



## **SERIOUS CASE REVIEW**

### **Executive Summary**

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

**In respect of the death of a child known as CS**

**Report by: Anne Binney, Independent Author**

**Presented to Sandwell Local Safeguarding Children Board on 7 October 2010**

## 1. Introduction

The purpose of a Serious Case Review (SCR) is as outlined in Chapter 8 of *Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children* (2010).

The primary purpose is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are both within and between agencies, how and what timescale they will be acted on, and what is expected to change as a result; and
- Improve intra-and inter-agency working and better safeguard and promote the welfare of children.

In carrying out this Serious Case Review, agencies have collated sensitive and confidential information in terms of strict confidentiality. There is a need to maintain confidentiality and privacy for the family but the Local Safeguarding Children Board (LSCB) has to balance this with the requirement for agencies to learn lessons and to publish sufficient information to enable others to understand these learning points.

A decision to undertake a Serious Case Review was made by Avriel Reader, the Independent Chair of the Sandwell Local Safeguarding Children Board, on 23 April 2010.

The criteria set out in the Working Together Guidance, mentioned above, require a Local Safeguarding Children Board to undertake a Serious Case Review in situations where a child dies or is seriously injured and where abuse or neglect is known, or suspected, to be a factor. In this case, cause of death was not immediately known but there was knowledge that agencies in another country had previous concerns about the care of this child. The LSCB Chair therefore decided that the criteria were met for carrying out a Serious Case Review in that a child had died and abuse or neglect may have been a factor. In addition, there were concerns about the services the child and the family had received or might have received.

An independent person was appointed to chair an SCR Panel comprised of senior managers who had not had any direct involvement with the case from a range of agencies. An independent overview author was also appointed to write the report and analyse the information provided from the range of agencies involved, all of whom produced individual reports and recommendations. The review period to be analysed was from October 2007 until April 2010.

The Sandwell Local Safeguarding Children Board received the Overview Report, the Executive Summary and the Action Plan on 7 October 2010.

## **2. Process for this Serious Case Review (SCR)**

- 2.1 The Independent Overview Author and Independent SCR Panel Chair were commissioned by the Local Safeguarding Children Board in April 2010. Both were invited to attend a briefing arranged for 7 May 2010 for the authors who would be providing the reports for the relevant agencies. The SCR Panel met on 5 subsequent occasions between June and September 2010 and panel membership was as follows:

Independent Chair – Sue Lane

Lead Nurse, Child Death Review, Sandwell PCT

Lead for Inclusive Learning, Sandwell MBC Children and Families Service

Detective Chief Inspector, Public Protection, West Midlands Police

Service Manager, Sandwell MBC Children and Families Service

The Independent Overview Author, Anne Binney, attended all Panel meetings.

The Panel also received expert advice on the subject of Volatile Substance Misuse and on issues in relation to European Migrants.

- 2.2 There are no parallel processes known to be underway. The Coroner opened an inquest and adjourned this to a date to be determined. He released the body of CS at the initial adjourned hearing. The inquest resumed later in 2010 and death was determined to be from anaphylactic shock with solvent abuse named as the cause.

## **3. Involvement of the family**

- 3.1 Attempts were made to involve the sister of CS who came from his home country to organise his funeral and take his ashes home. This contact was made via the coroner's office with an offer to meet, but no response was received at that difficult time for the family.
- 3.2 The SCR Panel determined that further efforts should be made to involve family members and letters were sent (in the preferred first language) to the family member in the country of origin who had raised concerns about the care of CS. She was invited to make comment via an intermediary with whom contact had been made. The letter was hand delivered to the family member

by an official in their own country. She responded by stating that further dialogue would be welcomed and this is ongoing.

