Joint Serious Case Review

Lewisham Safeguarding Children's Partnership
&
Harrow Safeguarding Children Board

Child LH

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Author: Jane Doherty
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1 Introduction

1.1 This Serious Case Review (SCR) was commissioned by Lewisham Safeguarding Children Board (LSCB) in conjunction with Harrow Safeguarding Children Board (HSCB) to examine and learn from the practice of the multi agency network surrounding Child LH and his family. Lewisham took the lead for the review as the incident had occurred in their borough. Representatives from Harrow Safeguarding Children Board assisted them.

1.2 Child LH (aged 4 at the time of the incident) suffered serious injuries at the hands of his maternal aunt (referred to in the report as Ms X) with whom he was placed via a Special Guardianship Order (SGO) (placed by Harrow in Lewisham). At the point the injuries were noted a child protection medical concluded that, "A great deal of force would have been used to cause this injury". Child LH's cousin (referred to as Child Y in the report), who was aged 10 at the time, confirmed that she had witnessed the incident and after being hit Child LH fell to the floor and his nose started to bleed. The cousin also gave a clear history of Child LH suffering repeated physical abuse by his aunt, at times with the use of an implement.

1.3 The child protection medical revealed 43 injuries to Child LH, consistent with non-accidental injuries. A large number of these injuries were in areas of the body where accidental injuries are not characteristically found in children i.e. the head, the abdomen, the buttocks, the thigh, behind the ear and at the back of the neck. Child LH also had what appeared to be extensive scarring to the front of his torso. When questioned by police officers he tapped his belly and said that 'aunty did it'.

1.4 As a result, Lewisham issued care proceedings on both children and a police investigation commenced in relation to the aunt. Ms X was charged with the assault of Child LH. She pleaded guilty and in August 2018 she received a 20 month prison sentence, suspended for 18 months.

2 The Serious Case Review

2.1 After the injuries to Child LH were discovered Lewisham Safeguarding Children Board and Harrow Safeguarding Children Board took the view that the criteria for a Serious Case Review had been met. This is entirely consistent with the guidance in 'Working Together to Safeguard Children'[1] (referred to in this document as Working Together) 2015. In this case, abuse of a child was either known or suspected and the child was seriously harmed: and there are concerns about how organisations or professionals worked together to safeguard the child. There was information at the outset to indicate that professionals did not always work together effectively.

[1] Working Together to Safeguard Children (Working Together) is the government's overarching guidance on safeguarding.

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2.2 Working Together (2015) Chapter 4 Para 11 states a Serious Case Review should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings

2.3 The purpose of the review is to;

- look at what happened in the case and why and what action will be taken to learn from the review findings
- identify actions that result in lasting improvements to those services working to safeguard and promote the welfare of children.
- provide a useful insight into the way organisations are working together to safeguard and protect the welfare of children.

2.4 Malcolm Ward was appointed to chair the Independent Panel. Malcolm is an Independent Social Work Consultant. He is an experienced Serious Case Review Chair and overview author with significant expertise in safeguarding, quality assurance and child protection. Jane Doherty was appointed to produce this overview report. Jane is an Independent Social Work Consultant with a considerable background in Child Protection and Quality Assurance. As an independent consultant she now specialises in multi-agency learning reviews including partnership reviews and SCRs. Jane is accredited as a reviewer using the Social Care Institute of Excellence (SCIE) Learning Together model.

2.5 The LSCB appointed a Review Panel to oversee the review. Membership is in the table below:

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Agency	Representative
Independent Chair of the Panel	Malcolm Ward
Independent Overview report author	Jane Doherty
Lewisham Council Children's Social Care	Service Manager, Quality Assurance, Children's Social Care, CYP
London Borough Lewisham Local Authority Education	Service Manager Access, Inclusion and Participation, Education Standards and Inclusion
Lewisham and Greenwich NHS Trust	Trust Lead Named Nurse Safeguarding Children and Young People
Lewisham Safeguarding Children Board	Business Manager
Metropolitan Police Service,	Lead Officer, Specialist Crime Review Group
Lewisham CCG	Consultant Community Paediatrician & Designated Doctor
Lewisham Legal services	Principal Lawyer London Borough Lewisham
Lewisham Safeguarding Children Board	Lay Member
Harrow Safeguarding Children Board	Business Manager
Children And Families Courts Advisory & Support Services – CAFCASS	Service Manager, CAFCASS
Harrow Children's Social Care (CSC)	Head of Service

