BARKING AND DAGENHAM SAFEGUARDING CHILDREN BOARD

Serious Case Review

Services Provided for Child T and Child R August 1997 – February 2010

Executive Summary

Barking and Dagenham LSCB Simon Hart Independent Chair

Serious Case Review Panel Steve Liddicott Independent Chair

Serious Case Review Overview Report Keith Ibbetson

Arrangements for the Serious Case Review

1. Barking and Dagenham Safeguarding Children Board (BDSCB) has conducted a Serious Case Review (SCR) of the services provided to two children who will be referred to as Child T and Child R. This document provides a summary of the case review including a full account of the findings of the review.

2. Child T was killed by his mother in February 2010 at a time when both children were the subject of Child Protection Plans and about to become the subject of care proceedings. The review was conducted in order to fulfil the requirements of Chapter 8 of *Working Together to Safeguard Children* [1] and the London Child Protection Procedures. [2] Simon Hart, Independent Chair of the LSCB consulted with the Chief Executives of LSCB member agencies about the need for a case review at a meeting held in March 2010 and made the decision to undertake the review on the 21st March. The findings of the case review were accepted by BDSCB at a meeting on 26 January 2011.

3. The purpose of the SCR is set out in *Working Together*:

   - to draw together a full picture of the services provided for the young people involved and their family
   - to establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children
   - to identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and hence improve inter-agency working and better safeguard children.

4. During the period covered by the SCR, the children and their parents lived in the London Boroughs of Ealing, Redbridge and Barking and Dagenham.

[1] Statutory Guidance issued by HM Government, *Working Together to Safeguard Children*,*2010* (December 2009 and April 2010)
[2] London Child Protection Procedures section 19

The latter authority took the lead in convening and managing the SCR because the children were resident in Barking and Dagenham at the time of Child T's death and had been since 1999. The case review was supported by all of the relevant LSCBs and covered the work of almost 30 agencies (including schools) over a period of some 12½ year.

5. The following agencies provided services to or had contact with the family:
    - London Borough of Barking and Dagenham
        - Safeguarding and Children's Rights Service (social care)
        - Legal Services
        - Education Services (including schools)
        - Other council services (including housing, anti-social behaviour team and corporate complaints)
    - Barking, Havering and Redbridge University Hospitals NHS Trust
    - London Borough of Ealing
        - Children's social care service
    - NHS Ealing
        - Health visiting and antenatal provision up to 1999
    - London Ambulance Service
    - London Probation Trust
    - Metropolitan Police Service
    - North East London (NHS) Foundation Trust (NELFT)
        - Health Visiting
        - School Nursing
        - Community Paediatric Services
        - Adult Mental Health Services
    - NHS Direct
    - North West London Hospitals NHS Foundation Trust
    - Redbridge Children's Trust (LB Redbridge and Redbridge NHS)
        - Education Services (including schools)
        - Health Visiting

- School Nursing
- Children's Social Care*

- UK Borders Agency
- A local Gudwara (Sikh Temple)*
- Parents of Autistic Children Together (a voluntary organisation)*

6. Under the SCR arrangements all of these agencies were asked to review their records, produce an internal chronology of their involvement, interview key staff and provide an individual management report review. The authors of individual management reviews were senior staff with expertise in children's safeguarding who had not previously been involved in the case. Those agencies marked "*" had limited involvement and were only required to submit summary reports.

7. The SCR panel was chaired by Steve Liddicott who is an experienced chair of SCRs and is independent of all the agencies involved. The SCR panel included senior representatives with expertise in safeguarding children and detailed working knowledge of the professional standards relevant to all of the services involved. The other SCR panel members were:

Organisation	**Service / Dept**	**Job title of SCR Panel Rep**
London Borough of Barking and Dagenham	Safeguarding and Children's Rights Service (social care)	Interim Divisional Director Safeguarding and Rights
		Interim Group Manager Safeguarding
	Legal Services	Legal Partner
	Education Services (including schools)	Head of Quality and School Improvement
	Other Council services	Head of Community Safety & Neighbourhood Services
B&DSCB		Business Support Manager

Barking, Havering and Redbridge University Hospitals NHS Trust		Executive Director Of Nursing
Ealing LSCB		LSCB Coordinator
NHS Ealing		Designated Nurse and Designated Doctor for Safeguarding
London Probation Trust		Assistant Chief Probation Officer
Metropolitan Police Service		Detective Inspector Child Abuse Investigation Team
		Divisional Commander Borough Police
North East London (NHS) Foundation Trust (NELFT)		Managing Director Community Health Services
Redbridge Children's Trust (LB Redbridge and Redbridge NHS)	Education Services (including schools)	Principal Educational Psychologist
	Children's social care service	Head of Commissioning
NHS Barking and Dagenham		Designated Nurse For Safeguarding

8. The overview report was prepared on behalf of the panel by Keith Ibbetson who is an independent person with expertise in children's safeguarding and substantial experience in preparing Serious Case Review reports.

9. A health overview report was prepared on behalf of the commissioning Primary Care Trusts. The author, Judy Barker is a qualified and registered health visitor and an independent consultant with substantial experience in child protection and children's safeguarding. This report evaluates the health provision made and focuses on matters relevant to the practice of health professionals and the commissioning of health services. The

findings of the health overview contributed to the findings of the SCR overview report.

Background information and reasons for conducting the SCR

10. The decision to undertake a SCR was taken following the death of Child T. He was aged 12 at the time of his death in February 2010 and his younger brother was aged 11. They were born in the UK to parents from families of Indian origin. The parents and the children are of the Sikh religion. This report contains an evaluation of the way in which agencies addressed matters related to the family's ethnicity, religion and language. Although there was no definitive multi-disciplinary diagnosis Child T had severe learning difficulties and was believed to have had a disorder on the autistic spectrum. The impact of his disability and the provision of services by agencies in relation to this have both been considered in detail throughout the SCR and are summarised in this document.

11. Child T died after his mother had forced him to drink a significant quantity of domestic bleach. His younger brother was in the house at the time but he was not physically harmed. The father of the children was living elsewhere at the time of the death.

12. In November 2010 the mother of Child T and Child R admitted causing the death of Child T. Her plea of manslaughter on grounds of diminished responsibility was accepted by the Crown Prosecution Service and the court based on the advice of two experienced consultant forensic psychiatrists. At the time of writing Child T's mother has been remanded for inpatient psychiatric assessment to determine the nature of her mental disorder and whether or not it is considered to be treatable.

13. *Working Together to Safeguard Children 2010* requires that the Local Safeguarding Children Board should conduct a SCR when a child has died and '*abuse or neglect is known or suspected to be a factor in the death'.* In addition, an initial review of the case records highlighted a number of factors that pointed to the value of holding a SCR and the important learning that might arise from the review. In particular:

- Both of the children and their parents had been well known to agencies with safeguarding responsibilities in all three local authority areas
- The children had been subject to child protection plans (before April 2008 the term used was 'on the child protection register') for three periods amounting to a total of more than six years between 1998 and 2010, including periods in all three of the boroughs where they had lived
- At the time of Child T's death a decision had been taken by Barking and Dagenham Council to seek a court order that would have given the local authority the power to remove him and his brother from the care of their mother, though no application had been made
- Child T had a statement of special educational needs (SEN) and was well known to education services. Both of the boys had missed substantial periods of schooling since 2003.
- At the time of his death Child T was 'home educated' by his mother.
- Despite his disability Child T had had no recent contact with specialist medical services or the multi-disciplinary child development team.

14. The Local Safeguarding Children Board is responsible for determining the scope and terms of reference for the SCR taking into account the circumstances of the particular case. The general terms of reference are set out in paragraph 3, above. Following consultation with member agencies in Barking and Dagenham, relevant agencies in other areas and Government Office for London (GOL) the terms of reference agreed for this review included the provision of a full account of events and to focus the evaluation of services on the following questions and themes:

- The overall character of professional contact with the children's mother – including the impact of complaints made by the mother and the response of agencies to them
- The nature of professional dealings with the children's father
- Professional contact with the children, including attempts to establish their wishes and feelings

- The role played by ethnicity, religion and immigration in the case and professional responses to these issues
- The role of domestic abuse in the case and the response of professionals
- Concerns about the mental health of the mother
- The education of the children, the response of agencies to the children's SEN, poor school attendance and the decision of the mother to educate Child T at home
- The impact of drug misuse and substance misuse
- The response of agencies to conflict between the mother and her neighbours and other members of the community
- The role of legal planning in the case – including legal advice given on the threshold for care proceedings
- The role of supervision and the role of more senior managers in the case
- The overall quality of interagency working
- The impact of Child T's disability on his safety and wellbeing and the response of professionals to this

15. Because of the long standing involvement of agencies with the family it was decided to undertake a comprehensive review of services provided from the point in 1997 when the Child T's mother first had contact with professionals during her pregnancy. The review also addresses the critical question of whether the death of Child T could have been foreseen and whether it might have been prevented. The evaluation of this question inevitably focuses most on the actions of agencies more recently involved.

Family involvement in the SCR

The SCR panel made determined efforts to involve family members so that they could offer their perspective on events and on the services provided to the children by agencies although detailed discussion with family members had to delayed until after the conclusion of the criminal proceedings in order not to prejudice the trial.

16. In his initial contacts with the LSCB the children's father indicated that he wished to contribute to the SCR. Subsequently, he did not respond to offers to do so but immediately prior to the conclusion of the SCR, requested an opportunity to discuss what had happened. He confirmed details of events recorded in agency records and provided some information not previously known about the mother; this has not been included in the case review since it has not been possible to verify the details with her as yet. The father reported that, with one exception, he did not feel that he had been adequately involved by professionals. His contribution will be properly evaluated once it has been possible to consult with the mother.

17. The mother was approached after the conclusion of the criminal trial. Through her solicitor she declined the opportunity to contribute until her psychiatric assessment was completed. Once this has happened the LSCB will review the position.

18. All of the extended family members who could be identified from the records of agencies were approached directly. None took up the opportunity to contribute. It has not been possible to establish their reasons.

19. Child R was told about the SCR by adults with whom he has developed a close relationship. They asked what he thought about the professional involvement with his family. Not surprisingly, many of his views reflected what he would have heard his mother say over a number of years. However, he valued the input of some professionals and recognised that they were trying to help his brother.

Key events 1998 – 2010

Information about the Family Background

20. Contemporaneous agency records contain almost no information about the background of the parents of Children T and R. Both are from Indian families of the Sikh religion. The mother is believed to have grown up in the UK as part of a large family living in the North West. The father was born in India and first came to the UK in 1995. He made an unsuccessful claim for asylum and then sought the right to stay as the spouse of a settled person. He left the UK in 2002 and returned in early 2009. The parents are believed to have met in 1995 and married in 1996 against the wishes of the mother's family.

Ealing 1998 - 99

21. The mother's GP confirmed her pregnancy with Child T in August 1997. By this point numerous instances of domestic violence had been reported as well as calls to the police because of disputes between the parents and neighbours. The mother persistently refused to give evidence to enable the police to prosecute the father and refused offers of practical support to protect herself. This pattern continued whenever there was domestic violence throughout the case history.

22. Child T suffered intra-uterine growth retardation and was born by caesarean section 10 weeks premature. During the birth he suffered respiratory distress, the likely cause of his severe developmental delay. He remained in hospital for 9 weeks; during visits his mother was anxious and sometimes aggressive to staff. Despite this and the domestic abuse, there was no interdisciplinary or multi-agency discharge planning meeting before Child T left hospital.

23. Following Child T's discharge there were further incidents of domestic abuse which placed Child T at risk of physical and emotional harm. Child

T's mother remained anxious and had him readmitted to hospital because of her concerns about crying, vomiting and constipation. No significant health concerns were identified. In mid August 1998 he was brought to A&E by his parents with a head injury. The mother gave contradictory accounts about how the injury had been caused, but strongly suggested that an accident had occurred linked to the father's violence and drinking.