- 3.3 A letter inviting participation was also sent to the cousin of CS who was still living in the region. This was again in her preferred language and she responded indicating that she would like to meet with the Panel Chair and the Overview Author. A meeting took place in August 2010 with an interpreter present. The cousin was able to confirm that CS was “a very good boy” and that he had been mistreated by his parents. She had asked them to leave her property but allowed CS to remain. They had become close and she and her partner viewed CS “like a son”. She did not identify any additional services she thought would have made a difference to CS but did comment on the difficulty for migrant families with children in accessing appropriate advice.
- 3.4 A further letter was prepared to invite the parents of CS to participate, but their address could not be located.

#### **4. Synopsis of this case.**

- 4.1 CS was 15 years old at the time of his death. The Coroner concluded that the cause of his death was from solvent abuse. This was as a result of misuse of aerosols, a relatively rare form of death which has decreased as a cause of death for young people in recent years.
- 4.2 CS arrived in England with his parents in 2007 when he was 13 years of age. They came here as European migrants from one of the East European countries who had joined the European Union in May 2004. These countries are known as the A8 Accession Countries. This provided the right for inhabitants of those countries to travel to work in the rest of Europe but in England they did not immediately accrue the rights to most benefits. They were expected to have sufficient resources to maintain themselves or to register for work and pay tax and national insurance.
- 4.3 CS moved home many times with his parents within the Borough. Some months after his arrival in this country, he presented (aged 14) at Accident and Emergency (A&E) with an accidentally broken wrist. It became known that he was not registered with a GP and was not attending school but there was no immediate action taken about this. It was only when CS was admitted for surgery for the fracture that a member of staff acted to get him the help he needed to get a GP and to apply for a school place. There were significant language barriers in obtaining correct treatment for his arm. This was only recognised after missed appointments at the Fracture Clinic and subsequent delayed treatment. Fortunately, CS and his father went again to the hospital

and a member of staff realised that there had been confusion about appointments.

- 4.4 The parents of CS recounted difficulty in registering with a GP as they had no proof of address, living in unaccredited private accommodation. They spoke no English and during contact with different organisations, there were often difficulties in ensuring access to appropriate interpreters. There was also insufficient attention to recording of their nationality and language. Correspondence was always sent to them in English.
- 4.5 There was an Initial Assessment of the needs of CS by the Children and Families (social care) service when alerted by the hospital. However, this only focused on his need for a school place and to be registered with a GP. No consideration was given to other potential difficulties in accessing services or advice. Shortly after this, there was official notification that social services in his home country had been monitoring the care CS received at the hands of his parents for some considerable time. A family member in his home country had contacted social services there to state that CS had been taken to the UK but was not attending school. This should have led to a detailed assessment of need in this country to establish whether he was still at risk or whether he was suffering any impact from earlier family problems, but this did not occur.
- 4.6 The family were eventually registered with a GP and CS was admitted to school. Almost immediately there were significant attendance problems. The school made good efforts to ensure his needs were met as a young person with English as an additional language and they were aware that his mother, named as the emergency contact, could not speak English. However, all correspondence with the mother was in English. She and her husband failed to attend meetings set up in the school.
- 4.7 The attendance of CS reached a level identified as persistent absence and Education Welfare became involved. A home visit which went unanswered and a police officer on a truancy sweep visited but noted that the home "looked un-lived in". There was no follow up to this. Letters were sent to the parents in English to arrange meetings, none of which were attended. Legal action was being considered but this was never discussed with a manager and no action ensued. Over time, the attendance of CS improved in his final school year and Education Welfare withdrew from the case. CS continued to make good academic progress at school and no behavioural problems were noted. He was described as a polite and popular young person.
- 4.8 CS had only limited contact with his GP for minor ailments but his GP did not undertake a new patient health assessment. Late notification of his school admission to the school health nurse with no identified additional needs meant

that he did not receive a full health assessment there either. These were missed opportunities. At his death, no professional was aware of his home circumstances or even where he was living. The only insight into CS and his wishes arose from two contacts with careers advice staff. He was considering a college course in travel and tourism to follow up his desire to work with people and to use his language skills.