2.6 As the review spanned two boroughs Harrow Safeguarding Children Board set up its own Serious Case Review Panel to oversee the scrutiny and quality of their Individual Management Report. The Panel helped to extract early learning (e.g. it instigated an immediate audit of SGOs regarding the agency checks) and monitored the progress of the SCR from a Harrow perspective. The panel in Harrow was made up of senior representatives from across the network who had had no involvement in the management of the case. Two of these panel members also sat on the Lewisham SCR Panel.

2.7 It was determined through the emerging facts in the case that the following agencies should contribute to the review. These agencies submitted Individual Management Reviews (IMR) and contributed through practitioner events and providing further documents to the reviewers.

Agency	Contribution
Primary School	IMR and chronology
Early Years' Service – Pre-school	IMR and chronology
General Practitioner (GP)	IMR and chronology
Lewisham and Greenwich NHS Trust	IMR and chronology
Lewisham Children's Social Care	IMR and chronology
Harrow Children's Social Care	IMR and chronology
London Metropolitan Police	IMR and chronology
CAFCASS	IMR and chronology

2.8 Agencies were asked to compile information and comment on their practice from 01 October 2015 to 22nd September 2017. This is the period from the initiation of care proceedings in Harrow to the date of the Interim Care Order being made in Lewisham. Significant historical information in relation to the aunt was required from Lewisham to understand the context of the events. These are outside the timescale of the Terms of Reference and so for ease of reference to the reader they are included at the beginning of the narrative summary. During the course of the review the national Disclosure and Barring Service (DBS) was also asked to provide information about its involvement.

2.9 The methodology used by Lewisham's Safeguarding Children Board in this review is a hybrid model. Each agency was asked to complete a chronology, and undertake an Independent Management Report. The reports are an opportunity for individual agencies to analyse their own practice and learn lessons both from records and practitioners who knew the family. Their analysis forms the basis of this report.

2.10 Lewisham Safeguarding Children Board hosted the review and held a series of panel meetings on behalf of both Boards. The Independent Reviewers led these and all the agencies contributed to the process of gathering and analysing the material provided. The panel considered at all stages how early learning could be shared with relevant agencies and staff and where necessary action plans were out into practice before the conclusion of the review. The recommendations and action plans will be shared with staff and implemented immediately where possible.

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2.11 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

> *'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children". (Working Together to Safeguard Children 2015, 4:7)'*

2.12 Consultation and learning events were held in Lewisham in July and December 2018 to enable those practitioners from both boroughs who worked with the family to contribute to the overall findings and lessons from the review. A separate event was held in Harrow in August 2018. It proved impossible for the practitioners from both boroughs to meet together for the initial event and so although not ideal, two events were held. For the December event however some Harrow and Lewisham practitioners were able to meet together.

2.13 The latter (December) event was held prior to the publication of the report to feedback findings from the review and to ensure views from the practitioners had been captured. Where relevant their views have been incorporated throughout the report rather than in a separate section.

3 Family Involvement

3.1 In line with expectations laid down in Working Together, consideration was given to involving the family in the review process and family members were advised that the review was underway. Ms X was informed that the Serious Case Review was being undertaken and offered a variety of options to enable her to take part. The reviewers were able to meet with her just prior to finalising the report. Child LH's mother chose to meet with the report author with the help of an intermediary. The contents of both meetings and their views are included in the report in section 8.