24. Child T was placed on the child protection register in September 1998 because of the risk of physical and emotional abuse resulting from domestic violence. The major focus of the protection plan was to attempt to relieve the stress factors believed to be causing the domestic abuse, including the father's drinking, housing problems, disputes with neighbours and the lack of support from extended family. The family refused offers of support intended to alleviate these problems. Attempts to monitor Child T and to seek to engage with the mother continued until the family moved to Redbridge in February 1999. Reports of domestic violence continued.

25. The mother had become pregnant again soon after Child T's birth; Child R was born at the same hospital as his brother in January 1999. Despite mother attending only about half her ante-natal appointments and the failure of the parents to cooperate with the protection plan, there is no record of joint planning for the birth and discharge of Child R from hospital and no re-evaluation of the risk to the children following the birth. The family moved to Redbridge in February 1999.

<u>Redbridge 1999</u>

26. The family lived for about 4 months in Redbridge. Mother said that she had moved to be near other family members; there is no record that they played a significant role then or later. The father was briefly in prison (following conviction for affray with police in Ealing) but returned to live with the family. The transfer child protection conference took place in late May after his release from prison. It made the children subject to a child

protection plan because of likely physical abuse. The protection plan specified a comprehensive assessment, regular visiting by the health visitor and social worker and review after three months. Regular visits were undertaken by the health visitor and social worker but no long term work could be undertaken because the family moved again in June to Barking. Incidents of domestic violence continued, the most concerning (in August 1999) involved an injury to Child R, similar to that involving Child T in Ealing in 1998. Responsibility for the children transferred to Barking and Dagenham at a child protection conference in September 1999.

Barking and Dagenham 1999 - 2002

27. In October 1999 Child T was identified by the Barking health visitor as having a possible global developmental delay and referred to the Child Development Team (CDT). The CDT planned referrals for physiotherapy, portage and audiology. Child T was notified to the local authority as a child who would be likely to have Special Educational Needs and to require formal assessment in the early years period.

28. At the first review conference in Barking (December 1999) the children were retained on the child protection register. The health visitor was extremely concerned about Child T's apparently severe developmental delay and lack of growth. The family did not attend, were not cooperating with social care services and there was little progress to report. The protection plan remained unchanged other than reference to a further appointment for Child T at the CDT.

29. In late December 1999 Child T was reviewed by the Community Paediatrician and referred to pre-school opportunity play skills sessions and the Speech and Language Therapy service [SALT]. He was understood to be due to attend a nursery at a Barking and Dagenham primary school and it was felt all the necessary support was in place. None of these services ever managed to work consistently with the

mother and Child T due to her unwillingness to cooperate; she gave professionals a variety of reasons why they could not attend services.

30. In February 2000 the family moved within Barking. It took the professional network some time to locate the children. A new social worker set out to engage with the mother in a constructive way and wrote a largely positive report to the next child protection review (June 2000). The children were retained on the child protection register because of concerns about the number of health appointments missed and mother's refusal to engage in the pre-school provision that professionals thought Child T needed. The category of registration was changed from 'likelihood of physical abuse' and 'likelihood of emotional abuse' to just the latter since there was now believed to be less evidence of a serious risk of physical abuse arising from domestic violence. The father was now believed to be living elsewhere though he made unannounced visits which were thought to have a negative impact on the children.

31. Professionals held differing views about the welfare and development of the children: some were very concerned about the extent of Child T's delay and his behaviour; others were impressed with how caring the mother was towards the children. However she continued to refuse to cooperate with professionals and frequently complained about anyone who challenged her approach to the care of the children.

32. The next child protection review was convened in September 2000. The children were retained on the child protection register despite a proposal from social care to remove them because none of the assessments required by previous protection plans had been undertaken, the children both appeared to have developmental or emotional problems and it had not been established whether these were medical in origin or how far they were caused by the parenting that the children received. The conference chair noted the lack of progress, reiterated the main points of the protection plan but did nothing more to put pressure on the staff or managers responsible to progress the work. This pattern was repeated

many times in the case history. Social care managers saw the case largely as being about a mother who would not take her children to nursery because of disagreements about special needs and not as a child protection matter.

33. Subsequently, intervention was focused on encouraging mother to take Child T to suitable pre-school provision to provide him with stimulation to assist his development and a setting within which an assessment of his special educational needs could take place. She rejected each alternative in turn, though for a brief period he attended three short sessions each week with his mother at a Family Centre. The initial assessment of his SEN was carried out there, though it was recognised that it was a far from ideal setting. This pattern continued until September 2002 when it was understood that his mother had accepted a place in the nursery of a special school in Barking which would meet Child T's educational needs for the foreseeable future.

34. Different reasons were given for each refusal; with hindsight it is clear that the mother was extremely anxious about attending any day care setting or leaving Child T with staff. The social worker and one health visitor became more frustrated and sceptical. However, other professionals were prepared to make allowances for the mother and presented a more positive assessment of her behaviour.

35. These attitudes echo earlier comments made in Redbridge where a social worker judged that there had '*never been concerns over the parenting of Child T and Child R'* despite their parents repeatedly exposing them to domestic violence. There are other examples of similar comments and assessments which appear to have arisen because the criteria for making judgements became the stated good intentions of the mother rather than on how she was actually parenting the children and the outcomes that the children were achieving.

36. The September 2001 conference changed the category of registration changed from 'emotional abuse' to 'neglect' reflecting the view that the

number of domestic abuse incidents had reduced and the focus of concern had shifted to the refusal of the mother to cooperate with day care and assessment arrangements. There had been a number of attendances at A&E because of unexplained minor injuries and repeated presentations with minor illnesses which might have sustained continuing concern about domestic violence or possible injury to the children. However these were not known to the child protection conference. This pattern of poor information sharing by GPs and the acute medical sector continued throughout the case history.

37. In February 2002 Child T was taken to a privately arranged paediatric assessment. The consultant diagnosed Child T as having a '*severe communication disorder consistent with a developmental disorder on the autistic spectrum'* as well as global developmental delay. This was treated by the mother as the definitive diagnosis of Child T's 'autism'. Whilst the wording is slightly different from that used by the multi-disciplinary CDT, the description of Child T's behaviour was entirely consistent as were the measures recommended to assess and provide for his special educational needs. Child T's mother focused on the differences rather than the similarities in the treatment and provision proposed; she subsequently treated the CDT as being incompetent for having failed to diagnose Child T's 'autism'. In 2003, after two more appointments, the mother withdrew Child T from attendance at the CDT altogether - he had no further specialist paediatric medical input. No action was taken in relation to the mother's disengagement with the CDT, although the consultant was aware of the history of child protection concerns.

38. By the time of the review conference in March 2002, Child T had been subject to a protection plan for 3½ years; it was presented with the bleakest assessment of the case up to that point because of the mother's continuing refusal to cooperate with any services. The social worker stated that the mother needed to understand that she was being given '*a final warning that the situation would not be tolerated'.* The local authority took legal advice as to what action could be taken to protect the children.

No detailed records of that advice have been found and at the next conference, it was stated that there were no grounds for legal proceedings.

39. In contrast, the September 2002 conference took the decision to remo*ve* the children's names from the child protection register. Two factors were critical: it was believed that the father's '*immigration status had been revoked'* and he was no longer in the UK (although the mother was helping him appeal); and mother had accepted a place at a special school which everyone agreed would be suitable for Child T. However, information about the father does not tally with the UK Borders Agency records which indicate that he left the UK in late October 2002 and that he was not deported but given dispensation to return to India. And, at the time of the conference Child, T had not actually started school. Given the attitude of the mother and history of non-cooperation, any objective assessment would have strongly suggested that it would be very unlikely that this would proceed without difficulties. This was a school that would have comprehensively met Child T's needs and offered his mother an enormous amount of support; mother never allowed Child T to settle and he only ever attended there for 23 days, remaining on roll into early 2003.

<u>Barking and Dagenham 2003 - 2007</u>

40. Between September 2002 and October 2004 Child T and Child R were dealt with as children in need by the local authority. Little was done by social care staff to monitor their progress or respond to new problems that emerged; the case then closed. There were a number of further referrals in 2005 and 2006; the children were discussed at a child protection conference in April 2006 but not placed on the child protection register again until March 2007.

41. Child T attended the special school sporadically until January 2003; he was then withdrawn from the school when his mother made allegations that school nurses had removed stitches from an operation scar without

consent and that school staff had attempted to undertake experiments on him. There is no evidence to support her allegations. It is likely that Child T was withdrawn from school because they wanted him to attend regularly and to discuss with the mother how there could be more consistency in managing him between home and school. She was extremely anxious as she was being challenged to separate from Child T and to change the way she handled him at home. The mother wrote letters of complaint to all the agencies involved making accusations of racism, lack of cultural sensitivity and unnecessary interference in family life. The local authority responded by seeking to placate the mother by reallocating the case to the children with disabilities team. Her actions were not considered as further evidence of neglect or emotional abuse nor was it recognised that the removal of Child T from school undermined the basis upon which he had been removed from the child protection register just three months before.

42. Subsequently, Child T did not attend school again until he was admitted to a Redbridge Infant School in September 2004. He attended there sporadically (on average, less than 50%) until July 2005.

43. Child R started to attend his local Barking and Dagenham Infant school in October 2003, in keeping with his expected school entrance date. He attended until early March 2004 at a level of approximately 60%. He too was withdrawn after the mother made allegations of bullying and sexual abuse by other pupils for which there was no evidence.

44. Child R moved to a Redbridge Infants School in March 2004 and Child T joined him in the autumn of 2004. Mother did not tell the school that Child T had a statement of SEN and it took some months for his needs to be clarified and support agreed. By then he had missed five terms of education since January 2003

45. In August 2004 Child T was seen for an Occupational Therapy (OT) and Physiotherapy assessment. Advice was given on a number of issues including toilet training and use of English at home, both considered

essential if Child T was to restart school. The OT offered to review Child T in 9 months time after earlier review appointments were rejected.

46. In March 2004 a family of Pakistani origin moved into the house next door. Almost immediately there was a high level of conflict between the mother and this family, as well as continuing disputes and "harassment" involving other neighbours which continued until 2010. Whilst there was a level of abuse and aggression on both sides, the evidence suggests that the mother was responsible for initiating a considerable proportion of the aggression by insulting and harassing her neighbours. There were subsequently physical conflicts resulting in her arrest and subsequently conviction for common assault and harassment in June 2005. She was sentenced to an indefinite Restraining Order and a Community Punishment Order (community service) equivalent to 70 hours of unpaid work (because of her child care responsibilities she was allocated work to do at home which was completed by November 2005).

47. By early 2005, relationships with the Redbridge Infants School had deteriorated to the extent that Redbridge Council considered banning the mother from the children's school. The school referred the mother to social care because of '*concerns about her mental health*'. That summer, she took the children to India with the intention of reuniting with the father. The school removed the boys from the school roll, leaving them without schools on their return. The school may have believed that the children were moving permanently to India. Child T did not attend school again until April 2007.

48. Attempts to get the children to school and to engage the mother had come to nothing by late November 2005 when mother again took the children to India. The SEN panel, the admissions service and the attendance service in Barking and Dagenham had all became involved. The authority made bureaucratic and administrative errors in relation to the allocation of school places to the two children, the mother ignored

letters offering school places in Barking and Dagenham schools and she did not respond to contacts over finding Child T a special school place.

49. When the educational psychologist established that the children had returned to the UK in February 2006 she re-referred them to social care. She reiterated the concerns of earlier referrals highlighting that the children had lost another year of education. The case was allocated straight away, the social worker attempted to engage the mother and undertake checks and enquiries.

50. The mother made approaches to three mainstream schools in Redbridge; Barking and Dagenham SEN panel consulted with the special school that Child T had previously attended who refused to take him on the legitimate grounds that the school was already well over capacity and that the previous relationship with the mother had been so poor.