- 4.9 About 8 months before his death, CS and his parents moved in with his young cousin and her family. She was 21 at that time and was also a European migrant as was her partner, by whom she was pregnant. She was divorced from the father of her other young pre-school child and this father had remained in her home country. After two months, she asked the parents of CS to leave but he opted to remain. This was then an unregulated private fostering arrangement but no professional was aware of this situation.
- 4.10 The cousin of CS worked hard to meet the needs of her child but her circumstances were becoming increasingly difficult. She was not in employment, had no access to public funds and experienced some difficulties with her pregnancy at the same time as her partner was having health problems. He was also breached for failure to carry out an unpaid work sentence for an earlier minor conviction. This resulted in short term imprisonment and left the family with no visible means of support.
- 4.11 Ambulances were called on a number of occasions both to the cousin for pain during her pregnancy and for her partner with abdominal pain. An ambulance crew noted the very poor home conditions that the cousin was living in and passed this on to a midwife but no further investigation ensued.
- 4.12 Even though CS was at the property on occasions when professionals called, there was no enquiry about his status. The “new to area” health assessment for the cousin and her child could not be carried out at that time because of language problems. Even though CS was there and offered to interpret, his presence in the household was not followed up. The assessment, which might have revealed some of the difficulties being experienced by this family, never actually took place.
- 4.13 In the week prior to the death of CS, there were noted school attendance problems again.
- 4.14 CS was found dead by one of the short-term lodgers in the household. After his death it became apparent that there was multiple occupancy of the household in order to meet the rent payments with no other source of income for the cousin and her family. CS was living in a makeshift bedroom in a 3-bedroom house with his cousin, her partner, her child and a number of

lodgers who had been present for about a week. The condition of the home was very poor and subsequent inspection resulted in a notice being issued to the landlord. The cousin had been unaware of assistance available to deal with landlords reluctant to effect repairs.

- 4.15 The Ambulance Crew attended and pronounced death. No immediate suspicious circumstances were noted and death was assumed to be from natural causes. The police were called and dealt with the matter initially as an unexplained adult death rather than following the agreed inter-agency protocol for dealing with unexpected child deaths. This incorporates a rapid response process which includes a range of agencies and also considers safeguarding needs of other children in the household. This process only began the next day, in breach of the protocol.
- 4.16 Enquiries were carried out following the death of CS into the safeguarding needs of the child of his cousin, and her baby born shortly afterwards, as well as the children residing in the household of the parents of CS. No child protection needs were identified but support as Children in Need was seen as necessary. A range of support services were provided with good multi-agency working, sadly not apparent prior to the death of CS.
- 4.17 Following the death of CS, it became known that his parents experienced problems with alcohol usage and that CS was mistreated by them. It also became known that he used aerosol sprays, previously unknown to agencies prior to his death.

## **5. Key themes arising from this case**

### **5.1 A child and family “below the radar”.**

- 5.1.1 There were numerous opportunities for agencies to enquire more fully into the circumstances in which CS was living. No professional was aware he was in the country until he presented at A&E with a broken wrist. Even when in touch with health professionals and having attendance problems in school, no one carried out a detailed assessment of his needs. What was on the surface was accepted. This was especially so when information came to light that concerns about the care of CS by his parents had existed in his home country. This should have signalled the need for a comprehensive assessment of risk and need but this did not happen.
- 5.1.2 CS remained below the radar when he moved to live with his cousin, initially with his parents, as no professional became aware of this – although he was quite often present when other professionals were in touch with his

cousin. The situation for the cousin and her family was also deteriorating and no professional recognised this either. No consideration was given to potential safeguarding issues such as “safe sleeping” advice, following identification of alcohol problems of the cousin’s partner. The cousin’s partner was treated as “a single man”. When he went to prison for a short period the situation must have been very difficult with the heavily pregnant cousin unable to work and with no income for the family. They had not accrued access to benefits, apart from child benefit.