4 Methodology used to produce this Overview Report

4.1 This report is informed by;

- The agency chronologies, Individual Management Reports and other reports
- Background information from agencies involved in the review
- Panel discussions and analysis
- Dialogue with Individual Management Report authors
- Input from practitioners via the 'Learning and Consultation' events

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4.2 The report consists of

- A narrative summary
- Analysis of how the agencies worked together from the information provided in their Individual Management Reports
- Commentary on the family situation
- Contribution from the family
- Key themes and lessons learned
- Recommendations

4.3 The review has been conducted and written with the benefit of hindsight, which often distorts the reader's view of the predictability of events, which may not have been evident at the time. It is important to be aware as Munro (2011) states just how much hindsight distorts our judgement about the predictability of an adverse outcome. Once an outcome is known we can look back and believe we can see where practice, actions or assessments were critical in leading to that outcome. This is not necessarily the case, and information often becomes much clearer after an event has occurred. The review therefore tried to avoid this hindsight bias.

4.4 With the above in mind the review is also sensitive to pressures on agencies and the demands of the work that are sometimes overwhelming for even the most capable of workers. It is therefore important to disseminate the learning and reflect on how the lessons from this review can help support better practice, rather than apportion blame to agencies or individuals.

5 Narrative Summary of professional involvement

5.1 Family Composition (living in the SGO household in Lewisham)

Names	Age at the time of the incident	Gender	Relationship	Ethnicity
Child LH	4 years and 3 months	M	Subject	Black African/Caribbean
Child Y	10 years and 3 months	F	Subject	Black African/Caribbean
Ms X	46 Years	F	Maternal Aunt to Child LH (SGO carer), Mother to Child Y)	Black African/ Caribbean
Ms Z	22 years	F	Adult cousin (Daughter of Ms X – sometimes resident)	Black African/Caribbean

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5.2 Other significant family members (Known to Harrow Children's Social Care)

Names	Age at the time of the incident	Gender	Relationship	Ethnicity
Child 2	14 years and 5 months	M	Half sibling to Child LH	British African/Caribbean
Child 3	8 years and 3 months	F	Half sibling to Child LH	British/American African/Caribbean
Ms W	38 years	F	Mother to LH and Children 2 and 3	Black British

5.3 Each of the agencies involved in this review submitted a detailed chronology of their involvement with Child LH and other family members in the period under review. Those submissions have been co-ordinated into a combined chronology, which is summarised here. Further factual information is provided in some subsequent sections where relevant.

Summary of historical Information provided by Lewisham Social Care (NB this information that was not known to Harrow)

5.4 Lewisham Children's Social Care became involved with Ms X's family in 2008 when her daughter, Ms Z made allegations of physical assault by her mother. Ms Z was 13 years old at this time. She alleged that she was hit on a regular basis, including with an implement and reported that she often had to shield her face to defend herself. On this occasion she stated that she had been hit in the face with a broomstick. The injuries were still visible when the Social Worker interviewed her. She also related that Child Y got similar treatment (NB: Child Y would have been about 16 months old at this time).

5.5 Ms X was interviewed by a social worker. She considered that her behaviour was reasonable in the circumstances and subsequently demanded that Ms Z leave her house. She did leave but returned after a short time. The social worker concluded that although the threshold for an Initial Child Protection Conference had been met, she thought this would be 'counter productive' for this family. A Child and Adolescent Mental Health Service (CAMHS) referral was made but the family never attended. No further concerns arose during this time and school reported very positively about Ms Z. In view of this the case was closed in April 2009 having been open for 6 months.

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5.6 A month later Lewisham CSC received another referral. It would appear that Ms Z had had a panic attack and collapsed not far from her home. Ms X was alerted and a passer by witnessed her 'dragging Ms Z back home'. Ms X assaulted the passer by when she tried to intervene. She also assaulted the police officer in attendance and Ms Z's friend. It was noted that she had Child Y (who would have been 23 months old) in her arms. Both Ms Z and Child Y were taken into Police Protection[2] and placed in foster care overnight. They returned home shortly afterwards.

5.7 In relation to this incident Ms X was charged with racially aggravated assault, Actual Bodily Harm and a racially aggravated public order offence. The case was however dismissed in September of 2009, as the police offered no evidence.

5.8 Lewisham Children's Social Care initiated Child Protection enquiries[3] and a core assessment was undertaken. This concluded that the children were not thought to be at risk of significant harm. The case was closed to Lewisham CSC with a recommendation that Ms Z should receive some counselling.