51. In late March 2006 an attempt was made to agree a way forward in a joint meeting of social care and education staff. Social care decided to initiate child protection procedures if there was no progress. In early April the social worker had detailed discussions with the mother – about which she complained. He contacted the CDT to clarify the diagnosis of autism which the mother had told him was crucial. However, CDT decided not to undertake a further evaluation of Child T.

52. A child protection conference was convened on 26 April 2006; the social worker highlighted the following concerns about the children:

- long absences from school
- witnessing mother's violence and aggression to neighbours
- refusal of mother to cooperate with the core assessment
- concern about parenting capacity
- the worker's inability to establish the wishes and feelings of Child T given his disability.

53. The conference did not decide that the children should be made the subject of a child protection plan, despite the refusal of the mother to

cooperate with any of the proposed plans. Again a number of professionals assumed that the mother looked after the children well, though there was little evidence to support this. The plans made were unrealistic and based on an underestimation of the level of risk to the children. After the conference the mother complained about the social worker; previous complaints had often been about cultural insensitivity but as he was Indian the complaint was made on the grounds of his gender. He was removed from the case but replacement (female) worker made no progress either.

54. In May 2006 Child R was accepted for a school place at Redbridge Primary School 1. He had missed two further terms of school, entirely as a result of choices made by his mother. No proper steps were taken by Barking and Dagenham Council to monitoring Child T's lack of education or offer home tuition. It is not clear why this was not addressed but it is likely that the mother had said she was actively seeking a school, that professionals in the attendance service believed that a school was going to be allocated through the SEN process and one or both children were on the rolls of schools in Redbridge leading to uncertainty about responsibilities between the two authorities.

55. In June 2006 Barking and Dagenham social care and education services met jointly with the mother who agreed to their proposal to approach three special schools seeking placements for Child T, despite having previously made it clear that she wanted him to attend a mainstream school. No progress was made before September 2006 and no alternative provision was made for Child T. At this point an offer of home tuition was made, but conditions imposed by the mother made it impossible to implement.

56. During the summer of 2006 conflict between the mother and neighbours heightened. This led to a meeting involving police, social care and the section of the local authority responsible for dealing with anti-

social behaviour. There was agreement to set up CCTV cameras to monitor events but this never happened.

57. No progress was made in finding Child T a school place until he was taken onto the roll of his brother's school in Redbridge in April 2007. He had missed a further 5 terms of schooling. Child R's attendance began to fall to levels of 60 – 65%.

Barking and Dagenham 2007 - 2008

58. In January 2007, despite opposition from Redbridge Council and the school, Barking and Dagenham agreed to name Redbridge Primary School 1 (Child R's school) on Child T's statement of SEN, thereby requiring the school to admit him. Child T attended the school from April 2007 for about six weeks, at which point his mother withdrew him after a dispute with the head teacher. This was the last time he went to school.

59. Between January and March 2007 the mother refused to be involved in the social care core assessment or to agree a proposed statutory educational assessment of Child R. Child R missed a considerable amount of school as his mother's relationship with the school was deteriorating. These concerns resulted in a child protection conference in March 2007 which considered all of the information about education and the concerns known to the police about anti-social behaviour. Health information was again limited and significant information about outpatient paediatric appointments and A&E attendances was not reported to the conference.

60. The mother walked out of this conference, abandoning the children. Both children were made the subject of a child protection plan; they were returned to the mother later that evening after local authority managers decided not to seek her agreement to accommodate them.

61. The concerns identified at the child protection conference heightened: the mother refused to allow the children to be seen, though she later relented; she continued to refuse to allow professionals to talk to them alone or to cooperate in the core assessment. Child T was admitted to the

same school as his brother but barely attended; his mother refused to speak to the school nurse. At the beginning of the autumn term the mother withdrew Child R from school and made no efforts to find him an alternative school for some months. She took the children to Italy giving the social worker little notice and providing no details of their address and contact details. The records contain explicit references to professional concerns about the mother's mental health and she continued to refuse any form of assessment.

62. The first of two legal planning meetings held in 2007 took place on 21 March. The solicitor was not sent background documents until after the meeting. The discussion focused largely on non school attendance and the refusal of the mother to cooperate with the protection plan. No medical information was provided to the meeting. Although the solicitor's written advice refers to Child T as being 'autistic' there was no information about the withdrawal of Child T from medical assessment and monitoring at the CDT in 2003, the refusal of pre-school provision or lack of cooperation with services such as speech and language therapy or OT.

63. The legal advice was that the threshold criteria for care proceedings were not met, noting that it was highly unusual to seek a care order solely on the basis of poor school attendance and that it was in good part the failure of the local authority to provide a suitable school place which accounted for Child T's poor attendance. It continued by saying that if the mother refused to allow the social worker to see the children at home they should be monitored at school, despite the history of non-attendance and very poor attendance.

64. Immediately after the legal meeting the social workers were refused entry and access to the children; mother was described as '*very agitated and angry'.* For reasons that cannot be established it was reported back to the lawyer that this visit had *'proceeded satisfactorily*'. Had he been given accurate information his advice might well have been different.

65. The first review conference took place in June 2007. By then, Child T had been withdrawn from school and there had been a complete breakdown in relations between his mother and the Redbridge Primary School 1. There was a high level of concern about the potentially adverse effects of Child T being educated at home. It noted that the mother was allowing the social worker to visit the home but that she had not attended core group meetings or otherwise cooperating with the protection plan. The chair emphasised the importance of avoiding drift, stating that the child protection plan was not enough and that there needed to be a further legal planning meeting. However, she does not appear to have taken any action to address her concerns, either through the protection plan or by pursuing her them in discussions with the managers responsible for the case. The protection plan largely reiterated the previous plan that had not been implemented. There is no recommendation in the minutes for a further legal planning meeting.

66. The second review conference was held in December 2007. It reiterated all of the concerns with added weight being given by the fact that neither child had attended school since June / July 2007 and the mother now had a firm intention to educate Child T at home. Child R was due to be taken onto the roll of a third Redbridge primary school, some 7 miles away from the family home.

67. A second legal planning meeting was held that month and focussed on: the children's chronic non-school attendance; the mother's disputes with neighbours, other parents, and the public and the children's witnessing of these arguments; mother's refusal to allow the children to have developmental checks and her decision to withdraw the children from school and take them to Italy (which had resulted in both children losing their school places.

68. The meeting reached similar conclusions to those of the March 2007 meeting, the advice being that the threshold for proceedings was not met even though the minutes state that '*there was a weight of evidence to*

suggest that the children continue to suffer significant harm whilst in mother's care'. It was agreed that the local authority would support Child R's school attendance by providing a taxi for three months, ensure that there was an adequate programme for education of Child T at home, send the mother a letter setting out the concerns clearly along with expectations for improvement and consequences of non-compliance and reconvene the meeting on 14 March 2008.

69. On 17 December 2007 core group members were briefed on the findings of the legal planning meeting and asked to prepare material for submission for court should it be required. There is no indication that any further detailed instructions were given or evidence of any further action being taken in relation to this by any agency.

70. A letter was delivered by the social worker to the mother in mid January 2008 setting out in detail the areas where her behaviour was believed to have harmed the children (or would do if it continued) and the changes required of her through fulfilling the requirements of the protection plan. The letter states that if insufficient change occurred in seven months the local authority will consider use of legal powers, a period identified because it was believed that this would provide time to show that any change had been sustained. The mother immediately made it clear that she had no intention of complying and she tore up the letter. No further action was taken nor was further legal advice sought.

71. Child R had not attended school since July 2007; there had been no direct contact with the mother over the home education arrangement by Barking and Dagenham education staff other than a visit by the attendance officer in August 2007 to tell her how it would be monitored.

72. Child R started Redbridge Primary School 2 in January 2008. The school knew that he was subject to a child protection plan. However the social worker did not invite the school to child protection meetings for some months and relied on a Redbridge education welfare officer from Child R's previous school to monitor him and report concerns. Child R

initially attended school regularly, being taken by a taxi provided by Barking and Dagenham Council, an arrangement that continued for most of the next two years.

73. Attempts were made to arrange to monitor the home education arrangements for Child T in early 2008 but mother refused home visits (as was her right under the regulations). As a result no direct observation of her teaching occurred until shortly before his death. Other members of the professional network may have been under the impression that monitoring visits were happening because they did not understand the limited nature of the local authority's powers.

74. A review legal planning meeting in March 2008 noted that mother was cooperating in the monitoring of home education and Child R's attendance at school had been reasonable. Issues to do with the immediate welfare of the children at home were presented as having been dealt with by the provision of the taxi; little attention was paid to the basic questions of neglect and medical assessment. Attention shifted to mother's plan to take the children to Italy again to see their father. This was viewed as potentially very harmful for the children; it was agreed that the local authority should apply for a Prohibited Steps Order to prevent this or to seek a means of safeguarding the children during the trip.

75. There were no changes prior to the next review conference which in May 2008. It was decided to retain the boys on the child protection plans under the category of neglect. The child protection plan consisted of many of the components of previous protection plans: core group meetings; children to be seen in the home without the mother being present; CAMHS assessment; review of SEN (an annual requirement anyway); assessment of the emotional well being of the mother and impact of her behaviour on the children; school and school nurse to continue to monitor the wellbeing of Child R. The protection plan did specify that the education officer and educational psychologist were to visit the home to assess the education being provided. If the conference had been better informed it

would have known that the education authority had no right to insist on this.

76. Following a minor incident in school in early July 2008 Child R did not attend for the rest of the term. On 23 July agreement was reached in court to allow the mother to take the children to Spain for a holiday with their father, subject to compliance with requirement to notify local services and establish where they will be staying. Initially it appeared that the trip passed without incident; later it was alleged that there had been violence and the mother had obtained an injunction in a Spanish court against the father. Exactly what happened remains uncertain.

77. In September 2008 a newly appointed team manager in social care decided that the children should be removed from the child protection plan and the department should move towards closing the case. It is believed that this judgement was reached with little knowledge of the case and without reading the files. His reasoning was said to be that the only issues of concern related to education. A further legal meeting scheduled for October 2008 did not take place. The reasons for this were not recorded.

78. The review child protection conference decided in November 2008 that the children no longer needed to be subject to a child protection plan. There was no representation at the conference from the school, which reported in writing that there were '*no concerns*' about Child R. The conference considered only a limited amount of information and it appears to have taken an extremely optimistic view of some developments. The decision to remove the children from the child protection plans only had the support of two of the four conference members and the chair. The decision making of the conference was characterised by professional denial about how little progress there had actually been. The underlying anxiety about the children was reflected in the child in need plan that was drawn up at the meeting which was little different from the previous child protection plans. However, arrangements for review are different and the

children would have not been seen by other agencies coming into contact with them as being at such a high level of risk as they were no longer subject to a protection plan.

Barking and Dagenham 2008 – March 2009

79. In November 2008 the mother rejected a secondary school with additional provision for children with communication difficulties - she decided that it would not meet Child T's needs and he would still be better educated at home. Relations between the mother and Child R's school had deteriorated to the extent that the school inclusion manager told the social worker that staff were '*reticent'* to approach her about assessment of Child R's SEN because they '*feared verbal abuse*'. Mother was said to be forcing him to hand deliver numerous letters of complaint about different members of staff.

80. Visits by the social worker continued as before. The social worker was allowed to see the children, but not to talk to them alone or see their bedroom. At the end of January the head teacher stated that she had been '*forced to take legal advice'* about the behaviour of the mother who had stormed into the school a number of times shouting at teachers and other parents and pupils, reducing members of staff to tears. Following a child in need meeting in January 2009, the mother complained about the "unprofessional" behaviour of school staff who in turn found her behaviour to be aggressive; subsequently, the school did not attend further meetings for several months.

81. In early March 2009 the social worker was told by the mother that the boys' father had returned to the UK during January and stayed with the family for three weeks. She said he was now staying in the North with family members. This does not appear to have been mentioned at the child in need review meeting the next day nor conveyed to the social worker's manager (who did not provide the social worker with any specific

direction when he was later informed). The meeting agreed to pursue aspects of the children's health and education.