5.1.3 Their solution was to take in a number of lodgers to help pay the rent and provide some income. This led to overcrowding. In addition, the house was already showing significant damp and mould. It was not suitable for children and although an ambulance crew member had reported this on to a midwife, this was not followed up until after the death of CS.

5.1.4 There is a concern identified in this Serious Case Review that families who are new arrivals in the UK from A8 Accession states who have no immediate access to public funds might not know where to get support and advice. It is likely that these families would be particularly vulnerable.

5.1.5 Some migrant families might also choose to remain “under the radar” even with children, to escape scrutiny. Migrants are meant to register for work on arrival or to have sufficient resources to support themselves, but there is no barrier to families travelling throughout Europe. This does raise the potential for a family under scrutiny for care of their child in their home country to arrive in another without anyone recognising they had a child with them. There is a parallel already recognised in safeguarding when families sometimes move frequently across local authority boundaries, to escape professional scrutiny.

## **5.2 Attention to Language, Nationality and Cultural Issues**

5.2.1 This Serious Case Review revealed highly inconsistent recording of nationality and first language for many members of this family. Three different nationalities were recorded for the father of CS and two for the partner of his cousin. There was inconsistent use of interpreters, resulting in missed medical appointments through apparent misunderstanding. Correspondence with the family was always in English, even though none of the adults could speak this. In order to correctly assess need in this situation, it would have required effective communication and this was not always forthcoming. Poor practice existed alongside good practice.

5.2.2 In addition, there was a lack of recognition of potential social exclusion in relation to CS and his parents and his cousin and her family. They could not readily access services or advice and they were not assisted to do this.

5.2.3 Attention to language and cultural needs is a significant overarching theme in this case.

### **5.3 Management Oversight and Recording Practices**

5.3.1 Most of the agency reports presented for this SCR recognised deficiencies in recording practices and proposed actions to address these. This is a common theme in many Serious Case Reviews and requires management oversight to ensure policy is put into practice.

5.3.2 There were clear deficiencies identified for some of the agencies in the extent of management oversight. There was no management discussion of the concerns in Education Welfare and the case was closed in Social Care without full assessment of need. This was a significant missed opportunity when concerns about the care of this child had been identified in his home country and passed to social care services in this country. The report from the Police also detailed some management failings in not following the correct process after an unexpected child death. This was recognised swiftly and had no adverse effects in this situation. The police have already put in place a new process for dealing with such incidents.

### **5.4 Information Sharing**

5.4.1 Lack of appropriate information sharing was noted in a number of reports provided for this SCR. The school health service was only informed a number of months after CS started school that he was in attendance. There was also a lack of sharing of information between the person undertaking the “new to area” visit to the cousin and her family and the health visiting team. This meant that the assessment was never actually completed and was a missed opportunity to recognise the pressures this family were under. The handover from the hospital to community midwife and then to the health visitor was not carried out according to procedure, meaning that information sharing opportunities were lost.

5.4.2 Social Care did not pass on the information about earlier concerns about the care of CS communicated to them from his home country, which meant that no other professional was aware of this history. When Social Care contacted the school to enquire whether CS was registered, the school did not pass on the concerns about his poor attendance.

5.4.3 It is unclear whether there was appropriate information sharing between hospitals and the GP when both the cousin and her partner were attending for pain symptoms. If so, this was not communicated to the health visitor and given the diagnosis of alcohol related illness for the cousin's partner, this was an omission as it could have safeguarding implications for her child and new baby in respect of safe sleeping advice. The number of ambulance call-outs for these two individuals over a relatively short period of time should have alerted professionals to increasing stress in this family but this was not communicated.

