Child D and Child B

A Serious Case Review Executive Summary

March 2011

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1. INTRODUCTION

1.1 This report is about two brothers, referred to as Child D and Child B, who are now aged six and five. They were brought into the care of the London Borough of Bromley in February 2010 after one of the boys was found to have injuries, said to be caused by his father. There had been substantial contact between the boys' family and various agencies in Bromley, and continuing concerns about neglect of the brothers, over a period of some five years.

1.2 On 23/3/10 the Bromley Safeguarding Children Board (BSCB) Serious Case Review Panel decided that a Serious Case Review was necessary. This is the Executive Summary of the Overview Report from that Serious Case Review.

1.3 This report has been anonymised to protect the entitlement of the family to privacy and confidentiality.

1.4 The composition of the family is as follows:

Name	M/F	Age	Relation ship	Ethnicity
Child D	M	Age 6	Subject	White British
Child B	M	Age 5	Subject	White British
Ms Q	F	Age 25	Mother	White British
Mr G	M	Age 32	Father	White British

2. INFORMATION ABOUT THE SERIOUS CASE REVIEW

2.1 The following agencies all played some part in working with the family, or dealing with the injury to Child D, and consequently contributed to the Serious Case Review:

AGENCY	NATURE OF CONTRIBUTION
London Borough of Bromley (LBB) Children's Social Care Service (CSC)	Individual Management Review (IMR) of their involvement
Metropolitan Police Service (MPS)	Individual Management Review
LBB Access & Inclusion Service	Individual Management Review
A local family charity (referred to in this report as Bromley Charity)	Individual Management Review
Bromley Primary Care Trust Community Provider Unit	Individual Management Review
Bromley Primary Care Trust General Practitioner	Individual Management Review
South London Health Trust Princess Royal University Hospital	Individual Management Review
A Pre-School service in Bromley	Individual Management Review
A Primary School in Bromley	Individual Management Review
LB Bromley Adult Education Services	Background information, minimal involvement
LB Bromley Adult & Community Services	Background information, minimal involvement
Lewisham Children's Social Care	Background information, minimal involvement

2.2 The Terms of Reference for this Review are attached at Appendix A. Agencies were asked to address the issues detailed in the Government's guidance[1] on Serious Case Reviews, and issues which are specific to this case, detailed therein.

2.3 A Panel was established to manage and assure the quality of the review process. In order to provide appropriate impartial leadership and challenge, the Panel was chaired by Mrs Jenny Dibsdall, an independent person with a background in children's services and currently Chair of the Bromley LSCB. Mrs Dibsdall has been an independent consultant since May 2009. She worked in social care agencies for over forty years, fifteen of which involved managing

[1] Working Together to Safeguard Children 2010, Paragraph 8.39

children's services at a senior manager level in three authorities. Mrs. Dibsdall was the lead for safeguarding children in LB Newham and supporting the LSCB there. The work included chairing serious case reviews and writing overview reports. Mrs. Dibsdall has a CQSW (Croydon College 1976), a Diploma in Management Studies (Medway 1995) and a Masters in Business Administration (University of Westminster 2000).

2.4 The composition of the Panel assisting Ms Dibsdall was as follows:

Designation	**Organisation**	**Role**
Assistant Director Safeguarding & Children's Social Care	London Borough of Bromley	Panel Member
Head of Service Children & Family Project,	London Borough of Bromley	Panel Member
Safeguarding Lead for Education	London Borough of Bromley	Panel Member
Designated Doctor for Safeguarding Children	Bromley Primary Care Trust	Panel Member & Health Overview Report joint author
Consultant in Public Health Medicine	Bromley Primary Care Trust	Panel Member
Investigator Serious Crime Review Group	Metropolitan Police Service	Panel Member & IMR author
Designated Nurse for Safeguarding Children	Bromley Primary Care Trust	Panel Member & Health Overview Report joint author
Business Manager, BSCB	London Borough of Bromley	In attendance

2.5 Kevin Harrington was appointed to produce an Overview Report and this Executive Summary. Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on over 30 Serious Case Reviews, in respect of both children and vulnerable adults. Mr Harrington is also involved in professional regulatory work, for the General Medical Council and for the Nursing and Midwifery Council. He has served as a magistrate in the criminal courts in East London for 15 years.