5.9 In August 2009 (3 months later) Lewisham received notification from the police that they had been called to the home of Ms X, because a neighbour had seen Ms Z collapsed on the floor outside their home. She had jumped from the window of her home, approximately 10 feet up, because her mother had locked her in. Ms Z was taken to hospital and her father agreed to collect her. It would appear that Ms Z went to live with her father after this incident. No further action was taken from Lewisham CSC once advice had been given re the father taking over care of Ms Z.

5.10 There was no further contact until 2011 when Ms Z was allegedly 'thrown out' of home by Ms X. She returned home after some negotiations.

5.11 A year later in 2012 Ms Z again made allegations of physical assault reporting to a Social Worker that she and her mother had argued and Ms X had punched her on the nose making it bleed. The information about these allegations was not shared with the police because Ms Z did not want to speak to them. Ms Z subsequently went missing from her home and went to stay with friends. It would seem that she returned home when Ms X reported her missing some three weeks later.

[2] Police Powers of Protection (s46 Children Act 1989) can be invoked by any police officer who has the power to remove a child to suitable accommodation, where they have reasonable cause to believe the child would otherwise be likely to suffer significant harm.

[3] Where a child is suspected to be suffering, or likely to suffer, significant harm, the local authority is required by s47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.

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Practice Learning Point
Although historical in the context of this Serious Case Review (2008- 2012), practice in relation to the allegations of physical assault made by Ms X's daughter over a significant period of time falls well short of expected standards. Repeated incidents were not linked together to form a more robust risk assessment which may have led to more meaningful interventions. Much of the detailed information that Ms Z disclosed to workers in Lewisham about the physical assaults and their severity was not shared with the police. *In addition the risks to a very young child (Child Y) in the midst of these incidents were not assessed.* *Ms X's children were not made subject to Child Protection Plans*

Summary of professional involvement in Harrow

October 2015 – May 2016 (initiation of care proceedings leading to final hearing)

5.12 Harrow Children's Social Care issued care proceedings in relation to Child LH and his siblings. They had been on a Child Protection Plan under the category of neglect since January 2015 but the situation had not improved for the children. Areas of neglect included inappropriate supervision, very poor basic care in terms of washing, clothing and feeding and the older child taking on many of the caring tasks for the younger ones. As part of the proceedings in Harrow Ms W was diagnosed as having a Learning Disability and her IQ was well below average.

5.13 London Borough of Harrow was granted Interim Supervision Orders in respect of all three children in October 2015. The Children's Guardian supported the Local Authority's position in the children remaining at home whilst assessments were carried out. In respect of Child LH an initial viability assessment had been completed on his maternal aunt Ms X, which was positive and would now progress to a full SGO assessment.

5.14 The social worker and the early intervention support worker in Harrow continued to visit the family on a regular basis. Visits to the family were characterised by visible signs of neglect. The children's hair was unkempt and there were concerns about the hygiene in the home. These concerns did not improve throughout the life of the care proceedings and hazards presented themselves (particularly to Child LH given his age) at every visit. As the proceedings went on Ms W became more avoidant of social workers.

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5.15 The full SGO assessment of Ms X was underway in November 2015 and at this time Harrow Children Social Care received a letter from Child LH's mother re Ms X. The letter complained about Ms X as a carer and explicitly refused consent for her to be the carer for any of her children.

Practice Learning Point
The review has highlighted the lack of sufficient understanding of Ms W's learning needs which meant that she did not receive the help and support she needed to be able to play an equal part in the child protection process, care proceedings and ensuring her voice was heard. This is discussed further in s6

5.16 During the assessment by Harrow CSC, Ms X disclosed historical contact with the police and Lewisham CSC in some detail. She shared that she had been accused of Grievous Bodily Harm and racial abuse towards a neighbour. She stated that she had been going through a hard time with her older daughter, who was a rebellious teenager at the time. Ms X said that she had learned from that experience and this had influenced the way she parented her younger daughter which was now very different. She further clarified that the incident had happened around the time of her mother's death, and as she was a single carer, life was difficult. She denied having been racially abusive or assaulting the neighbour and said that it had been dismissed at court. When challenged about these incidents, both mother and daughter (Ms Z) said that they had learnt from this and things had changed. It would appear that Ms Z was not spoken to alone.