## 5.5 **Substance Misuse**

5.5.1 Substance misuse was a problem in this family. The parents of CS and the cousin's partner all had problems with alcohol use. It became known after his death that CS was a regular user of aerosols, categorised as volatile substance abuse. Research links the dependent use of such volatile substances with poverty, abuse, family problems and low self-esteem. Aerosol use can be particularly dangerous as the propellant is often sprayed directly into the mouth or nose and can produce rapid ill-effects as well as the desired effects of euphoria. Aerosol usage as an inhalant is not illegal, but the sale of these products for this use is illegal. However, it is extremely hard to identify whether the sale is for reasonable or other purpose. It is also hard to identify when these substances are being used. Death in young people from use of volatile substances is rare, although can occur suddenly.

5.5.2 No professional was aware of the aerosol usage of CS. While there were missed opportunities to assess his needs and potentially to provide more adequate support, there is no guarantee that usage would have been prevented. His history and situation would certainly suggest that he was vulnerable and that usage may have been adopted as a coping mechanism, but this could not have been foreseen or prevented.

## 5.6 **Lack of Professional Curiosity**

5.6.1 There were many opportunities identified where professionals could have been more searching in their questions and could have "widened the lens" of their professional focus to understand more about CS and his living situation.

5.6.2 Agencies tended to focus on specific tasks and to follow procedures, but did not exercise sufficient professional curiosity to identify vulnerable children. Assessments and enquiries did not go far enough to understand the current risks or potential effects of past history on CS and no-one asked questions about why he appeared to be in the family of his cousin when they visited.

## 5.7 Capacity Issues

5.7.1 Health visiting, midwifery and social care services all reported that they are experiencing capacity problems with the volume of work and sometimes with staffing shortages. All services were aware of the problems and were putting in place measures to address them, but there is recognition that there was impact on the delivery of services.

## 6. Good Practice

6.1 There was a range of good practice identified in this Serious Case Review as follows:

- Sandwell Metropolitan Borough and its partner agencies have made efforts to identify and address the needs of migrant groups. The PCT was reviewing the GP services available and the school was piloting a “Welcome Centre”. The school also showed sensitivity in responding to the needs of a migrant pupil.
- The GP sought PCT advice on treatment of lone children registering with the Practice. Treatment was offered in advance of registration.
- The PCT is already undertaking a review of Walk-in Centres to ensure effective communication processes are in place.
- On occasion, there was good practice in pre-booking the use of interpreters.
- Staffordshire and West Midlands Probation Trust will in future send letters in the appropriate language.
- The nurse in the unit to which CS was admitted for surgery had direct dialogue with him and showed good understanding of his wider needs. She made appropriate referrals and was tenacious in following up.
- Action has already been taken by Sandwell PCT to address inconsistency in the role of the Paediatric Health Visitor Liaison Nurse across two hospital sites.
- West Midlands Police has taken early action to address the concerns arising from the lack of appropriate use of the protocol for dealing with sudden unexpected child deaths.
- There is already a Task and Finish Group established considering the Rapid Response processes.
- There was noted good joint work across agencies following the death of CS to ensure the needs of other children in the relevant households were assessed and met. Bereavement counselling was also offered.
- There was good practice within the SCR in inviting experts to share their views with the SCR Panel on substance misuse and on issues

affecting European Migrants. There was also good practice in involving the authors of the individual agency reports in a Panel Meeting to allow for direct dialogue and embedding of learning.

- The SCR Panel also showed sensitivity in seeking guidance from appropriate agencies in this country and in the country of origin of this child in engaging with family members abroad.

## **7. Conclusions**

- 7.1 CS was a young man who was brought to this country by his parents presumably in search of a better life. He had a history of poor care in his own country but the effects of this and any ongoing risk was never effectively assessed. Initially, he was not in receipt of health or education services, but even when he was, opportunities to understand and address his needs were missed.
- 7.2 CS moved from one family with problems to live with his cousin who was also experiencing increasing difficulties. These were not identified by the agencies in touch with her, nor were any enquiries made as to why CS was in her household in what was an unrecognised private fostering situation. They remained “under the radar” and their home circumstances were not identified.
- 7.3 Although proper assessment should have resulted in better support for CS and his cousin’s family, there is no guarantee that this would have prevented his usage of volatile substances. His tragic death was therefore not predictable or preventable.