3. INVOLVEMENT OF THE FAMILY IN THE SERIOUS CASE REVIEW

3.1 Mr Harrington and the BSCB Business Manager wrote to the parents separately and to a legal representative, seeking to involve them in the Review. Mr G did not respond and the Review is not informed by any input from him.

3.2 Ms Q did meet with representatives from the Serious Case Review Panel. The main point she wished to make was that professionals working with the family had allowed themselves to be directed by Mr G, and failed to work with her in her own right. It is accepted that there is some truth in this. Those interviewing her felt that Ms Q had become "ground down" over the years, living an increasingly isolated life, and that agencies had not responded adequately to this.

3.3 The boys are too young to have been directly involved in the Serious Case Review. They have generally settled well in their placement. The matter in the care courts is still proceeding and is expected to be concluded later this year.

4. SUMMARY OF EVENTS LEADING TO THE SERIOUS CASE REVIEW

4.1 A tabular chronology detailing the contact between the family and all the agencies, over the period under review, runs to some 250 pages in length. This is a brief summary of that contact.

4.2 Mr G appears to have grown up in the Bromley area and remains in contact with his extended family. In 1997 he was diagnosed with epilepsy for which he continues to be treated.

4.3 Ms. Q was adopted at the age of five. There is little information about her early life. As an infant she had apparently been left by her mother in the care of her father. She had then moved around a lot with him, spending periods in public care, before coming fully into the care of another local authority in London. She was adopted through that authority by a couple living in Bromley.

4.4 Throughout her adolescence her adoptive parents sought assistance in caring for Ms Q, saying that they could not cope with her mood swings, poor self care and an inability to relate to others. She spent a short period in respite care, organised by the London Borough of Bromley, and was treated with medication and psychotherapy. There were no particular problems at school and she was seen as academically able.

4.5 We do not know the circumstances in which the relationship between Mr G and Ms Q developed. By 2003, when she was seventeen years old, they were living together in his parents' home and, in that year, Child D was born. The pregnancy was at an advanced stage before she sought any medical advice.

Child B was born some 18 months later, at home, without any ante-natal care or medical assistance. Ms Q said that she had been unaware of either pregnancy. Around this time she also made allegations that she had been sexually abused as a child.

4.6 During 2005 the family secured their own accommodation, although they did not move to live there until some time after that. Mr G reported that his health was causing increasing problems for him. He was unemployed and does not appear to have been in regular work again during the period considered in this review.

4.7 Child care concerns first emerged in 2006, when both boys displayed signs of faltering growth, and various professionals identified developmental delays. During 2007 there were also concerns about the level of practical care of the children. There was evidence that they were not kept clean and that the family home was dirty. However there was also evidence of a warm relationship between the children and their parents. A voluntary organisation, Bromley Charity, became involved in supporting them, working with the Health Visitor for the family, and other agencies.

4.8 Over the next three years the situation of the family gradually deteriorated. Ms Q became increasingly withdrawn and lethargic, apparently taking little responsibility for the day to day care of the boys or the home. Her own self-care deteriorated. She now presented, and was seen by professionals, as having learning difficulties. During this time Mr G's medical condition seems to have taken an increasingly high profile in the life of the family. Despite input from a range of professionals, the home conditions were poor and there were financial problems. Mr G's extended family helped them, both practically and financially, but there was no enduring improvement in the situation. The relationship between Mr G and Ms Q was said to have become strained and difficult.