Practice Learning Point
The SGO assessment contained worrying pieces of information that were not verified or analysed sufficiently. This, and the lack of other scrutiny led to poor decision making about Child LH's placement with Ms X. This is discussed further in s6

5.17 After these conversations, and as the SGO assessment progressed, the assessing social worker expressed doubts as to Ms X's suitability to parent Child LH. Her doubts in particular related to Ms X being able to provide positive explanations to him about the reasons he could not live with his mother. Her manager shared these doubts and questioned whether the viability assessment was right to recommend a full assessment. The manager responded to the worker's concerns by going on a joint visit. At the visit she was somewhat reassured, but urged a deeper consideration of the returns of checks requested from Ms X's local authority (i.e. Lewisham)

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5.18 In due course however, the assessment was due to be filed with the court and various checks (Ofsted, Medical and personal references) came back positively. The Local Authority, School and Disclosing and Barring Service (DBS) checks were still outstanding at this time. It was noted that a discussion took place with Ms X in January 2016 about the fact that the assessment could not be finalised or a definitive recommendation made, without the final checks having been completed. The assessment was therefore filed and shared with the Children and Family Court Advisory and Support Service (CAFCASS) without a recommendation.

5.19 Other assessments including the parenting assessment of Ms W concluded that she was not able to meet with the needs of her three children. This was filed accordingly with the court as the final hearing approached.

5.20 In January 2016 the final hearing for the case to be heard was set for May. All parties agreed that the children should remain at home during this time but the concerns for them were such that they should be visited every day.

5.21 The final hearing was contested with Ms W giving evidence alongside professionals. The judge made the SGO in respect of Child LH and made orders to place the older two children with their respective fathers. In between January and the final hearing which took place at the end of May 2016, the issue of the outstanding checks on Ms X were overlooked. The DBS checks in relation to Ms X were received by Harrow a few days after the hearing and were returned clear, despite the history of police involvement, alleged violence by Ms Z and the partial disclosure of the same by Ms X.

Practice Learning Point
The issue of the outstanding checks was not addressed despite many levels of scrutiny such as case supervision, Harrow's internal Care Planning Panel or the scrutiny of the court, including the Children's Guardian and the Judge. *Lewisham Children's Social Care did not respond to Harrow's request for information and Harrow did not follow up their request, leaving a gap in the information that Ms X had partly disclosed to them.* *The Lewisham School attended by Ms X's daughter did not receive the request.* *There is a further issue in that when The Disclosure and Barring Service check was received it came back clear despite relevant police intelligence being available* *These issues are discussed further in s6*

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June 2016 – January 2017 (Child LH's placement with Ms X and support for him on a Child in Need plan and SGO regulations)

5.22 Child LH was placed with his aunt following the court hearing. In June he and his siblings were stepped down from the Child Protection Plan in Harrow due to the permanent arrangements that were now in place. Harrow practitioners erroneously thought there was a Supervision Order in place in respect of Child LH (there was not) but this is unlikely to have affected the decision to step down. An SGO support plan (ratified by the court) was in place, supplemented by Child in Need procedures to support Child LH's transition. As such the social worker in Harrow visited Child LH monthly, a contact schedule was made to promote contact with his mother and siblings, and provision was made for him to attend a Lewisham pre-school. The health visiting service in Harrow handed over to Lewisham and the family were discussed at the Lewisham health visiting service's internal safeguarding meeting. The Health visitor completed her assessment and placed them on the targeted health visiting service. This was due to past domestic violence, the recent neglect and the SGO.