Barking and Dagenham March 2009 – February 2010: The death of Child T

82. In March 2009 a Barking and Dagenham special needs advisor and an attendance officer met with the mother to discuss the home education arrangement. A report judged the home education provision to be '*satisfactory but capable of being improved*' in a number of areas; it suggests that the provision actually being made for Child T fell far short of what he needed. Child R's school attendance for the previous term was reported to be 79% which could have triggered statutory action in its own right. However the absences were mainly authorised by the school and consequently statutory legal action was not considered.

83. Later that month, the head teacher of Child R's school wrote to the mother warning her about her conduct as she had *'shouted at another parent and used abusive language and gestures*'; it was also reported that '*parents have complained and were visibly distressed'* and 't*eachers had to speak to numerous children who were very distressed'*. The head threatened to ban the mother from the playground and involve the police because of '*language and behaviour very threatening to parents and inappropriate in school which children as young as three can witness*'.

84. On 26 March the first domestic abuse incident to be reported to the police and the local authority since the return of the father to the UK occurred. Low level incidents of harassment continued spasmodically until the death of Child T. There were no reports of injuries and they appear to have been much less serious than the incidents that occurred prior to 2002. They clearly made the mother anxious and upset the children but she refused to provide formal statements or to accept practical support over incidents of domestic abuse.

85. On 30 March the social worker met the father for the first time; mother spoke positively about his return. He stated that he was looking for work and wanted to move the family to be nearer his relatives in

Yorkshire. On 2 April the social worker responded to a further complaint of domestic abuse by telling the father to *'calm down'* and to go to stay with his family. There is no indication that he discussed this with a manager until after returning from leave nearly four weeks later by which time further incidents had independently come to the attention of the team manager.

86. A strategy meeting held on 18 May decided that there were grounds to hold a child protection conference which was convened on 4 June 2009. It was well attended and considered all of the significant developments since the return of the father as well as the outcomes for the children since removal from the child protection plan in 2008. The children were made subject to a child protection plan again. The protection plan was similar in most respects to the plans that had been made during 2007 – 8 except that on this occasion more stress was placed on supporting the mother in relation to the threat of domestic violence.

87. Again there was no cooperation from the mother in the implementation of the protection plan and she refused to sign the child protection agreement. Despite her disclosures about domestic violence in the UK and Spain the mother had a number of further contacts with the father placing herself and the children at risk. For example in June and August, it is recorded that she arranged for him to look after one of the children citing lack of an alternative carer as her reason.

88. Subsequently, the mother alleged that the father had raped her and also sexually assaulted Child T when she had allowed him to stay. The police arrested the father; he completely denied the allegations but was charged in relation to the alleged sexual abuse and remanded into custody where he remained for the next six weeks. The charges were subsequently dropped: mother said that she was unsure if a sexual abuse had happened and refused to provide a witness statement.

89. Legal advice at that time was that there were no grounds for an Emergency Protection Order (EPO) as the suspected abuser had been

removed and charged. Managers saw the mother and offered to accommodate the children. She refused on the grounds that what had happened was '*not her fault'*.

90. A legal planning meeting in late August confirmed that so long as the father was in custody there were no grounds to apply for an EPO. The solicitor agreed to consider the chronology and provide further advice. A review meeting was set for 2 September. Later the same day the mother indicated to the social worker that she was '*no longer sure'* about the allegations she had made. The social worker did not realise the potential significance of this and there is no evidence that he informed anyone.

91. The solicitor's advice was that there were many aspects of the case that might meet the threshold for care proceedings and that evidence needed to be gathered systematically. However if the father was released from custody then immediate consideration needed to be given to taking protective measures. The lawyer was not aware that the mother had doubts about what she had seen and was continuing to refuse to make a formal witness statement. If she had she might have emphasised the need for the local authority to take the initiative since both factors pointed to the father's very likely early release. The review meeting scheduled for 2 September was postponed by the social care team manager and not convened until 29 October.

92. In August police had referred the mother to the Multi-Agency Risk Assessment Conference (MARAC), in keeping with the Metropolitan Police criteria. The case was discussed on 3 September but after unsuccessful attempts by an independent domestic violence advisor to contact the mother no further action was taken.

93. On 4 September a child protection conference reviewed recent events with a particular focus on education. A lengthy child protection plan was drawn up confirming that an EPO should be considered if the father was released from custody and proceedings should be initiated if there was a further incident of domestic violence. The plan included an appointment

for Child T at the CDT which would have been the first specialist paediatric contact for more than six years. The mother initially agreed to attend but failed to do so - further appointments were offered until January 2010 when Child T was discharged from the service - he never attended.

94. In September the mother referred herself to the mental health brief intervention and assessment service which undertook a telephone screening interview. There had been no previous contact between children's services and the mental health service so this was treated as a routine referral at this point. The mother identified a list of problems causing her stress and she was judged by the service to have a 'moderate' degree of depression and 'mild' symptoms of anxiety.

95. After consultation with a supervisor the mental health worker offered the mother a referral to a domestic violence project; she refused on the grounds that her main problem was 'social services'. Subsequently, it was decided that the mother should be referred to the community mental health team for a full assessment. She refused this on the grounds that it had arisen out of discussion with social care and was irrelevant to her. The mental health team closed the case.

96. The mother later advised police that she was not prepared to make a statement in court to support her allegations, although she claimed that they were '*true'*. This ended any prospect of a successful criminal prosecution and inevitably meant that the father would be released soon. A delay in advising the social worker mean that the child protection core group meeting was not appraised of this development; the social worker subsequently noted that a legal planning meeting would be convened.

97. This social worker then left the authority; he wrote a brief transfer summary on the case, advised the lawyer that a legal planning meeting would be needed and made one final visit to the family. The father was released from prison on 29 September and the assistant team manager was made aware of this. Child T's mother subsequently stated that the

father stayed with the family on his release from prison. Social care had no knowledge of this.

98. Despite previous discussion about the high level of risk that would be posed by the release of father there are no significant entries in the social care records between 30 September and 5 October when the newly allocated social worker began work on the case. According to the agency management review she received no proper briefing from the team manager who was responsible for supervising her.

99. On 15 October the social worker attempted an unannounced visit and reminded the lawyer of the need for a further legal planning meeting. This was more than two weeks after the father's release from prison and four weeks after the former social worker had been told about the likely release. She made a further visit on the following day when she had a hostile reception and met the children although like the previous social worker she was not allowed to see them alone.

100. Subsequently, the mother called the police complaining about the father phoning her and repeatedly banging on the door. When arrested, he confirmed that he had done this and claimed that he had lived with the family between 29 September and 6 October. The mother again declined to provide evidence to support any charges. A further referral to the multi agency domestic violence forum (MARAC) resulted in a referral to a domestic violence advisory agency who made three unsuccessful attempts to contact her and then closed their file.

101. A legal planning meeting was held on 29 October; no one present had any long standing involvement in the case. The meeting decided to seek interim care orders on both children and to serve the mother with 'short notice' of the application. Some details of the care plan were discussed. These essentially sound decisions underestimated how complex it would be to gather and present the evidence required to initiate care proceedings. There was a substantial delay in implementing the decisions, no clear list of actions or timescale. There was no confirmation as to what

'short notice' meant. No record was made of the information required from other agencies.

102. Three weeks later the social worker provided a draft statement and care plan; the lawyer sent back the documents with amendments indicating that he was going to prepare a 'letter before action' which showed that he did not now intend to issue the proceedings as a matter of urgency or on 'short notice'.

103. The s*ocial worker too*k no further action before returning from leave in mid-December. During her absence, there were no contingency arrangements in place and managers did not track progress with the implementation of the decisions of the planning meeting. The lawyer then informed the social worker that he was reconsidering his advice and doubted if there were grounds for proceedings although continued to suggest amendments to her proposed statement and asked that she provide a series of background documents. Three weeks later, on 7 January, amended documents were returned. There is no clear account of the reasons for this delay; there was no further pressure from managers in either department for action to be taken.

104. Having sought further details from the social worker in mid January, the lawyer left the authority. His replacement soon met the social worker although her next involvement was to attend a meeting with the mother on the morning of Child T's death.

105. Following the October legal planning meeting there had been further allegations of sexual abuse which were not substantiated; they did not affect the assessment of risk to the boys, appear to have been fabricated by the mother and demonstrate that she was prepared to subject her sons to further serious emotional abuse.

106. In November 2009, mother failed a series of appointments related to the review of Child T's statement of SEN and his home education. Serious doubts were raised about whether Child T was receiving appropriate education. In early December, a report describes Child T as having little

language and simple achievements, said to be in line with the development of an average child of about two. Mother was urged to consider special secondary school options after observations confirmed that the provision being made was not suitable because Child T's complex communication and behaviour needs were not being met. Information about this negative assessment was not passed to social care staff.

107. On 5 January 2010 the social worker visited the mother who again refused to sign any child protection agreement, stated that she agreed that the children should not be allowed contact with their father and that she did not want him to be contacted or invited to future meetings. A subsequent decision by the social worker to see him and consult him led to a further deterioration in her relationship with the mother.

108. On 6 January a consultant paediatrician discharged Child T from the child development team due to non-attendance. He informed the family GP but there is no indication that other professionals were informed. The school nurse discovered this out when she contacted the clinic on 15 January; consequently, it was not discussed at the (final) core group meeting that was held on the 13 January.

109. In the three weeks prior to his brother's death Child R missed only one day of school; no specific concerns were raised about him over this period. On 20 January the children were seen by an educational psychologist during a home visit. On 21 January a social work home visit was attempted but there was no reply.

110. On 26 January the mother cancelled a pre-arranged social work home visit but the father went to the office alone to see the social worker. This was the first (and only) time that he had been interviewed alone about the children or that case records hold any substantial account of his views. He expressed dissatisfaction that he did not live with his family and had not seen them for 6-7 weeks. He said that he would like with the children and made some simple practical suggestions about ways in which the children's lives could be improved. He denied the allegations of sexual

abuse and rape. He claimed that the couple had in fact divorced 3-4 years ago but no details were given.

111. The following day the social worker visited the family; the boys were seen briefly at the door but because the social worker would not tell the mother if she had seen the father, she was refused admission to the house. The children appeared "*to be fine*"; this was the last time that the social worker saw the children before Child T was killed.

112. The next day, father and mother attended the social work office together! It is impossible to know why the mother's attitude to the father had changed. Unusually, Child T was not present; no enquiry was made as to his whereabouts. The mother was hoping to pursue various complaints against the social worker; an appointment was made for the parents to meet the team manager on 9 February.

113. Later that day, a meeting was held involving a new lawyer, the team manager and the social worker. The lawyer gave her opinion that the local authority would struggle to obtain an interim care order at the first hearing but that an application would place the case in the court arena and a refusal to cooperate would be a basis for asking for an interim care order. This was the first time that such an approach had been advocated; it is not clear why it could not have been adopted at a number of previous points in the case history, going back to 2002.

114. A "letter before action" was hand-delivered to the mother on 1 February. It stated that the local authority was '*thinking about starting care proceedings in relation to Child T*' which '*means we may apply to court and the children could be taken into care'*. It lists the local authority's concerns comprehensively, highlighting:

- concerns about domestic violence
- failure to respond to offers of help from the MARAC
- lack of open and honest engagement with professionals

- allegation of sexual abuse and the lack of care given to the children in the aftermath of this
- the impact of disputes with neighbours on the children
- allowing the father into the home and enabling other contact with him
- refusal to cooperate with the child protection plan, attend core groups or sign the child protection plan
- failure to attend all but one core group meeting since June
- removing the children from three schools
- being unable to sustain any improvement since 1999
- limiting access to the children subject to the mood of the mother
- Child T having no contact with other children and making no progress in education
- large scale unauthorised absences from school
- mother's failure to be consistent and honest when providing information

115. The mother was asked to attend a meeting to discuss this letter on 9 February, advised to seek legal advice and to bring a solicitor to the meeting.