4.9 There was a pattern of periodic improvement and partial compliance with agencies, followed by deterioration in the home circumstances and refusal to co-operate with professionals. There was continuing liaison between agencies throughout this time but attempts to refer the family to Children's Social Care were unsuccessful. There were continuing concerns about the day to day care of the boys and their developmental delay. There were school attendance problems, with attendance hovering just below the 80% level.

4.10 Four physical injuries to the boys were noted in the period from September 2007 to November 2008. They were not serious and medical treatment appears to have been sought appropriately. None of them prompted any investigation, either at hospital or in the community, into the possibility that they may have been deliberately caused.

4.11 In February 2010 Child D came to school with a cut to his head, which he said had been caused by his father. He told a teaching assistant that Mr G had ‘kicked and punched him against a wall’. Police were notified and searched the family home, which was in a chaotic state, with dirty clothing and rubbish in every room.

4.12 There was initially some confusion about the home address, which was believed to be in the London Borough of Lewisham. As a result that local authority’s Children’s Social Care services became involved before the error was noticed. The London Borough of Bromley then took over the conduct of the safeguarding investigations with the Metropolitan Police Service.

4.13 Mr G said that Child D had slipped and lost his balance. Ms Q said she was not aware of any injury to Child D. The parents were released on bail and both boys were taken into Police Protection. They were placed with local foster carers where they remain. Mr G was subsequently prosecuted and found Not Guilty of assault.

5. ANALYSIS

This section of the report summarises the analysis and conclusions of each of the key lines of enquiry in the Terms of Reference.

5.1 Did the agencies involved adequately identify the level of neglect to these children and at what stage did the level of neglect suggest child protection procedures should have been invoked?

5.1.1 The condition of these children, and their home, at the point of their admission to care provided clear evidence that the level of their neglect had not been adequately identified and addressed. Bromley Charity had made a referral to Children's Social Care in March 2008, when there were concerns regarding the children's eyesight, weight and overall failure to thrive, Child D's poor attendance at playgroup, Mr G's health, debts and benefit issues and the poor condition of the home. As time went on, there were also problems of poor school attendance.

5.1.2 This was a situation requiring an assessment by Children's Social Care but no assessment was carried out. There were discussions and meetings with Children's Social Care, but that agency misjudged the situation. Children's Social Care decided that they did not need to have any contact with the family, as the level of concern was not sufficiently serious, and other agencies were involved. Those agencies then continued to underestimate the level of neglect, were too prepared to accept inadequate levels of care and were deliberately misled by the parents.

5.2 Was there sufficient sharing of information between agencies to assist in the decision making around the level of neglect of these children and whether child protection procedures should have been employed?

5.2.1 The Serious Case Review found that there were some failures to share information but that this was not a significant factor in the overall management of the case. Generally the agencies that were involved liaised appropriately with each other. The key issue was that agencies failed to respond appropriately, or at all, to the fact that these children were not being adequately looked after in their family. Agencies misjudged the level of neglect, and were too ready to tolerate unacceptable standards of care.

5.3 Did agencies take sufficient account of the mother's background and how this would have impacted on her parenting ability?

5.3.1 It is known that Ms Q was separated from her birth parents in infancy, was in local authority care as a young child, was adopted and then again was in local authority care in her teenage years. She subsequently made allegations that she

had been abused in childhood. During the period under review, there was evidence of an increasing lack of self care, including her presenting as having deteriorating intellectual capacity. There were tensions in the marital relationship. At the same time there is evidence of her actively colluding with Mr G to distract and divert professionals from investigating concerns about the boys.

5.3.2 The agencies involved with Ms Q did not take sufficient account of her background, or the deterioration in her presentation and coping capacities. This failure to give sufficient weight to Ms Q's experience of being parented was a weakness in the management of the case. That was compounded by an ongoing failure adequately to assess and respond to her deteriorating presentation. This view is supported by what Ms Q told Serious Case Review Panel members. This was seen by the Panel as suggestive of some psychosocial or medical condition requiring further investigation.