Practice Learning Point
Child LH was transferred to another borough on a Special Guardianship Order, which was supported, by the SGO Support Plan and Child In Need Plan. Despite this there were no multi agency meetings to facilitate the transfer and ensure that the information about Child LH and his circumstances were passed to relevant professionals in Lewisham. The pre-school and (later) school he attended, had no knowledge of the extent of the neglect he had suffered or the meaning of a SGO. This is discussed further in s6

5.23 In July 2016 (less than two months after Child LH was placed with his aunt) Ms X emailed the social worker in Harrow, threatening to return him to their care due to what she described as 'financial issues'. She stated her family were suffering because of caring for her nephew. These issues appear to have been resolved, as this was not raised again during the time period; nonetheless this was a significant action on the part of Ms X.

5.24 Child LH appeared to have some minor speech problems that were dealt with in the first few months of his placement. Contact with his mother and siblings was regular and went well. The summer holidays were described as a good period for the family and Child LH's older sibling came to stay which both children enjoyed. There were some minor behavioural problems in pre-school that were responded to appropriately.

5.25 In view of the seemingly positive progress he was making, the SGO team in Harrow closed Child LH's case in August 2016 and the social work team followed suit in January 2017.

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Practice Learning Point
There was no provision in the SGO support plan developed by Harrow to handover to services in Lewisham or facilitate therapeutic support to any members of the household. More specifically there is no consideration in the plan about Child LH e.g. Life Story Work, to help him understand his new circumstances and support other members of the household whilst they adjusted to Child LH coming to live with them. In practice this meant that the support plan was reduced to financial payments and an annual review. More is said about this in s6.

February 2017 – September 2017 (the end of involvement from Harrow Children's Social Care)

5.26 Throughout the first half of 2017 the members of the household in Lewisham had routine contact with professionals from universal services and no major concerns were noted.

5.27 In June and July of 2017 Child LH was absent from pre-school for a number of days with no phone call from Ms X. The Pre-school contacted her and she said that her stepfather was very ill and she was finding it difficult to bring LH in. NB Ms X later stated (as part of this review) that she kept him home from pre-school in an attempt to manage his behaviour. Child LH continued to be absent and pre-school encouraged Ms X to bring him in for his last few days of term to assist the transition to primary school. She did not bring him and he missed a number of days in July including what would have been his last day. This meant that Child LH was not seen by professionals for a number of weeks, including the school summer holidays. In September 2017 the events leading to this Serious Case Review unfolded and Child LH sustained serious injuries. Ms X presented with Child LH at the GP surgery – she admitted to having hit him and injuring his nose. She stated she could no longer cope with his behaviour and that he was 'disruptive and destructive' at home. Child LH was reported to be quiet and looked scared.

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5.28 The GP advised that Child LH be taken to Lewisham Hospital to assess his injuries. The GP also advised that Ms X make an appointment with the surgery to talk about managing her anger

Practice Learning Point
The actions of the GP were taken from a medical perspective to ensure that Child LH's injuries were treated. There was no consideration of a referral to Children's Social Care despite Ms X having admitted to hitting Child LH and the GP witnessing the extent of his injuries. In addition there was no consideration given to the welfare of other children in the household i.e. Child Y. This is discussed further in s6

5.29 Child LH was examined at Lewisham Hospital and was found to have bruising and swelling to the nose. Social Care and the police were informed at this stage.

5.30 Police spoke to Child LH at the hospital. He disclosed that he fell down and that *'aunty'* did it and pinched his arm. He showed the officers his nose which appeared swollen and grazed and tapped his belly (which had a number of scabs on it) saying 'aunty did it.' His cousin confirmed that Child LH was very naughty all the time and that Ms X told her that she had hit his nose and made him fall over. She said her mother 'has anger issues' and 'slaps their bums and bellies' if they are naughty. NB The following day Ms X informed school that LH had fallen in the garden and grazed his nose.

5.31 Police and Lewisham Children's Social Care initiated joint s47 enquiries and Harrow CSC were informed. After a Legal Planning Meeting in Lewisham, care proceedings were initiated in respect of both children. The police commenced their investigation into the alleged offences against Child LH.