116. On 3 February the SEN panel rejected the mother's request to cease Child T's statement of SEN statement and indicated that it would continue to monitor the provision made by the mother. This was clearly the correct decision. On 8 February a letter was sent notifying the mother of the decision and asking the mother to bring along samples of work completed by Child T to a further review. It is unlikely that this letter had been received by the mother before she killed Child T.

117. On 9 February, the mother met with the team manager and the social worker. The team manager asked the mother if she would comply with the proposed requirements of the local authority; they were all points that she had consistently refused to agree when put forward as part of previous child protection plans. The mother responded by saying that she had no intention of complying with several aspects of the proposed child

protection plan. She was told that the authority would be issuing proceedings in respect of her children with a view to them being removed from her care; she was advised to seek legal advice. When she left the meeting, she was described as 'calm', reportedly muttering under her breath that she 'would not be emotionally blackmailed', a phrase that she had often used before.

118. The mother is known to have visited a solicitor immediately after the meeting but it is not known what discussions took place. She later rang Child R's school, asking to talk to the head teacher about the meeting that she had attended at social care that day, but the head was not available.

119. The mother contacted police at around 10.30 pm that evening saying that she had made Child T drink bleach and that she was going to kill herself in the same way. Paramedics arrived to find her lying on the floor and she appeared to have been sick. Child T was unconscious and attempts to revive him at home and in the ambulance failed. He was pronounced dead at hospital. Child R was present throughout the events, though possibly in another room in the house for some of the time. He was not forced to drink bleach and suffered no physical ill effects.

120. Although mother was taken to hospital, she was later discharged into police custody. Her rapid discharge suggested that she had not consumed any significant quantity of bleach. Assessments of the mother's mental health that took place at the hospital and at the police station in the hours after the death found no evidence of mental illness and indicated that she was fit to be detained and interviewed by the police.

121. In her statements to police and in written notes addressed to a relative found in her house, the mother attributed responsibility for her actions to pressure from social services, the decision to remove the children and to the harassment from the children's father. She stated that she had planned to kill herself from the time when the local authority wrote to her at the end of January warning her of the possibility of care proceedings. She said that she had heard voices 'calling her on' to kill Child T. This was

interpreted by one of the consultant forensic psychiatrists who interviewed her in prison as evidence of '*fleeting psychotic features'* which were part of a '*depressive illness'*.

Summary of the harm suffered by Child T and Child R - Prior to the death of Child T

122. Despite his complex health needs, Child T's mother withdrew him from contact with the local Child Development Team and he was not seen there for almost seven years prior to his death. There was, therefore, no consistent oversight of his health and development and no monitoring of his progress.

123. This lack of assessment and oversight makes it impossible to say exactly what the nature of Child T's disability was. It is agreed that he suffered from a severe developmental delay and that in particular his ability to communicate and to learn were severely impaired. Beyond this it is not possible to say specifically if he suffered from autism or another disorder on the autistic spectrum.

124. In addition, whilst it was known that Child T had developmental delay and special educational needs, he was only ever allowed very limited contact with the professionals and services such as nurses, doctors and therapists that could have helped his family to maximise his potential development. The home education arrangement that she made for him was wholly inadequate.

125. As a consequence, there was no clear baseline assessment of Child T's needs, uncertainty about his potential for development and an inability to assess the extent to which his health and development was impaired by the care that he received from his mother.

126. Child R's emotional development was determined by his claustrophobic and enmeshed relationship with his mother and dominated by her need to have the support and involvement of Child R in her conflicts with professionals and others outside the family. She removed him from three schools because of her disputes with other professionals. He experienced

significant disruption to his education, missing four school terms over six years and only ever attending at a level of between 60% and 80%.

127. Both children lived very isolated lives with little of no ordinary social contact with friends, extended family and neighbours. Most ordinary social activities were denied to them.

128. Both children were raised in an atmosphere of chronic domestic abuse from the time of the mother's first pregnancy until 2002. This is likely to have had a substantial negative effect on their emotional development. When they were infants it caused injuries and placed both boys at risk of serious physical harm. The children's mother failed to take the steps required to offer protection. Domestic disputes and conflicts continued with the father and other family members during contact overseas in 2005, 2007 and 2008.

129. The children were also exposed to a high level of conflict and aggressive behaviour, involving neighbours, other members of the community and professionals, in which their mother was the main perpetrator. It was present throughout the period under review and almost always occurred in the presence of the children. Their mother was unable or unwilling to modify her actions despite being repeatedly told they were having a harmful effect on the children

130. In mid 2009 the children's mother made an allegation that Child T had been sexually abused by his father. There is no corroborating evidence to confirm that this happened. Later in 2009 Child R alleged that he had also been sexually abused by his father. This allegation bore many of the hallmarks of an allegation that a child had been encouraged to make by another adult. Again there was no supporting evidence whatsoever - both sets of allegations were strongly denied. These episodes point to the possibility of sexual abuse but are much more likely to be further evidence of emotional abuse by the mother.

131. Throughout the period under review, both children were taken on a large number of occasions to the Accident and Emergency Departments of

a number of different hospitals. With the exception of two specific injuries (in 1998 and 1999) which were known to be linked with domestic violence these hospital attendances were not in themselves individually significant. However they formed part of a pattern of unexplained minor injuries and potentially concerning presentations which may have been evidence of physical abuse or a lack of care of the children. These injuries and concerning presentations were not evaluated in detail at the time and the majority were not reported to the local authorities involved.

132. From 2000 onwards professionals expressed concern about the deteriorating mental health of the mother, although no assessment was carried out until late 2009 because she refused to have any contact with mental health professionals. The extent and nature of the harm to the children described above was probably due in good part to the deteriorating mental health of the mother though there was never any suggestion that she experienced a psychosis or was not aware of what she was doing. Beyond this it is impossible to be precise about how the mother's mental disorder impacted on her parenting of the children day to day.

Key findings of the agency management reviews and the SCR overview report and lessons for changes required in services

133. The evaluation conducted by the SCR has focused on two distinct matters: the provision of services throughout the children's lives and the specific actions of professionals in the four month period prior to the death of Child T. Given the circumstances of his death it is recognised that it is in the public interest for the agencies involved to give a full account of their actions and decisions during this period. The SCR has therefore tried to understand whether the death of Child T was predictable and whether it could have been prevented.

134. The overall review of provision during the period 1998 – 2010 has highlighted a number of shortcomings in practice which contain important lessons for professionals though they have no direct bearing on the

circumstances in which Child T was killed. Many of the themes identified were found to be significant throughout the whole period under review. Some have been addressed by subsequent changes in policy and practice. Those that remain to be addressed are the subject of recommendations, either in individual management reviews or in the SCR overview report.

135. It is clear from the narrative provided above that the children had suffered significant harm through many phases of their lives. There were missed opportunities to intervene more decisively at a number of points. In particular:

- during 1998-2002 when the children were exposed to risks arising from serious domestic violence and the mother failed to protect them
- during 2003-2008 when both children received a very limited amount of education and Child T was withdrawn from many of the health and developmental services that he needed
- from 2008 onwards when Child T was being inadequately educated at home and both children were exposed to the effects of the mother's deteriorating mental health
- from March 2009 onwards when the father returned to the UK and had a disruptive impact on the family and the care that the children received. This was particularly so at the time of his release from prison at the end of September 2009
- in October 2009 when the local authority correctly decided to seek a court order to remove the children but there were avoidable delays in implementing the decision.

136. However the nature of the circumstances in which Child T was killed by his mother could not have been anticipated by the professionals involved. There was no evidence in the case history to indicate that the mother might seriously harm or kill either child. After 2002 professionals had no evidence of physical harm or threats to the children.

137. The death of Child T would have been prevented if an application to

remove the children had been made at an earlier point and it had been granted by the court. However given the very complex nature of the case history and the nature of the evidence that was available it is far from certain that a court would have ordered the removal of the children at the first hearing. The nature of Child T's disability and the desire to improve his care and offer a stable and predictable routine would also have made it less likely that a court would have sanctioned his removal from his mother's care without a very thorough independent assessment of all the circumstances.

138. The killing of Child T was triggered at least in part by the decision of the local authority to seek to remove the children from the care of their mother. After 2002 all of the professional concerns about the children related to chronic neglect and emotional abuse. These would not have provided grounds for the local authority to seek the removal of the children in an emergency or without giving the mother notice. In these circumstances the current legal framework for the protection of children requires a 'window' between the notice of care proceedings and the removal of the children unless there was evidence of immediate risk. With the benefit of hindsight it is clear that during this period the mother might become more mentally unstable and the children would be placed at a much higher level of risk but there was no evidence of this available before the death that would have been likely to have persuaded a court to order the removal of the children in an emergency.

139. The professionals involved could not have reasonably predicted that the threat to remove the children would lead the mother to attack Child T. She had been warned about the possible removal of the children before. On previous occasions she had continued to refuse to cooperate with professionals but there had been short term improvements in the care of the children and their engagement with professionals.

140. There were many other features of the nature of the manner and circumstances of Child T's death that made it highly unusual and therefore

more difficult to predict or anticipate. The circumstances of the death did not fit a pattern of risk factors that any established approach to risk assessment would have predicted.

141. The killing of Child T occurred within 12 hours of a meeting in which the mother was told about the intention of the local authority to seek the removal of her children. It is recognised that there were some procedural shortcomings in the manner in which this meeting was conducted. However there is no reason to believe that these were decisive or that if they had been dealt with differently the actions of the mother would have been different.

142. There were a number of specific shortcomings in the assessment of the children and their family which are referred to below. In addition, there was a failure to seek background information about the parents in order to fully understand their circumstances and the impact that their formative years may have had upon them. Despite references to extended family at many points over the years, there is no evidence that contact was made with them, either as a source of information about the parents of a source of support for the children.

Recommendations 1 and 2
All member agencies of Barking and Dagenham SCB should ensure that their staff carry out and contribute to dynamic assessments of parenting capacity in which the fullest possible knowledge of parental history informs assessment of parenting along with observation of current behaviour. Supervision, training and quality assurance activities should reflect this as a priority.
When safeguarding concerns have been identified professionals carrying out and contributing to core assessments should seek out information from members of the extended family when they believe that this will assist in safeguarding a child. BDSCB should issue a practice guidance note on this. Child protection conference chairs should always consider how extended family members can contribute to the assessment and protection of children.

The overall character of professional contact with the mother – including the impact of complaints made by the mother and the response of agencies to them

143. The most significant influences on the mother's behaviour were her personality and her mental health. It is now understood that she may have a personality disorder – i.e. personality traits that amount to an enduring impairment of her ability to make and sustain normal relationships. Her aggressive and difficult behaviour led professionals in a number of different agencies to avoid challenging her which had a profound bearing on the assessment of risk to the children, the services that the children received and the overall management of the case. For example:

- Some professionals were intimidated by her hostile behaviour
- Agencies responded to repeated complaints by making concessions that were not in the interests of the children – e.g. reallocating the case or not sharing information
- Managers and supervisors in all agencies failed to recognise the impact of this behaviour and to provide adequate guidance and support to staff dealing with the mother.

144. At times throughout the case history a number of professionals in a number of agencies also showed an unjustified level of sympathy for the mother because she was perceived as a victim of abuse and isolation from her family. This led them to lose their focus on the children and to underestimate the level of risk. These factors all contributed significantly to the failure to take action much earlier to protect the children.

145. The mother faced significant adversities and practical problems in her life. The hostile behaviour that she used to keep control of discussions about her children and keep professionals at bay prevented her from receiving the sort of support that might have made it possible for her to care for her children better. The behaviour that she exhibited to family, neighbours and professionals alike left her isolated particularly when

dealing with the crisis that she faced when the local authority threatened to remove the children from her.