5.4 How did the impact of the late knowledge by the mother of her pregnancies affect her parenting capacity and was this was addressed by any agency?

5.4.1 Ms Q was 37 weeks pregnant when her pregnancy with Child D came to light. Child B was born at Mr G's parents' home without any ante-natal care. It was claimed that neither parent, nor any extended family member, had any prior knowledge of these pregnancies. The accounts given by midwives and other health professionals at the time suggest that Ms Q was genuinely unaware of the pregnancies.

5.4.2 Following the birth of Child B a referral was made from maternity services to Children's Social Care. This was in part a response to an initial request by Ms Q that Child B be adopted, as well as a recognition that the circumstances of the birth were in themselves a cause for concern. It would have been appropriate for Children's Social Care to carry out an assessment in these circumstances but they have been unable to trace any record of their response to the referral. It appears that it did not lead to any contact with the family.

5.4.3 The Serious Case Review judged that there had been no real assessment by any agency of the circumstances of the late-recognised and concealed pregnancies. Consequently it was not possible to specify how these matters affected Ms Q's parenting. However they raised concerns both about her parenting capacity and about the relationships within the family. The Serious Case Review also noted that the London Child Protection Procedures did not adequately address the issue of concealed pregnancy.

5.5 In what way were the father's epilepsy and the impact it may have had on his parenting ability assessed by agencies?

5.5.1 During the period covered by this review Mr G was seen regularly by neurological services in relation to his epilepsy, which had been diagnosed in 1997. He became unemployed and apparently told professionals that this was due to his epilepsy.

5.5.2 There was no thorough assessment of the consequences of Mr G's health for the care of the children or family life generally. The agencies accepted that he had a debilitating illness which was central to the way the family functioned. The Serious Case Review questioned this. Although epilepsy is a serious condition, most people with epilepsy lead normal lives most of the time. Epilepsy can be managed and the risks associated with the condition can be minimised and controlled.

5.5.3 The misunderstanding and stigma that still surrounds epilepsy was used by the family to ward off closer examination of their overall dysfunction. A good assessment of family functioning should have included a robust challenge to this pathological picture presented by the family, especially when it became known that Child D was being seen and presented by his parents, at age 5, as a "young carer".

5.6 Why, in the light of other concerns about the parenting, were the physical injuries sustained by the children not investigated more fully?

5.6.1 There were four physical injuries in the period September 2007 to November 2008. None of them prompted any real investigation, either at hospital or in the community, into the possibility that they may have been deliberately caused. Following the incident in November 2008 Bromley Charity recorded that a Health Visitor did not feel the injury was consistent with the explanation given by the parents, and that the Health Visitor *"expressed unhappiness with the GP's assessment".* However, this did not lead to any further investigation.

5.6.2 The Serious Case Review found that some of these injuries should have been investigated more fully. The Review also found that the response by the boys' school to the "trigger incident", leading to their admission to care, was not sufficiently robust or compliant with safeguarding requirements. The Review judged that professional views of the family were preconceived. There was a common view that the family was ill - organised and neglectful, but that these were not physically abusive parents. The agencies were concerned about failure to care and protect rather than the commission of harmful behaviour.

5.6.3 The multiplicity of other problems diverted professional attention from the possibility of deliberate physical harm. Professionals should have been more alive to the likelihood that neglect might be accompanied by abuse. As the NSPCC has found
"Neglect often co-exists with other forms of child maltreatment. Boundaries

between abuse and neglect can become blurred".[2]

5.7 Why did the significant number of agencies involved not work more effectively together to protect the children from harm?

5.7.1 The Serious Case Review identified two key issues:

- a shared and mutually reinforcing misreading of the situation.
- a lack of effective challenge and leadership across the agencies.

