local systems to identify and remedy this situation should be of concern to the local authority but also to SSCB who must recognise that children missing from education is a safeguarding issue and strengthen strategies in this area.
- 3.4. It was also of concern to hear that recent improvements in information sharing arrangements on this issue are being frustrated by some local academies opting out of them. Again this needs to be robustly addressed by SSCB.

#### **Key Issue 2 – Assessments in Children's Social Care**

- 3.5. This Review provided evidence that quality assurance measures in respect of social work assessments are not sufficiently robust to prevent superficial and poorly informed assessments being undertaken which then impact negatively upon the safety and welfare of vulnerable children.
- 3.6. Conducting assessments is a basic social work function which is well supported by research, practice guidance and appropriate assessment

tools. Systems must be robust enough within the local authority to enable Managers to identify and challenge poor practice.

- 3.7. An important part of undertaking assessments is to take a good family history and to understand cultural and lifestyle issues in the family under assessment. Again this Review indicated poor practice where assessments were undertaken on presenting information only, with little or no attempt to research relevant family history.

### **Key Issue 3 – Domestic Abuse**

- 3.8. Despite significant investment by partner agencies of SSCB to promote better awareness of the risks to children as a consequence of domestic abuse, this Review indicated that some practitioners still do not have a basic knowledge or understanding.
- 3.9. Failures were identified by Officers from West Midlands Police and by local Midwives that may just represent poor practice in those individuals, but seemed more likely to be as a result of systemic failure whereby senior managers have not enabled an appropriate culture in their agency, whereby safeguarding children is at the forefront of everyone's thinking.

### **Key Issue 4 – Adults Co-Sleeping With Babies**

- 3.10. It has not conclusively been proved that co-sleeping was a factor in the serious injuries suffered by AS on his first Hospital admission or in the fatal injuries received before his second admission.
- 3.11. However, sufficient concern was raised during this Review to suggest that this couple did not receive robust and appropriate advice about co-sleeping following the birth of their first two children and certainly not in the wake of the first Hospital admission where co-sleeping was being considered as a factor in trying to understand how the injuries were sustained.

- 3.12. There is clear research evidence suggesting that co-sleeping with a baby can pose serious risks to their safety if the parent has consumed alcohol or is under the influence of drugs. There are also risks attached to falling asleep with a baby on an armchair or settee.
- 3.13. Ensuring that parents understand these important messages, and the development of a safer sleeping information strategy, can only enhance safeguarding Children's Services in Sandwell.

#### **Key Issue 5 – Workload of Named Nurse**

- 3.14. Information was brought to the attention of the Serious Case Review Panel suggesting that the Named Nurse (Safeguarding Children) in one of the local NHS Trusts was struggling to meet her responsibilities in this area due to capacity/workload issues.
- 3.15. The Panel was concerned to hear that this was not only compromising her ability to provide advice and support to local practitioners, but it was also causing delay in making appropriate submissions to other Serious Case Reviews on behalf of her agency.
- 3.16. The Designated Safeguarding professionals in NHS Trusts are an extremely important part of local systems for safeguarding children and any weakness in this area must be a source of concern to SSCB.

#### **Key Issue 6 – Previous Serious Case Reviews**

- 3.17. SSCB have conducted a number of Serious Case Reviews in recent years, all of which resulted in robust recommendations and Action Plans to improve local services for safeguarding children.
- 3.18. It was concerning therefore to discover in the course of this Review that some of the earlier recommendations had not been fully implemented, a situation that undermines the credibility of the whole Serious Case Review process.

### **Key Issue 7 – Case Recording**

- 3.19. A disappointing feature of this Serious Case Review was the number of agencies who reported that poor case recording by practitioners made it very difficult to understand and evaluate the interventions made, or the services offered, by that agency.
- 3.20. This is an area that features regularly in Serious Case Reviews conducted locally and nationally and, as such, it is disappointing to evidence continuing indifferent practice. It is also concerning that the problem appears to be across all agencies despite some of them having robust policies and procedures that promote good practice in this area.