## **8. Recommendations**

- 8.1 The specific recommendations of the Overview Author are as follows:
- For Education Welfare:  
Where parents or carers fail to respond to a planned home visit or to a letter (written in an appropriate language) inviting them to a meeting to discuss their child’s school attendance, notification of this must be sent by the allocated worker to their manager for discussion as to appropriate next steps. The discussion and actions proposed are to be entered on to the appropriate case recording and communicated to the school and any other agency involved.
  - For all agencies with a duty to co-operate:  
All agencies with a duty to co-operate must have arrangements in place to enable effective communication with individuals and families.

All such agencies must identify to the Safeguarding Board their plans to improve performance in relation to identification and recording of the first language, religion, ethnicity and nationality of individuals and the monitoring arrangements to ensure that this is embedded in practice.

- For the Safeguarding Board:  
The Chair of the Sandwell Local Safeguarding Children Board will make contact with the Department for Education to raise awareness about the lack of specific national guidance for the safeguarding of migrant children, who may be especially vulnerable.
- For health and education agencies:  
Universal Services (health and education) will report to the Local Safeguarding Children Board their arrangements for verifying the home circumstances of “new to country” families.

8.2 The action plan developed to implement these recommendations is appended to this Executive Summary for information.

8.3 The Health Overview Author and authors who reviewed practice in their individual agencies also made a range of recommendations. These recommendations primarily focus on the need for consistent recording of ethnicity, language and religion, on appropriate information-sharing between professionals, and on ensuring that all services are accessible to children and families who are new to the area.

8.4 There are accompanying action plans based on the recommendations of the report author as well as the recommendations from the individual management reviews and health overview author. All of these recommendations will be monitored to ensure that the learning is disseminated, embedded in policy and procedure, and impacts positively on future practice.

## **9 Arrangements for implementation and monitoring of recommendations**

9.2 A meeting of the Sandwell Local Safeguarding Children Board on 07 October 2010 ratified the Overview Report and findings. Agencies were asked to ensure that the emerging recommendations and IMR recommendations will be acted upon promptly and fully implemented by the agreed target date.

- 9.3 With respect to IMR recommendations, the LSCB Business Manager will formally write to the signatory and IMR Author of each respective agency requesting specific information about the outcome/progress of the recommendation and where applicable, how this can be evidenced. The exceptions to this relate to the IMRs submitted by those agencies whose services Sandwell Primary Care Trust is presently the responsible or coordinating commissioner for. In these instances all requests will be sent to the Assistant Director for Clinical Governance.
- 9.4 With respect to the recommendations arising from the Overview Report, the LSCB Business Manger will formally write to the identified lead officer requesting specific information about the outcome/progress of the recommendation and where applicable, how this can be evidenced. In the event of satisfactory updates not being provided within certain timescales (both to the initial request and a subsequent reminder) the matter will be escalated to the LSCB Chair who will then liaise with the Chief Executive of the respective agency.
- 9.5 This cycle of monitoring the implementation and progress of the recommendations will be repeated quarterly until such time as the recommendations are considered complete and evidenced as such. The information will feed into the Serious Case Review Sub-committee, where a report on the level of compliance and progress in implementation will be a standing agenda item at each monthly meeting to ensure that early lessons are learnt. Members of the SCR Sub-committee will also undertake timely audits of completed recommendations to ensure compliance. Quarterly performance reports to the LSCB will also highlight outstanding recommendations.
- 9.6 The broader dissemination of the key learning will be through the LSCBs comprehensive programme of multi-agency interactive briefing on 'Lessons Learnt from Serious Case Review', as well as through its website ([www.sandwelllscb.org.uk](http://www.sandwelllscb.org.uk)), in order to highlight good practice and key themes. In addition all statutory agency safeguarding leads are provided with a copy of the Executive Summary, Overview Report and Action Plan together with other contextual information as an aid to learning lessons.