5.7.2 The agencies in contact with the family misjudged the level of neglect of the boys, and its consequences. Then, once there was a prevailing view that their care was "good enough", it became increasingly difficult to challenge this fundamental premise that the situation was generally acceptable. The fact that large numbers of professionals and agencies are involved is no guarantee of effective intervention. Conversely, the involvement of increasing numbers of professionals can promote a situation where those professionals may minimise their concerns. They become unduly influenced by the consideration that other agencies, which may have been involved for longer, seem to accept that there is no need for intervention or escalation.

5.7.3 As time went on, and the pattern of interactions between the family and professionals became more established, there was a growing need for someone outside the network to stand back and take an objective view. The Common Assessment Framework arrangements delivered this to some extent, but the Health Visitor, the only professional to maintain a continuing relationship with the family, took a view that some progress was being made. This assessment was not sufficiently rigorous and was not adequately challenged, either through individual supervision or any of the multi-agency arrangements for case management.

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[2] Child Neglect: Child Protection Research Briefing (NSPCC 2007)

6. KEY LEARNING POINTS

6.1 The circumstances of these children strongly indicated that they were “in need” and that an assessment by Children’s Social Care was necessary. Children’s Social Care failed to recognise this and the other agencies did not adequately challenge that decision by Children’s Social Care.

6.2 The Serious Case Review found that there was a need to clarify local thresholds for the investigation and management of children at risk of neglect.

6.3 The children were not at the centre of the agencies’ work. There was not enough emphasis on direct work with the children, rather than the parents.

6.4 Similarly, the parents were not given adequate individual consideration by the agencies.

6.5 Overall, there was never a thorough, comprehensive assessment of the strengths and weaknesses of this complex family, followed by routine, rigorous analysis and effective review.

6.6 The hostility of the parents to some professionals, and their lack of co-operation, should have been more consistently challenged. The legitimate concerns of professionals were too easily deflected by this “tactic”.

6.7 There should have been more work directed at understanding extended family relationships and the capacity of the extended family to support the parents’ care of their children.

6.8 Neither the supervision arrangements for the lead workers, nor the involvement of a range of agencies, provided sufficient challenge to the failure to achieve identifiable and enduring improvement in the children’s circumstances.

6.9 There may have been a negative effect from the involvement of many agencies, mutually reinforcing the view that the care of these children was “good enough”, so that there was a collective failure to intervene.

6.10 The Review demonstrated again the particular complexity of working with neglectful families, where the evidence of cause for concern is often cumulative rather than incident based.

6.11 The Review found that the agencies should have been more concerned about the possibility of physical abuse of the boys. Professionals had formed a stereotypical view of the family as neglectful but had overlooked the evidence that such neglect is often accompanied by physical abuse. This is linked with weaknesses in the management, by the boys’ school, of the incident leading to their admission to care.

7. RECOMMENDATIONS FROM THE OVERVIEW REPORT

7.1 Introduction

7.1.1 These are the recommendations from the Overview Report. They reflect the views of the Serious Case Review Panel and the independent Overview Report author. Participating agencies have also made recommendations from their Individual Management Reviews, some of which overlap with these recommendations.

7.1.2 These recommendations are in line with the Government's guidance[3] that Serious Case Reviews should "focus on a small number of key areas with specific and achievable proposals for change". They arise directly from this Serious Case Review.

7.1.3 The London Safeguarding Children Board has suggested that Serious Case Reviews should consider the relative urgency of their recommendations. These recommendations are all important. However, none of them are so urgent that they require immediate attention. They can be dealt with in the normal course of service planning.

7.1.4 Each recommendation includes in parentheses a date by which the objective should have been achieved and that is reflected in the accompanying action plan. That action plan is monitored regularly by the Safeguarding Board.