### **Key Issue 8 – Placement of Siblings with Maternal Grandparents**

- 3.21. I have commented earlier in this report about the decision of Children's Social Care to place a sibling of AS with maternal grandparents in the face of concerns, raised by Police Officers about their lifestyle and information held about their physical health exacerbated by their alcohol consumption.
- 3.22. It is also of concern that action to remedy this misjudgement took six months, all of which raises concern about assessment processes in Children's Social Care concerning the approval of family and friend carers.

### **Key Issue 9 – Safeguarding Arrangements in NHS Trusts**

- 3.23. The failure of a Hospital NHS Trust to implement child protection procedures when AS was first admitted to Hospital raises concerns about the effectiveness of local systems for safeguarding children.

- 3.24. A review of such arrangements using the Care Quality Commission's standards would either give greater confidence in current arrangements or identify areas where remedial action is indicated.

#### **Key Issue 10 – Section 11 Children Act 2004**

- 3.25. The above legislation enshrines the duties of local agencies to cooperate in the interests of safeguarding children, and the associated guidance gives a framework within which to develop those arrangements.
- 3.26. The weaknesses identified in this Serious Case Review suggest that SSCB could enhance local arrangements for safeguarding children by auditing agencies' compliance with the guidance.

#### **Key Issue 11 – Information Checks**

- 3.27. At the very beginning of this Serious Case Review, an issue had been identified which undermined the effectiveness of agencies' checking of Children's Social Care case records to ascertain if a family is known or whether there are concerns about the children's safety and welfare.
- 3.28. At that time, the Serious Case Review Panel was assured that measures had already been taken to address the problem. More recently however the Panel has been advised that there continue to be problems in the arrangements for accessing information and there remains a risk that information sharing is compromised and that children's safety and welfare is placed at continuing risk.

#### 4. **Priorities for Learning**

- 4.1. It is my primary conclusion that the death of AS was predictable and preventable had robust child protection procedures been implemented by staff at the Hospital where he was admitted on the occasion of his apnoea attack. Where the cause of such an attack cannot be satisfactorily diagnosed or explained, as was the case here, then Hospital staff should have considered abuse as a potential issue and, at the very minimum, should have discussed the case with the Designated Nurse or Doctor for Safeguarding Children. There were a number of known factors of concern at the time of the child's admission which, although not conclusively proof of child abuse, should have led to further enquiries and a referral to Children's Social Care.
- 4.2. In practice, what happened was that a member of staff was asked to check Children's Social Care records to see if AS was known to them and, upon receiving a negative response, he was allowed to go home with his parents. This check of Children's Social Care records proved to be a false positive in the Hospital's assessment as, while it was true that AS was not known to Children's Social Care, his family certainly were having been the subject of a core assessment that was completed only four months earlier.
- 4.3. A formal referral under child protection procedures would not only have revealed that information, it would also have revealed that only six hours before AS's Hospital admission, there had been a serious domestic abuse incident (four 999 calls at 0230), an incident fuelled by excessive alcohol intake.
- 4.4. Considering all these factors, the decision of Hospital staff to send AS without having diagnosed the problem that led to his admission and without proposing any kind of follow up, must be considered flawed.
- 4.5. The IMR produced by the relevant NHS Trust recommends robust remedial action in respect of their safeguarding procedures and

practice, and it will be the responsibility of SSCB to monitor the proposed changes.

- 4.6. The second priority for learning concerns the need for Children's Social Care to implement and sustain quality assurance systems for monitoring the work of Social Worker staff, particularly in respect of initial and core assessments.
- 4.7. While this Serious Case Review was in progress, an Ofsted inspection of local services for safeguarding children rated Sandwell's services as 'inadequate'. This damning verdict has prompted a robust response from the local authority and SSCB, and an over-arching improvement plan has led to widespread changes to local systems including assessment processes.
- 4.8. Given this ongoing work, which is monitored closely by the relevant government department, I make no additional recommendation from this Review other than suggesting that Children's Social Care routinely report on quality assurance issues to SSCB thereby inviting scrutiny and comment.
- 4.9. The third priority for learning concerns children missing from education. As stated earlier in this report, such children miss out on more than a formal education, they miss out on a range of social and leisure activities that are derived from the overall educational experience and are so important to the future quality of life of the young people concerned.
- 4.10. From the perspective of SSCB, children missing from education are also at risk of sexual exploitation as evidenced in a number of high profile criminal trials and, for younger children, there is a risk of neglect. Other Serious Case Reviews conducted nationally and regionally have evidenced some parents withholding their children from school to avoid teachers and other professionals witnessing signs of neglect or other abuse.