5.32 Child LH was placed with his adult cousin Ms Z under s20 (Children Act 1989)[4] but moved to foster care very shortly afterwards. When it came to the question of where Child LH and Child Y should stay in the immediate future, there were disagreements between Lewisham CSC and Police re appropriate orders, with the police resisting CSC's requests to exercise their Powers of Protection.

5.33 At the time of writing the report the children were placed separately. The police investigation had concluded and Ms X was sentenced as stated in the introduction (paragraph 1.4).

[4] Section 20 of the Children Act 1989 allows children to accommodated by the local authority with parents or carers permission

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6 Analysis of Practice

The robustness of the quality assurance measures in place to enable the successful assessment and approval of Special Guardianship carers.

6.1 The decision to assess Ms X as a prospective guardian for Child LH was taken in the context of her being a close family member. She was an aunt who was, (and always had been) known to Ms W's children for a significant period of time. She was also likely to be able to maintain links with Child LH's mother and siblings. Research tells us that the age of children being subject to SGOs is varied but there is an increase in younger children becoming subject to them. They are also playing an increasing role in the menu of permanency options available to family courts[5]

6.2 This is all in keeping with the principles behind the making of SGOs in families where children are not able to live with their parents; preference should be given to extended members of the family. Ms X had been involved in the Child Protection process in Harrow, with regard to Ms W, and attended Family Group Conferences where she offered her support. The two youngest children stayed with her for an extended period of time over the school holidays in the summer of 2015. In this respect it was entirely appropriate that she was assessed as an SGO carer for Child LH.

6.3 The initial viability assessment was completed by the allocated social worker. Within the assessment period Ms X withdrew her intention to care for the children (originally it was thought that two of the children may be placed with her) but then quickly changed her mind. This was responded to well by the social worker arranging a further visit with a manager from the Placements Team. The assessment does not contain the reasons or an analysis of Ms X's motives for wanting to withdraw or subsequently change her mind back again. It appears that on the visit she was given more information about what SGO's entailed but was still undecided at the end of that meeting. At the end of October 2015 after a period of uncertainty, she confirmed that she was willing to go ahead with the assessment but there is no clarity in terms of what her doubts were about.

[5] https://www.cfj-lancaster.org.uk/app/nuffield/files-module/local/documents/HARWIN%20main%20report%20SO%20and%20SGOs%20_%204Mar2019.pdf

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6.4 The initial viability assessment by Harrow CSC contains worrying information of Ms X's own disclosure about previous contact with social workers in Lewisham in relation to her older daughter. The assessment quotes Ms X's own words; *social workers getting involved in simple cases of discipline…. not realising the difference between discipline and abuse…. but in real cases of abuse…. children end up dead before social services make moves to remove the children".* The analysis of Ms X's attitude to, and understanding of, the role of social workers, is poor and was made without the information we now know was available in the Lewisham CSC and police records.

6.5 Ms X's description of her involvement with services was, at best, disingenuous as it contained minimal information and was not a full explanation of the involvement over several years. She did however mention that she had been 'acquitted' at court and this should have alerted practitioners and their managers that there was important information that needed to be followed up. Ms X led workers to believe that she was acquitted at court because the allegations were not true and she had been therefore found innocent. This is however untrue as the evidence was never tested at court as the police did not offer any.

6.6 In the fuller SGO assessment there is further information about the period of time Lewisham Children's Social Care were involved in the family's life and there is mention of Ms Z's allegations of physical assault. These were however minimised by both Ms Z and Ms X who gave plausible explanations as to why things had got difficult between them. They seemed able to reflect on their relationship and explain how they overcame their difficulties. The seriousness of the alleged assaults (e.g. being hit with an implement) does not come across strongly.

6.7 In the SGO assessment Ms X appeared as a capable parent. She had a good understanding of the issues of neglect in relation to her sister's care of the children and accepted that taking on Child LH would have its challenges. Practitioners and managers had doubts about Ms X's ability to present positive images and helpful explanations to Child LH about why he lived with her and not his mother. Again they were reassured by her reasonable answers about how important family contact was. These factors were (understandably) seen positively in the assessment but Ms X's disclosures of significant pieces of information that should have been subject to further scrutiny, were based largely on incomplete information. The emphasis of the report was therefore Ms X's self reported information rather than a more balanced analysis of the information. This was also true much later in the period under review when the assault came to light. The police accepted Ms X's self admission for LH's injuries and they did not carry out an examination of the home to confirm the extent of harm LH (or Child Y) may have suffered.