7.2. Recommendations to the Bromley Safeguarding Children Board

7.2.1 The BSCB must satisfy itself that

a) safeguarding concerns lead to thorough assessment and rigorous review of families, including extended families, by all agencies
b) those processes of assessment and review are always informed by attempts to understand the situation from the viewpoint of the child

7.2.2 In disseminating the lessons learned from this SCR, the BSCB should highlight the challenges of working with unco-operative parents and how agencies can best respond to those challenges

7.2.3 The BSCB should

a) recommend to the London Safeguarding Children Board the development of procedures and practice guidance on concealed pregnancy
b) in the interim, adopt local policies and procedures on concealed pregnancy

[3] Working Together 2010

7.2.4 The BSCB should ensure that, in the event of any future SCR, full consideration is given to the support and assistance that some smaller-scale agencies may need, to ensure that their ability to contribute to the Review is maximised.

7.3 Recommendations to all agencies participating in this Serious Case Review

7.3.1 All agencies[4] should review arrangements for the provision of safeguarding supervision to ensure that it is adequately challenging, and seeks to identify drift in case management, particularly in cases where a principal concern is neglect.

7.3.2 All agencies should remind staff of the requirement of the London CP Procedures, when making referrals to other agencies, to confirm those referrals in writing.

7.3.3 All agencies whose services are provided within specific catchment areas must ensure that staff are equipped with clear, accurate guidance about those geographical boundaries

7.4 Recommendation to the London Borough of Bromley

7.4.1 The London Borough of Bromley must ensure that CSC services are adequately staffed so that they can meet their statutory responsibilities for the safeguarding of children.

7.4.2 The LBB should lead a multi-agency review of the arrangements for implementing the Common Assessment Framework to ensure that

a) the service is appropriately challenging
b) all agencies are clear about the role and responsibilities of the CAF Team
c) local multi-agency procedures require that a Team Around the Child meeting is considered in all cases where there are more than 3 agencies involved (excluding GP)

7.4.3 The LBB should satisfy itself that arrangements for the safeguarding of children at the school attended by these children are sufficiently robust to meet statutory requirements for safeguarding and promoting the welfare of their pupils

7.4.4 The LBB should use the lessons learned from this case to remind all schools of the statutory requirement (section 175 Education Act 2002) to exercise their functions with a view to safeguarding and promoting the welfare of their pupils

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[4] These are recommendations to all agencies participating in the Review with the exception of the Metropolitan Police Service, which did not have a continuing involvement in the case

7.4.5 The LBB must ensure that arrangements for the provision of Education Welfare Services are sufficiently flexible to meet the statutory requirements for the safeguarding of children

7.4.6 The LBB must ensure that there are clear arrangements for the line management and supervision of all Children & Families Centre staff.

7.4.7 The LBB Early Years Service should review arrangements for support to private sector providers, particularly in small-scale provision, to ensure that they have adequate access to safeguarding advice and assistance and are encouraged to make use of this help.

7.5 Recommendations to the Bromley Primary Care Trust

7.5.1 The PCT should review arrangements for the Community Paediatric service to ensure that

a) referrals are processed, prioritised and reviewed as efficiently as possible
b) the Community Paediatric service has sufficient capacity to contribute fully to the management of cases in which the service is involved

7.5.2 The PCT should remind all staff in the school nursing service of their individual responsibility to take action or seek advice when they have concerns about children who may be vulnerable or in need of protection.

7.6 Recommendation to the South London Healthcare Trust

7.6.1 The SLHT should ensure that staff at the West Kent Eye Centre are reminded of the arrangements for accessing advice and assistance in situations where they have concerns about the welfare of children

TERMS OF REFERENCE

1. AGENCIES TO BE INVOLVED IN THE REVIEW

The following agencies are asked to be involved in the review.

Individual Management Reviews

- LB Bromley Children's Social Care
- LBB Bromley Access and Inclusion Team (CAF, Children and Family Centre Team, Education Welfare Service, Community Vision, Pre-School)
- South London Healthcare NHS Trust (Princess Royal University Hospital, Accident and Emergency services, midwifery)
- PCT (including Health Visiting Services, School Nurse, and GP)
- Health Services including
  - Community Paediatrician
  - Orthoptist,
  - Ophthalmologist
  - Dietician
  - Occupational therapist
  - Community Paediatrician
- Metropolitan Police Service
- Bromley Charity
- School

Background/Contextual Information

In some instances the involvement of an agency with the family is minimal and a full IMR is not appropriate and therefore contextual or background information has been requested.