4.11. The lesson for SSCB is that a child missing from education is a safeguarding issue and local systems must be sufficiently robust to identify and track these children using appropriate sanctions where necessary, including legal intervention. As can be seen from the following section, I have made fourteen recommendations that I, and the Serious Case Review Panel, considering will improve local services for safeguarding children. They are all important in their own right and will be fully implemented by SSCB who have accepted and endorsed all of them.

## 5. Recommendations

- 5.1. A total of 14 recommendations have been made to improve services for safeguarding children in Sandwell, and these are listed in full below.
- 5.2. Happily, one of the benefits of having to delay completion of the Review process for over a year is that SSCB have been able to evidence significant progress in implementing the recommendations. I have received evidence confirming that 12 of the 14 recommendations have been actioned and are impacting beneficially upon local safeguarding practice.
- 5.3. The thirteenth and fourteenth recommendations were only added after a meeting with the Serious Case Review Sub-Committee on 18<sup>th</sup> May 2011 which cast doubt upon assurances given early in the process of this Review. These recommendations will be closely monitored by SSCB until satisfactorily addressed.
- 5.4. The recommendations from this Review are:

**Recommendation 1 : That 'children missing from education' is recognised as an important issue to monitor via the collation of information provided from schools that continue to voluntarily co-operate with LA data tracking systems.**

**Recommendation 2 : That, in recognition of the significant safeguarding issues involved, all educational establishments in Sandwell commit to implementing and support the new tracking system for children missing from education.**

**Recommendation 3 : That the Board seeks assurances from Children's Services regarding proposed quality assurance measures in respect of assessments, and establishes systems where management information in this area is routinely reported to the Board.**

**Recommendation 4 : That the Board re-examines its programme for multi-disciplinary safeguarding training in respect of initial and core assessments, in order to satisfy itself that staff receive adequate guidance on the importance of taking a good family history and understanding cultural/lifestyle issues in the extended family.**

**Recommendation 5 : That the Board establish, via the Domestic Abuse Strategic Partnership (DASP), what partner agencies are doing to promote awareness of domestic abuse issues in safeguarding children and their proposals for addressing any shortfalls in that programme.**

**Recommendation 6 : That the Board recognise co-sleeping as a significant safeguarding issue and takes appropriate action to make practitioners and the general public aware of the issues.**

**Recommendation 7 : That the Board draw the attention of the Acute Trust to the current workload on the Named Nurse for Child Protection and its impact upon her capacity to provide essential safeguarding training for Trust staff and to service Serious Case Reviews across two local authorities.**

**Recommendation 8 : That the Board provide documentary evidence to Government Office confirming that any outstanding recommendations from previous Serious Case Reviews have now been successfully actioned.**

**Recommendation 9 : That the Board again asks affiliated agencies to clarify their arrangements for scrutinising case records to ensure that they are consistently of an acceptable standard.**

**Recommendation 10 : That Children's Social Care undertake an audit of practice regarding the placement of children with relatives, in order to give confidence that current arrangements promote the safety and welfare of children so placed.**

**Recommendation 11 : That all NSH Trusts operating in Sandwell respond to the Care Quality Commission request for them to urgently review their arrangements for safeguarding children in the areas defined in the July 2009 research document.**

**Recommendation 12 : That the Board, through its Quality Assurance and Audit Group, repeat their audit of partner agencies' compliance with Section 11 of the Children Act, 2004, in particular those areas related to promoting safeguarding of children as a priority in their agency and supporting staff through training.**

**Recommendation 13 : That the Board urgently review the written guidance given to agencies in respect of their contact with Children's Social Care when considering a safeguarding referral or asking for an information check. Such guidance should clarify the need to distinguish between a safeguarding referral and an information check, and the nature and level of information that should accompany such requests i.e., full details of parents, siblings and recent addresses.**

**Recommendation 14 : That Children's Social Care review, and if necessary update, the guidance given to staff who receive and process such requests to ensure that agencies do not receive incomplete or inaccurate responses.**

**Alan Ferguson  
Independent Author**