Recommendations 7 and 8
All member agencies of the LSCB should ensure that they have mechanisms in place whereby information about the number and nature of complaints made by an individual can be shared with staff in other member agencies of the LSCB for the purpose of protecting children.
Barking and Dagenham SCB should ensure that all managers with operational responsibility for child protection cases, all chairs of child protection conferences and all staff in specialist advisory roles in all member agencies are aware of the findings of this SCR in relation to the misuse of complaints by the mother of Child T and alert to the potential misuse of complaints as a means of diverting attention away from concerns about children.

The response of professionals to concerns about the mental health of the mother

146. Professionals in all agencies had long standing concerns about the mental health of the mother. In the overwhelming majority of instances the signs and symptoms were not linked to any obviously recognisable mental illness. No one recognised that the mother might have a personality disorder and the potential impact of this on her ability to parent the children.

147. The mother repeatedly refused requests to undergo an assessment or to let a mental health professional assess the impact of her parenting on the children. The professionals involved should have sought consultation and advice about the nature of the mother's behaviour, the likely prognosis and treatment and the likely impact on the children. A knowledgeable mental health professional is likely to have been able to recognise the nature of her problems and this would have added to the understanding of risk to the children. If it had been established that the mother had a personality disorder the risk of her mental health deteriorating when she was under a high level of stress might have been recognised. As the mother repeatedly refused consent, a psychiatric assessment could only have been ordered through initiating legal

proceedings. The local authority should have given more careful consideration to this in the legal planning meetings that took place.

148. It would be wrong to suggest that this should all have been obvious to the professionals dealing with the mother. The tentative diagnosis of the mother's mental disorder only emerged after the death of Child T once psychiatric reports had been prepared for the criminal proceedings. This was new learning for almost all of the senior managers and professional involved in the SCR. This underlines the need for all professionals working with children to become more familiar with the concept of personality disorder, to understand how it may impact on the care of children and to understand its association with other conditions such as substance misuse, other forms of mental illness and domestic violence. Supervisors in all agencies need to be able to help their staff reflect on their work in a way that allows consideration of the impact of mental health problems. Advice and consultation from those with expertise in mental illness and personality disorder needs to be made available and all professionals in the child protection network must feel able to take access such advice.

Recommendations 9 – 11
North East London Foundation Trust should consider how it can make a range of advisory and consultation services available to its own staff and to staff in other agencies with safeguarding responsibilities in order to increase their knowledge and understanding of parental mental health problems and their impact on children, including personality disorder and other less widely understood mental disorders.
The BDSCB should undertake an investigative audit of children subject to child protection plans and initial child protection conferences in order to understand how currently staff dealing with such cases access advice and expertise about the impact of parental mental health problems. The audit should make recommendations to the LSCB on further action required.
Barking and Dagenham Council Safeguarding and Rights and NELFT should develop a programme of briefings and training to ensure that all key staff with decision making responsibilities in relation to child protection have a good understanding of the characteristic presentation of personality disorder and its implications for parenting and are able to integrate this knowledge in their child protection decision making.

<u>The nature of professional dealings with the father</u>

149. Engagement of the father and assessment of his role was limited and there was no specific assessment of the risk that he presented or the protective factors and strengths that he or his extended family might have had This is a common finding in SCRs and reflects wider professional practice. In this case it was influenced by a number of specific factors:

- For long periods contact with agencies was focused exclusively on his role as a perpetrator of domestic abuse
- His use of English was limited and interpreters were not always used
- He was absent from the household for long periods
- The mother dominated contacts with professionals even when the father was on hand.

150. All professionals need to make specific efforts to identify and speak to fathers and other male carers so that the risks arising from their contribution and the resources that they have to offer are fully understood. The presence of domestic violence as a central concern in the case history increases rather than diminishes this need.

<u>Direct professional contact with the children, including attempts to establish their wishes and feelings and respond to their specific needs</u>

151. Seeing the children alone and establishing their wishes and feelings was rightly part of all of the child protection plans once the children were of an age when it could reasonably be expected. The observation of Child T and Child R established basic pointers to their needs and the risks that they faced. Beyond this only a limited amount was achieved, largely because the mother did everything that she could to limit professional access to the children and heavily influenced any comments made by Child R to professionals. There is no doubt that all professionals faced objective difficulties but there is also evidence that more could have been done. For example more was achieved when social workers visited in pairs or with another professional and this should have been attempted more often.

152. In Child T's case his disability presented additional difficulties since establishing his wishes and feelings would rely almost exclusively on detailed observation of his behaviour, development and emotional state. The recorded observations made about Child T by professionals in most agencies are very limited, stating for example that he 'was smiling', 'seemed happy' or looked 'relaxed'. No consideration was given to whether these observations might be less authentic because of Child T's communication difficulties and that it might be overoptimistic to interpret them in a way that might be legitimate for a child without Child T's disability.

153. To get to know and understand Child T would have required that a significant amount of time was spent with him which could only have been achieved through a court order requiring a specific assessment. This is another matter that the local authority should have considered more fully at legal planning meetings.

Recommendation 12
The LSCB should issue practice guidance to ensure that every core group meeting should have direct work with the child(ren) and observation of the child(ren) as a standing item on its agenda. Schools, nurseries and other bodies that are in direct regular contact with a child should be asked to prepare a report on any relevant communication with the child so that it can be incorporated in the continuing assessment. If access to children and the ability to communicate with them is being impaired or obstructed this should be discussed in the core group and reported back to the social worker's supervisor who should be expected to agree specific proposals as to how this will be addressed and to monitor their effectiveness.

<u>The role played by ethnicity, religion and immigration in the case and professional responses to these issues</u>

154. Religion, ethnicity and immigration status had a significant influence on the case history and on the care provided to the children. For example:

- The father's status as an asylum seeker impacted on his ability to work and support his family

- Cultural and religious factors may have shaped the reaction of the mother's extended family to the parents' marriage and led to the family being more isolated
- Differences in cultural norms may have contributed to the domestic abuse
- Cultural factors may have heightened the mother's mistrust of services
- The mother had some limited contact with a local Gurdwara but no significant involvement or support followed from this

155. However there is no evidence that religious or cultural concerns would have automatically influenced the mother's attitude to Child T's disability or the way in which she cared for him.

156. Professionals from a number of agencies knew about these background factors but did not consider their significance and were prevented from exploring or understanding them because the mother refused to discuss them or provide additional information.

157. On a large number of occasions the mother gave professionals 'cultural' or 'religious' explanations as to why she did not want to use a service, why she was parenting the children in a particular way or to complain about services. At times she complained that services were being 'insensitive' or that white workers did not 'understand her culture' and then withdrew from the service or demanded to have the worker changed. These complaints and comments were not valid or justified but professionals and agencies frequently failed to question or challenge these views. Overall professionals attributed too much weight to the mother's ethnicity and religion in explaining her behaviour and insufficient attention to her individual psychology and personal history. They lacked confidence in dealing with a service user from a minority ethnic group.

158. All of the local agencies with safeguarding responsibilities need to ensure that staff and managers are knowledgeable about the cultural and religious factors that can impact on service provision (e.g. research about

Asian women, mental health and domestic violence). Agencies should review the training that they provide on these matters, the availability of expert advice and how these matters are discussed in supervision. Staff need to be confident that they are able to challenge parents who raise matters of culture and religion that are not pertinent and that they can keep the focus of concern and activity on the child.

Recommendations 3 and 13

The London Safeguarding Children Board and the UK Borders Agency should establish a simple mechanism whereby accurate information about the immigration status of a child or a parent can be made available to the local authority where it is required to inform a child protection risk assessment. Details of the agreement should be circulated to all local authorities in London and the London Child Protection Procedures should be revised to integrate this when appropriate.

The LSCB and the Inter Faith Forum should work jointly to establish a network of faith-based community organisations who are linked to parenting and social work support networks and have received safeguarding training and can ensure that services are accessible to families in the Asian community and particularly to women who are experiencing difficulties in parenting as a result of domestic violence or mental health problems.

<u>The role of domestic abuse in the case and the response of professionals</u>

159. Between 1997 and 2002 the response of a number of professionals involved underestimated the risk posed to the children. Some professionals separated the impact of domestic violence from a wider assessment of the mother's parenting, which was viewed as good. This was exemplified by a number of comments made at child protection conferences. However, domestic abuse was a defining feature of the parents' relationship and its impact on the children was severe. This underestimation of risk mirrored contemporary understanding of domestic violence - the significance of domestic abuse was not properly reflected in national or local policies and procedures at that time.

160. The incidents of domestic abuse reported during 2009 added significantly to the stress on the mother, making her care of the children more chaotic. Her ambivalence towards the father failed to prioritise the needs of the children. In 2009 responsibilities for information sharing and risk assessment arrangements were clearly set out in multi-agency child protection procedures. There was a more consistent response from agencies reporting incidents to the local authority but the local authority and the multi-agency network failed to respond with sufficient vigour to the father's return and to reported incidents. There were both individual shortcomings in practice and a collective failure to appreciate the significance of events.

161. The decision to hold a child protection conference and make the children subject to a protection plan in 2009 was clearly correct. The protection plan placed its emphasis on the mother as a victim of abuse but took no account of the risk to the children arising out of her ambivalent attitude towards the father. This indicates that detailed guidance and procedure is of limited value if staff and managers are not able to appreciate the significance of incidents of domestic abuse in the context of the particular concerns in the case and do not act on them.

Recommendation 4
The Corporate Director of Adult and Community Services (Barking and Dagenham) should commission a review of domestic abuse training to ensure that it emphasises the need to support victims of domestic abuse and underlines the need to evaluate the risks posed to children by perpetrators of abuse and by non-abusive parents whose capacity to protect their children is compromised for any reason.

<u>The education of the children, the response of agencies to the children's SEN, poor school attendance and the decision of the mother to educate Child T at home</u>

162. The review has considered four aspects of service provision and decision making in relation to the education of Child T and Child R in which there are important implications for the safeguarding of the children:

- Engagement of schools and other education professionals in the child protection process.
- School attendance (see appendix X for details)
- Special educational needs (SEN) provision
- The 'home education' of Child T

163. Schools and education authorities failed to do everything in their power to encourage and enforce the attendance of both children. Social work managers stated a number of times that they viewed poor school attendance or even wholesale absence from school as being 'educational problems'. The managers making these statements did not always understand the full extent of the absences. They should have made sure that they were informed, asked social workers to challenge schools and attendance staff in both Redbridge and Barking and Dagenham to provide comprehensive information and to take more decisive action. Because of his vulnerability Child T's non-school attendance should have been addressed within a wider safeguarding framework. To treat poor school attendance as just 'an education problem' was significantly to underestimate its importance for both of the children.

164. Over a protracted period the mother preferred to seek her own school placements. She identified a number of unsuitable placements while rejecting almost every option presented to her by the local authority. At other times the mother expressed no clear preference, changed her mind with no apparent rationale and pursued different options at the same time. There were no logical or consistent reasons for her approach (other than a preference for schools outside of Barking and Dagenham). Professionals in the local authority education service tried hard to identify acceptable management solutions to the significant educational, psychological and practical needs of everyone concerned but often responded too readily to the mother's changing wishes.

165. The circumstances in which the children had been removed from schools and missed substantial periods of education were poorly

understood by the legal planning meetings held in 2007 and 2008. This led to the risk to the children and the extent of the mother's responsibility for them missing school being underestimated and a failure to take action.

166. Child T's mother was undoubtedly acting in a way that was persistently obstructive or neglectful of the SEN of her child. The SEN Code of Practice gives no guidance as to what steps schools and local authorities should do in these circumstances. The law only allows this to be dealt with under safeguarding arrangements and if necessary, ultimately through a court application under the Children Act 1989. The continuous failure of the mother to provide a suitable education for her children should have been regarded as a safeguarding issue.