- LBB Adult & Community Services (Care Assessment, Housing)
- LB Lewisham
- Bromley Adult Education: Family Learning Service

2. SCOPE OF THE REVIEW

Content

The IMR report must include:

- a comprehensive chronology of agency involvement and / or professionals in contact with the child and family over the period of the review (see timescale of review later in this terms of reference) using the template provided (Appendix1)
- a narrative of the agency involvement and
- an analysis of the work, which is open and objective, identifying any areas of good practice as well as lessons to learn
- recommendations which are drawn from the lessons to be learned for the agency

- an action plan, using the template provided (Appendix 2) which demonstrates how the agency is going to progress any changes to be made in a timely way.

Further guidance on completing IMRS is included in Appendix 3. An integrated genogram will be developed and agreed as part of the process.

It is important to following the formatting guidelines to ensure that information is provided in a consistent way to support the integration of information into a chronology.

The format and content of a *Serious Case Review* report must follow the guidance set on in *Working Together Chapter 8 Serious Case Reviews 2010 p247*

The Overview Report, Executive Summary, Individual Management Reviews, genogram, Chronology and Action Plan should be fully anonymised.

- Mother - Ms Q
- Father - Mr G.
- Child 1 – Child D
- Child 2 – Child B.
- Paternal aunt – Ms H

Maternal and paternal grandparents will be addressed as MGM. MGF, PGM, PGF.

Specific Issues

The specific issues which the review should consider are:

1. Did the agencies involved with the children and their family adequately identify the level of neglect to these children and at what stage did the level of neglect suggest child protection procedures should have been invoked?

2. Was there sufficient sharing of information between agencies to assist in the decision making around the level of neglect of these children and whether child protection procedures should have been employed?

3. Did agencies take sufficient account of the mother's background and how this would have impacted on her parenting ability?

4. How did the impact of the late knowledge by the mother of her pregnancies impact on her parenting capacity and was this was addressed by any agency?

5. In what way were the father's epilepsy and the impact it may have had on his parenting ability assessed by agencies?

6. Why, in the light of other concerns about the parenting, were the physical injuries sustained by the children, not investigated more fully?

7. Why did the significant number of agencies involved with these children not work more effectively together to protect the children from significant harm?

In addition, the issues set out in *Chapter 8 of Working Together to Safeguard Children 2010 p 245 - 246* need to be addressed:

- Were practitioners aware of and sensitive to the needs of the children in their work and knowledgeable both and about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken into account when making decisions about the provision of children's services? Was this information recorded?

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

- What were the key relevant points/ opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessment and decisions made? Were appropriate services offered/ provided or relevant enquiries made in the light of assessments?

- Were there any issues, in communication, information sharing or service delivery, between those with responsibility for work during normal office hours and others providing out of hours services?

- Where relevant, were appropriate child protection or care plans in place and child protection and/or looked after reviewing processes complied with?

- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family and were they explored and recorded? To what extent was this significant in the case?

- Were senior managers or other organisations and professionals involved at points in the case where they should have been?

- 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?

- Were there organisational difficulties being experienced within or between agencies? Were these due to lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

- Was there sufficient management accountability for decision making?

3. COLLATION AND ANALYSIS OF INFORMATION

SCR Overview Report

The overview report must consider how and why events occurred, decisions made and actions taken or not taken. The reviewer will consider whether different decisions or actions may have led to an alternative course of events. It must be open and objective with clarity on where systems could improve. Examples of good practice should also be highlighted. It is important that learning from this review is considered alongside learning from previous serious case reviews by BSCB and from findings from relevant research.