## Serious Case Review

# CS Action Plan

September 2010

**Sandwell Safeguarding Children Board**



[www.sandwellscb.org.uk](http://www.sandwellscb.org.uk)

**Recommendation 1:**

Where parents or carers fail to respond to a planned home visit or to a letter (written in an appropriate language) inviting them to a meeting to discuss their child's attendance, notification of this must be sent by the allocated worker to their manager for discussion as to appropriate next steps. The discussion and actions proposed are to be entered on to the appropriate case recording (ONE) and communicated to the school and any other agency involved.

REF	Action (SMART)	Lead Officer	Target Date for Completion	Desired Outcome	Monitoring Arrangements	How will success be measured?
1.1	Produce standard EWS letter in a range of non-English languages.	Education Welfare Service Manager	Dec-10	Production of appropriate letters for language of recipient. Initially 6 most commonly used languages	Appropriate letters sent to parent/carer	Sampling of Education Welfare Officers at Supervision meetings
1.2	All EWOs to discuss at supervision cases where unauthorised absence is >20% and where no response to letters has been received	Head of Education Welfare Service	Dec-10	Action plan implemented for all such cases	Improved levels of engagement	ONE records

**Recommendation 2:**

All agencies with a duty to co-operate must have arrangements in place to enable effective communication with individuals and families. All such agencies must identify to the Safeguarding Board their plans to improve performance in relation to identification and recording of the first language, religion, ethnicity and nationality of individuals and the monitoring arrangements to ensure that this is embedded in practice.

REF	Action (SMART)	Lead Officer	Target Date for Completion	Desired Outcome	Monitoring Arrangements	How will success be measured?
2.1	As part of the Section 11 audit process the Quality Assurance & Audit sub-committee undertake an initial audit to identify how language (written & spoken), religion and nationality of individuals are currently recorded	Chair of Quality Assurance and Audit Sub-committee	Jan-11	Have a comprehensive understanding of how language (written & spoken), religion and nationality of individuals are currently recorded	Quality Assurance and Audit Sub-committee	100% Returns
2.2	Future Section 11 audits to incorporate questions identifying	Chair of Quality	Apr-11	Have a comprehensive	Quality Assurance and Audit Sub-	100% Returns

	first language, religion and nationality of individuals and how agencies are going to improve their performance in collating such information	Assurance and Audit Sub-committee		understanding of how language (written & spoken), religion and nationality of individuals are currently recorded	committee	
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**Recommendation 3:**

The Chair of the Sandwell Safeguarding Children Board will make contact with the Department for Education to raise awareness about the lack of specific national guidance for the safeguarding of migrant children, who may be especially vulnerable.

REF	Action (SMART)	Lead Officer	Target Date for Completion	Desired Outcome	Monitoring Arrangements	How will success be measured?
3.1	Chair to write to the Education Secretary, Michael Gove	LSCB Chair	Oct-10	Increased awareness	SCR Sub-committee	Letter sent and acknowledgement received

**Recommendation 4:**

**Universal Services (health and education) will report to LSCB their arrangements for verifying the home circumstances of “new to country” families.**

<b>REF</b>	<b>Action (SMART)</b>	<b>Lead Officer</b>	<b>Target Date for Completion</b>	<b>Desired Outcome</b>	<b>Monitoring Arrangements</b>	<b>How will success be measured?</b>
4.1	Request a report from the Health Group on their arrangements	Assistant Director for Clinical Governance	Jan-11	That children who are new to country are better safeguarded	SCR Sub-committee	Report confirming appropriate details
4.2	Request a report from the Education Advisory Subgroup on their arrangements	Principal Advisor, Inclusive Learning Services	Jan-11	That children who are new to country are better safeguarded	SCR Sub-committee	Report confirming appropriate details