167. This case points to the need for a much better mutual understanding between professionals who lead on safeguarding (predominantly but not exclusively social care staff) and professionals who work predominantly in the area of SEN. The authority's safeguarding duties and powers should have been used to add pressure to try to ensure that proper educational provision was made and that the children attended school. Children with SEN are over represented amongst children who are subject to child protection plans and looked after children. In such cases educational issues and concerns need to be a consistent part of the agenda of discussion at child protection conferences and steps to implement the plans to meet the children's SEN should be an explicit part of the protection plan and care plan.

168. Child T was home educated by his mother between July 2007 and his death some two and a half years later. There has been considerable national concern about the safeguarding implications of home education arrangements which led the previous government to commission a report by Graham Badman, published in May 2009.[3] The Badman review makes

[3] Graham Badman, *Report to the Secretary of State on the Review of Elective Home Education in England* (2009) Stationery Office.

strongly worded findings on the inconsistency between government intentions to improve the safeguarding of children and a number of weaknesses in legislation and guidance on home education. It recognises that without legislative changes children's services authorities can tighten their procedures but that no decisive change in the arrangements is possible. These findings were supported in both in a subsequent national inspection report by Ofsted and by a SCR published by Birmingham Local Safeguarding Children Board.[4] The findings of this SCR add further weight to the argument in favour of implementing the recommendations of the Badman review.

169. The home education arrangement did not in itself expose Child T to physical harm or prevent him from being 'seen' (literally) by professionals. It did contribute to the overall pattern of neglect and emotional abuse that he suffered because the quality of education and stimulation that he received at home was substantially worse than what was available in either a mainstream or a special school. The choice made by his mother compounded other safeguarding concerns; protecting Child T was made more difficult by the very limited powers of the local authority to inspect and regulate home education arrangements. This was exacerbated by the fact that education service staff who monitored his home education were not always clear how little had been achieved and did not communicate this clearly to social care colleagues. Social care professional had unrealistic expectations about what level of monitoring and inspection could be undertaken by those in education. A better understanding of the guidance about home education is required by everyone concerned with safeguarding children.

Recommendations 14 – 19
Barking and Dagenham Council should review its strategy for the provision of training to staff dealing with Special Educational Needs so as to ensure

[4] Ofsted, Local Authorities and Home Education, June 2010, The SCR panel also considered material provided by Birmingham LSCB including the published SCR overview report on Case 14, http://www.lscbbirmingham.org.uk/training-and-development/serious-case-reviews.html

that all such staff are sufficiently aware of the framework for safeguarding children and areas in which it might interface with the code of practice for SEN. Staff with responsibilities for SEN should be able to contribute fully to assessment of risk and actions
Barking and Dagenham Council should provide training and briefing to ensure that social care managers, child protection conference chairs and independent reviewing officers have a good understanding of the SEN code of practice and its implementation in the borough so that they can ensure that educational issues are fully addressed in child protection conferences and looked after children's reviews and that the interface between SEN and safeguarding is always properly addressed. Joint training and briefing of staff should be undertaken.
The Chair of BDSCB and the Director of Children's Services should bring the findings of the SCR to the attention of the Secretary of State for Education as further evidence to support the need for the implementation of the recommendations of the Badman review into the education of children otherwise than at school. This letter should be copied to the Association of Directors of Children's Services to seek their support in persuading the Secretary of State to implement those recommendations and to the LSCB Chairs in Birmingham and Doncaster who have raised similar concerns.
The Director of Children's Services should ensure that staff in the safeguarding and rights service of the local authority are sufficiently conversant with the framework for the education of children otherwise than at school to appreciate that it cannot be relied on to safeguard the welfare of vulnerable children and ensure that their education is being monitored and that in case of 'home education' that give cause for concern the need for action under safeguarding legislation should always be considered.
The Director of Children's Services should ensure that once completed the council's revised procedures for the monitoring of children educated otherwise than at school are brought to the attention of managers and staff in the safeguarding and rights service.
The chairs of LSCBs in Barking and Dagenham and Redbridge should write to all schools in their borough setting out the expectations of the LSCB in relation to the basic steps required in relation to any child who is admitted to a school who is known to be the subject of a child protection plan, including what is expected of the school and what the school should expect from children's social care services.

<u>The impact of substance misuse</u>

170. The father's heavy drinking was a factor in his domestic violence towards the mother during 1996 – 2002. Otherwise, there is no evidence that drug or alcohol misuse was a significant factor in the case history. After his return to the UK in 2009 the father claimed to no longer be drinking and there is no evidence in the case records to contradict this.

171. The father received no specific assessment or treatment for his use of alcohol prior to 2002 and it did not appear to have been discussed with him. There is now much more substantial guidance available to staff on alcohol and drug misuse and its links to domestic violence. It would now be expected that relevant specialist assessment and treatment could be accessed if indicated. This should support better practice in relation to the assessment of risk in relation to domestic violence.

<u>The response of agencies to anti-social behaviour, conflict between the mother and her neighbours and other members of the community</u>

172. Aggressive conflict between the mother and neighbours, other members of the community and other parents at her children's schools continued throughout the case history. Despite the efforts of a number of police and council officers the services designed to curtail harassment and anti-social behaviour were ineffective. Although this was not the main focus of this SCR it should be a cause for reflection and further review among those responsible for commissioning and managing such services.

173. Expectations about what should and can be done to eradicate anti-social behaviour are high. The level of resources devoted to this work was limited which must have reduced the ability of the local authority to deal with a persistent and complex case in an effective way.

174. Shortcomings were identified in the contribution that services provided to combat anti-social behaviour made to the safeguarding of the children. At times police and council staff were unduly sympathetic to the mother because of the perceived pressures of her caring responsibilities; information about anti-social behaviour was not always reported or reported in a timely fashion to child protection services because staff may not have appreciated its potential significance for the children. Attendance of housing staff and members of the anti-social behaviour team at child protection conferences and core group meetings was very poor, despite regular invitations being sent.

Recommendation 20
On completion of the SCR the Chair of BDSCB should submit a copy of the overview report in confidence to the Chair of the Borough Community Safety Partnership. The partnership should consider whether there is any further learning from the SCR in relation to local strategies to combat anti-social behaviour and provide a written account of the outcome of its discussions to the BDSCB Chair.

The role of legal planning in the case – including legal advice given on the threshold for care proceedings

175. The evaluation of the implementation by the local authority of its legal powers and duties is central to the findings of the SCR. On three occasions in 2007 and 2008 legal planning meetings were advised by the local authority's legal representatives that the threshold to initiate care proceedings and seek the removal of the children was not met. This advice shaped the subsequent thinking and actions of the local authority and other agencies in the child protection network. They believed that there was no possibility of using legal powers to protect the children and no alternative but to continue to seek the voluntary involvement of the mother even though she consistently refused to cooperate with significant aspects of the child protection plans.

176. At subsequent legal planning meetings in August and October 2009 the advice given changed reflecting changes that had taken place since the return of the father to UK and his disruptive contact with the family. In October 2009 it was advised that there were grounds for proceedings and at that point the local authority began to take action to prepare the evidence to seek an interim care order. However there were significant delays in implementing this decision.

177. Crucial information was not presented to the legal planning meetings, particularly those held in 2007. Information about health and development was barely represented at all and information about the children's education was poorly represented and interpreted. Therefore, there was a considerable difference between the understanding reached

at the meeting and the reality of the current and previous treatment of the children.

178. The principal focus of all of the discussions was on whether the threshold for legal proceedings to remove the children was met or not. Rather than consider how the welfare of the children could best be promoted through the use of a range of orders that the local authority might seek to obtain, the legal advisors who were involved during 2007-8 responded only to the narrow question of whether the court would agree to the removal of the children on an interim care order as the first step in seeking their permanent removal from the care of their mother. Regardless of whether this was considered to be the best long term care plan for the children, the legal planning meetings should have been more flexible and should have considered the full range of orders that the local authority could seek.

179. Responsibility for the shortcomings of these meetings did not rest solely with the legal advisors. It was appropriate for the lawyers to offer advice as to the threshold for proceedings and to offer tactical advice as to the steps that the local authority should take to present its case in the best way. However such meetings are chaired and led by social care professionals and it was ultimately their responsibility to determine whether the welfare of the children was being seriously jeopardised and whether or not the limited implementation of the protection plan provided adequate safeguards. At no point did any of them challenge the advice provided by the lawyers involved. A number of the staff who were involved did not feel that it was their role to question legal advice or did not feel competent to do so.

180. There is a need to clarify and strengthen accountability to ensure that the distinctive responsibility and expertise of the different professional groups who contribute to legal planning meetings is clear and that all of the issues that the meeting needs to consider are dealt with fully. This

supports the need for fuller and clearer minutes of legal planning meetings that address all of the functions of the meeting.

181. At a number of important points in the case history social care staff failed to implement the decisions of legal planning meetings, either by not acting upon them at all or by failing to keep the circumstances of the case under review. Records of legal planning meetings held in different departments lacked important detail and were sometimes inconsistent. This added to the uncertainty and delay in implementing decisions. Fuller and more formal minutes of such meetings are required and they should be agreed by all parties present before they are circulated.

182. The manner in which legal advice was obtained meant that there was little opportunity for members of other agencies to understand or question the outcomes. For example, feedback to other agencies was often given some weeks or months later. There was little connection between multi-agency child protection meetings and the process of seeking legal advice. In so far as there was discussion about the legal advice given, other agencies accepted it without question and did not see it as being their responsibility to offer any challenge. The principal responsibility to obtain and act on legal advice must remain with the local authority. However in a healthy multi-agency system other agencies must feel able to ask for a full account of the reasons for decisions taken at legal planning meetings. They should be able to comment and if necessary ask for a reconsideration of the decisions made where it is felt that they do not correspond with the best interests of the child. The LSCB and the local authority must consider how best to ensure that this can happen in future.

Recommendations 6 and 7
Barking and Dagenham Council Safeguarding and Rights Service and the council's legal practice should jointly review the training and guidance given to staff on the Public Law Outline to ensure that it takes full account of the findings of this SCR and any lessons learnt from it.
Barking and Dagenham Council should ensure that social work professionals,

managers responsible for decision making in complex child protection cases, the council's legal advisors and staff in child protection advisory roles have a shared sound framework within which to make decisions about the following:

- The level of risk to children
- The management of decisions to remove them from their parents
- The potential impact of parental flight and the tendency of families who fear the removal of their children to withdraw from all professional contact (or 'closure') when dealing with children who are believed to be at a high level of risk. The implementation of the framework should be monitored so that it can be reviewed and improved in the light of practice experience.

Recommendations 21 – 22

Barking and Dagenham Council legal services and social care services should undertake a joint review of the format for the recording of decisions and outcomes of legal planning meetings so as to ensure that the record of such meetings includes a comprehensive account of all matters falling within their remit including:

- the evidence of significant harm obtained so far across all dimensions of a child's life
- steps that need to be taken to gather more evidence of harm or improve the quality of the evidence
- the legal duties of the local authority relevant to the circumstances
- the range of legal powers that are available to the local authority and the range of orders that a court might make
- the criteria that the court will apply in considering whether to grant any of the range of orders
- the likelihood that an application will be successful and any tactical considerations in preparing evidence
- how best to present the evidence that is required by the court taking into account the range of information that is available
- the steps that should be taken if any one party disagrees with the outcome of the legal planning meeting
- the steps that will be taken by the safeguarding and rights service in the event that the accepted legal advice is that there are no grounds for proceedings

how the outcome of the legal planning meeting will be reported to other agencies and professionals involved

Barking and Dagenham Council should ensure that policy and practice in relation to all aspects of the conduct of legal planning meetings takes full account of the contribution that all agencies in the multi-agency professional network can make. In particular agencies and professionals outside of the local authority should be informed of the outcome of legal planning meetings in a timely way and given an opportunity to comment on the outcomes and the actions proposed.