IMRs

The agencies identified in Section 2 are required to prepare an Individual agency Management Review (IMR) report that covers their involvement with the family during the timescales identified within these terms of reference. The aim of IMRs are to look openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and if so, to identify how those changes can be brought about.

Lessons

It will be important in analysing the information to consider at both individual and inter-agency level whether any lessons can be learned in terms of: ways of working, training, supervision and management of cases, partnership working, resourcing as well as policy and procedure. It is also important to consider lessons in relation to previous serious case reviews in which the agency or LSCB has been involved.

4. QUALITY ASSURANCE OF REPORTS

The IMR reports should be quality assured by the senior officer in the organisation which has commissioned the report and when they are satisfied, the findings accepted. The senior officer will be responsible also for ensuring that

the recommendations of the IMR, and where appropriate the overview report are acted on. *(WT Ch8 SCR para 8.35)*

The Overview Report and Executive Summary will be quality assured by the Serious Case Review Panel. The BSCB Executive Committee must be assured that the report and its process has been robust and thorough prior to approval of the report and its submission to Ofsted.

5. PERIOD OF TIME COVERED BY THIS REVIEW

From the period of the pregnancy with the first child estimated as **01.01.2003 to 09.02.10.**

During the course of the review it may become evident that information outside the time period may be required from particular agencies in order to better understand the circumstances of the family.

The children's social care IMR will cover the period of the mother's involvement with social care in her childhood and adolescence but this will not form part of the chronology for the case.

6. INDEPENDENCE OF THE REVIEW

An Independent person has been appointed to write the review including integrating the chronologies of the agencies. The SCR Panel will be chaired by the BSCB's Independent Chairperson. The reports progress and findings will be discussed by the BSCB Executive Committee.

7. PANEL MEMBERSHIP

Members of the panel will be (as set out in the final report). The Overview author, IMR authors and representatives of agencies providing background information may attend as observers

8. INVOLVEMENT OF THE FAMILY

The independent author supported by the BSCB Business Manager will attempt to arrange for an interview with the family (parents and possibly grandparents) through their solicitor.

9. TIMESCALE FOR COMPLETION OF REVIEW

Bromley Safeguarding Children Board gave consideration to the need for a Serious Case Review on 02 March 2010. It was deemed that further information was necessary in order to determine whether the case met the criteria for a serious case review.

- It was agreed that agencies should be required to provide a chronology of their involvement with the family by 5th April 2010.

As further information about the case emerged it was agreed on 23rd March that the case met the criteria for a Serious Case Review. Ofsted was notified on 26 March. The review is therefore due to report its findings in six months to Ofsted on **26 September 2010.**

- IMRs are to be submitted by 18 June 2010 to the overview author and copied to the BSCB administrator
- The BSCB Executive will give final approval of the report at its meeting on 14 September 2010 prior to its submission to Ofsted.

10. PARALLEL INVESTIGATIONS

Care proceedings are underway. Criminal investigations are being undertaken by the MPS. The Executive Summary will not be published until the criminal proceedings and evaluation of the SCR are concluded.

11. COMMUNICATION

The Head of Service Safeguarding and Quality Assurance will manage and co-ordinate the review on behalf of Bromley Safeguarding Children Board. Contact Details: 0208 313 4610. First Floor, Stockwell Close, Civic Centre, Bromley BR1 3UH.

A strategy for communication with agencies, other authorities and with the media should be developed. A member of the LB Bromley Communications Office will provide advice and guidance as relevant.

Communication with agencies involved will be the responsibility and at the direction of the appointed Independent Chair of the BSCB. Communication with the media will be the responsibility and at the direction of the Chair of the Safeguarding Children Board in conjunction with an agreed statement with the Communications Officer within London Borough Bromley Chief Executives Office.

THESE TERMS OF REFERENCE MAY NEED TO BE REVISITED AS THE REVIEW PROGRESSES AND NEW INFORMATION EMERGES.