<u>The role of supervision and the role of more senior managers in the case</u>

183. In attempting to safeguard the children staff in all agencies faced complex challenges and were required to make difficult decisions. There was considerable frustration about the inability to act to protect the children and different professionals had different perspectives, though these were not always apparent. Good quality of supervision should have played a critical role in helping staff to address these problems and it was a significant shortcoming that it did not do so in any of the agencies involved. Research and guidance recognises that it is inherently difficult to predict specific incidents in which children are killed or seriously harmed. However supervision is a significant protective factor. [5]

184. In a number of agencies there is no evidence of involvement of supervisors, specialist advisors or more senior managers in the case history. This applied to:

- Barking, Havering and Redbridge NHS Trust
- Barking and Dagenham Council Services dealing with housing, community care and complaints provision
- Barking and Dagenham Council legal services.
- London Probation Service
- Redbridge Council school and education services
- North West London Hospitals Trust

185. Weaknesses in supervision and management involvement were identified in a number of agencies:

- Ealing PCT
- Ealing Council (social care services)
- Barking and Dagenham Council's school and education services
- Metropolitan Police Service
- North East London Foundation NHS Trust

[5] Professor Eileen Munro, *The Munro review of Child Protection – part one a systems analysis*

186. As the agency with lead responsibility for safeguarding the children most attention must focus on supervision and management involvement in the lead agency, Barking and Dagenham Safeguarding and Rights (social care services). The SCR identified a number of serious concerns in relation to the following aspects of management and supervision:

- gaps in the supervision provided
- shortcomings in the nature and the quality of the supervision offered in relation to a number of key episodes in the case history
- a lack of consistency and coherence in the approach taken to the case by managers in the children's disability team
- evidence that the team responsible for the case functioned in a dysfunctional way and that this may have had an impact on the decision making on the case.

187. Many supervision sessions in this agency were focused exclusively on procedural matters (such as arranging and preparing reports for meetings) and there was little reference to the pressing and difficult problems that the social worker was currently facing in the case. Whilst it is right that a manager should ensure that basic procedural requirements were being met, the task of the supervisor goes far beyond this and supervision should never become 'routine'. Citing the review of findings of SCRs, the initial report of the Munro review underscores the need for '*reflective supervision where the supervisor helps the worker notice what is happening and revise their reasoning'.* This is a critical means of avoiding overoptimistic assessment and protection against the loss of focus on the needs of the child. [6]

Recommendations 23 – 30
The Director of Children's Services and the Director of Adult and Community Services (Barking and Dagenham Council) should ensure that each department or service within the council that has contact with vulnerable children and adults who may be at risk has a designated senior manager with the following responsibilities:

[6] Eileen Munro (2010) *The Munro Review of Child Protection – part one, a systems analysis, para 1.28*

• Ensuring that all staff in the service have policies, procedures and training that are fit for purpose • Ensuring that staff are able to identify vulnerable children and adults who may be at risk • Ensuring that staff are able to refer such vulnerable individuals to the appropriate body and participate in measures to safeguard them • Ensuring that staff work within effective multi-agency arrangements.
Every professional or member of staff working with children should know how to access supervision and advice in relation to the safeguarding of children. As part of their responsibility under section 11 Children Act 2004 to monitor the performance of member agencies the LSCBs in Barking and Dagenham, Ealing and Redbridge should undertake an audit of the effectiveness of arrangements for supervision and consultation with senior members of staff in relation to children's safeguarding. Member agencies and the LSCBs should take whatever steps are necessary in order to address gaps in arrangements identified.
Barking and Dagenham Council should introduce robust arrangements to ensure that all staff in the Safeguarding And Rights Service receive supervision at the levels required by the council's policies and that there are mechanisms to ensure that supervision continues to be provided when managers are absent for whatever reason. Group managers are held accountable for ensuring the provision of supervision to all staff in their services and should put in place effective arrangements for monitoring compliance.
The Safeguarding and Rights Service of Barking and Dagenham Council should undertake a review of the quality and effectiveness of supervision across all teams dealing with safeguarding cases so as to ensure that the approach taken reflects the full range of professional responsibilities of the service and not just procedural requirements.
The Safeguarding and Rights Service of Barking and Dagenham Council should ensure that Professional Development and Appraisal systems provide the monitoring and support necessary to enable team managers and deputy team managers to learn openly from errors and mistakes and to challenge the views of others (including more senior managers) over the management of cases in an open and accountable way in which the interests of the child are always the paramount consideration.
Barking and Dagenham Council should review the performance of all of the staff and managers in the service for children with disabilities who were involved in this case.
The service lead with responsibility for audit and quality assurance in the Safeguarding and Rights Service should review arrangements for case audit and feedback in the light of the findings of this SCR. There needs to be clarity about the focus of audit (i.e. whether it is on compliance with procedures or on the quality of work). Particular consideration should be given to ensuring that there is clear accountability for implementing the recommendations of audit exercises by a senior operational manager and a review of the

implementation of such recommendations after an agreed period.
Barking and Dagenham Council should undertake an audit of its conference chairing in a sample of cases in order to establish how effectively conference chairs are chairing conferences in complex cases and implementing their wider quality assurance role. Any action necessary should be taken arising from the findings of the audit.

The overall effectiveness of interagency working

188. The terms of reference asked the SCR to establish if there were family focused and 'wrap around' services for the children. The finding of the review is that there was no prospect of voluntary arrangements for coordinated provision of services because the mother sought to restrict or control the involvement of every professional with the children. Concerted attempts were made to coordinate provision through a child protection plan but even this approach proved to be ineffective.

189. In procedural terms the child protection arrangements largely worked well during the periods when the children were subject to child protection plans; judged against outcomes for the children, the arrangements had serious shortcomings. The children were discussed at 19 child protection conferences in three periods over the 11 years from September 1998 – February 2010.

190. Without exception the conferences were held within the timescales required by statutory guidance. From an administrative point of view they were well organised, they were generally well attended and the majority of professionals who attended also prepared written reports. The major exception to this was the lack of an effective input from some health professionals. Some professionals were extremely reliable in their attendance at child protection meetings. Others (e.g. housing staff and officers from the anti-social behaviour team) only attended sporadically and did not attend core groups despite regular invitations and reminders. Persistent absence was only challenged by conference chairs late in the case history. The SCR has also noted serious concerns about the non

attendance of Redbridge Primary School 2 at core group meetings. There was very uneven attendance from some health professionals - whereas health visitor and school nurses attended a very high proportion of the conferences GPs and paediatricians did not.

191. There were strengths and weaknesses in the contribution made by child protection conferences. They made child protection plans that reflected the concerns that professionals reported about the children at the time. They were largely effective in keeping the focus of concern on the children especially when, on two occasions, conferences offered an appropriate challenge to the view of local authority managers that the children no longer needed to be subject to child protection plans without objective evidence to support this. However the child protection conferences failed to recognise how little progress had been made and too often the plans made repeated those made at earlier conferences, despite the evident difficulties in making progress. In 2002 and again in 2008 the children were removed from child protection plans despite very limited evidence of progress.

192. Sometimes, conference chairs were mindful of the lack of progress in the case which should have been actively addressed in discussion with operational managers. Consideration needs to be given to strengthening the role and confidence of conference chairs so that they are able to take forward their concerns about the safeguarding of children and the management of cases. This needs to happen within the conference itself, in the lead up to the conferences and in discussion with managers afterwards.

193. Generally, core group meetings were held regularly and in keeping with the requirements of the child protection plans and the London child protection procedures. This was because the two main social workers responsible for the case were diligent in organising these meetings and because the social workers' manager made the arrangement of these meetings and circulation of minutes and decisions a priority. Where there

were gaps in the required meeting schedule they had no discernible negative impact on the outcomes for the children.

The specific contribution of health professionals

194. Health visitors, school nurses and other health professionals such as speech and language therapists shared information about needs and risks effectively. Paediatricians and GPs could have made a much more significant contribution to the understanding of risk to the children because they held a large amount of information about the children which was not shared.

195. Very few of the many referrals made by GPs to paediatricians made explicit reference to the fact that the children were or had been subject to child protection plans. No GP considered Child T's condition sufficiently concerning to engage in a concerted discussion with the mother or with other professionals about whether Child T needed to be seen at the CDT. Some GPs appear to have positively avoided attending meetings or engaging in the child protection arrangements because they feared that this would provoke complaints from the mother. Others failed to provide relevant information for conferences, even when it should have been apparent from their records (for example writing 'none' when asked for information about history of domestic violence or mental health on report formats) and not reporting injuries for which no explanation had been provided.

196. Hospital paediatricians showed very little curiosity about the pattern of referrals, appointments, unexplained injuries and concerning presentations of the children and at no point did any paediatrician or staff in A&E make a formal enquiry to the local authority or the child protection register. They were also very ill informed about the wider child protection concerns about the family. They contributed very little to the child protection network and communicated details of their involvement only to GPs. Community paediatricians at the Child Development Team (CDT) had

no involvement with the family after 2003 and their involvement and expertise was not sought, despite Child T's disability.

Disagreement and dissent between professionals

197. To a degree all of the professionals involved recognised that despite the good general level of inter-agency working and information sharing the child protection meetings were making limited progress. Social workers and their managers took the view that there was no more that could be done because of the legal advice that had been given. Staff at Redbridge Primary School 2 now state that during 2009 they experienced frustration at the child protection meetings because they seemed to revolve around her problems, resulting in a loss of focus on the children. Similar concerns apply to school nurses, particularly over complaints about the behaviour of the mother at the core group meeting in January 2009.

198. These concerns appear to have been expressed privately at the time and emails were sent to the social worker about the mother's conduct at the January 2009 child in need meeting, but there is no evidence that these concerns were brought to the attention of more senior managers in the local authority.

Recommendation 31
The LSCBs in Barking and Dagenham and in Redbridge should ensure that staff in all agencies are familiar with the sections in the London child protection procedures dealing with professional disagreement and dissent and that they are able to make use of them, if necessary seeking support from a more experienced manager or professional advisor in their agency or service who can assist in escalating concerns to the attention of more senior staff.

Lessons in relation to the safeguarding of a child with a disability

199. Research has established that disabled children are more vulnerable to all forms of abuse. [7] A number of the features identified in this wider

[7] See for example Department for Children Schools and Families (2009) *Safeguarding Disabled Children – practice guidance.* This quotes an American study which found that disabled children were 3.4 times more likely to be abused or neglected than non-disabled children, across all

research applied specifically to Child T. He was extremely socially isolated because his mother removed him from schools and other supportive service. He was unusually dependent on her sole care because she refused to allow therapists and schools to work with him to develop his self-care skills and she refused to take professional advice about how to promote his independence. Professionals very rarely challenged the mother. Child T was severely impaired in his ability to communicate, though it is not clear how far this was due to an inherent medical state and how far any condition was worsened by the way he was cared for. Schools and education professionals helped in so far as they were allowed access to Child T, but once he was educated at home no progress was made and there is evidence that his ability to communicate and care for himself deteriorated. Most professionals were aware that Child T could not communicate his experience, but this appears to have been accepted as an inevitable feature of his condition rather than being treated as an additional risk factor that strengthened the case for intervention.

Learning the lessons of the SCR and the implementation of recommendations

200. The findings of the SCR and the recommendations that flow from them have been adopted by BDSCB. They have also been discussed in detail with the two other LSCBs involved (Redbridge and Ealing). BDSCB has produced an action plan that sets out the actions needed, who is to be responsible for taking them and the timescales for completion. Many of the recommendations have already been implemented. The LSCB will oversee implementation over the coming months to ensure that lessons are learnt and practice improves. The LSCBs in Redbridge and Ealing have agreed to take on the actions required of them and to monitor the implementation of actions required of agencies in their areas.

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categories of abuse. Sullivan, P.M. and Knutson, J.F. (2000) Maltreatment and Disabilities: A Population Based Epidemiological Study. Child Abuse and Neglect, 24, pp1257-1273.

201. In all such case reviews BDSCB asks agencies to ensure that detailed feedback is given to staff and teams or establishments who were involved in this case on the findings of the review in order to ensure that all of the relevant lessons are learnt. The Executive Summary will be widely circulated to staff working with children and used as the basis for briefings and training on the findings of the case.