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6.8 Although some aspects of the assessment were of good quality, no party raised issues of potential difficulties within the assessment. This includes direct line managers, members of the Care Planning Panel or the Children's Guardian. The Care Planning Panel in Harrow is a strategic meeting to oversee the progress of proceedings. It also considers children who are in the long term care of Harrow until such a time as permanency is achieved. Children placed in SGO placements remain on the panel agenda until orders are confirmed.

6.9 At the time of this SCR there was no internal scrutiny of SGO assessments, other than the overview of the line manager to authorise and sign it off. Consequently, there was no interrogation of the information disclosed by Ms. X, and no analysis of the possible implications for the placement in Harrow. There is an opportunity in terms of learning to strengthen the role of the Care Planning Panel and for its function to include scrutiny of SGO assessments.

6.10 The missing information from Lewisham and DBS checks was acknowledged in the assessment. The SGO assessor was unable to make a final recommendation due to the missing checks (at this stage Lewisham LA, the older child's school and DBS). Harrow's legal team and the Children's Guardian should then have noted this in the lead up to presentation in court. From the information provided it is not entirely clear why the outstanding checks were overlooked but the SGO was made without the information from these and this is addressed in the next section.

6.11 In the SGO assessment Ms X's view of the historic contact with Lewisham's CSC in relation to her own children, mirrors her attitude at that time. Lewisham records (accessed after the assault and available to the panel) show that she was dismissive of how serious the allegations were. When challenged about the alleged assaults, she stated that she thought that her actions were justified because of her daughter's unreasonable behaviour.

6.12 In Lewisham the family were never taken to a Child Protection Conference so were never subject to formal Child Protection procedures in that sense. It is true that the police charged her with serious offences of assault but she was never convicted. In the latter times of involvement with Lewisham CSC, despite serious, repeated allegations of physical assault by Ms Z, they were not investigated either by CSC or the police. There were therefore, no consequences to Ms X's actions. Lewisham CSC's historical contact with Ms X did not reinforce to her that her actions were unacceptable and no work was carried out to try and change her behaviour to reduce the risks to her children. A consequence of this inaction by Lewisham was that Ms X's abusive behaviour went unchecked for many years.

6.13 In relation to the robustness of the Harrow SGO assessment, the decision of the court to allow the children to remain at home under an Interim Supervision Order meant that the proposed SGO placement for LH was not tried out during the care proceedings. This is quite an unusual circumstance and meant that the

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assessment was not able to benefit from a period of testing Ms X's actual longer term care of Child LH. As such there was no 'lead in' or much preparation time for Child LH and he was placed almost straight away after the proceedings ended.

The importance of checks to supplement the information for SGO assessments

6.14 The process of assessments for SGO carers is part of a system wide approach to ensure that the carers are suitable to care for particular children. In Harrow the initial viability assessment is completed by the allocated social worker who makes a recommendation to proceed (or not) to a fuller assessment. This assessment is then undertaken by a social worker in the Adoption Support and Kinship Team. Individual practitioners receive supervision and there is scrutiny via Harrow's Permanency Tracking Panel. In relation to care proceedings further examination is provided by the Harrow Legal Department, the Children's Guardian and ultimately the Judge.

6.15 Sufficient background checks and information about adults putting themselves forward are a vital part of the process when undertaking assessments about prospective carers. The checks provide context to the assessment being undertaken and are an opportunity to corroborate (or not) information provided by potential carers. In this case the systems by which this information should have been considered and scrutinised slipped through the net. We know from research and high profile cases[6] that in situations where recruitment processes are compromised, this is likely to lead to unsuitable placements being made.

6.16 The SGO placement was made without the information from Lewisham which under the SGO guidance should not have happened:

The 2015 ADCS/Cafcass guidance on the assessment of Special Guardians as the preferred permanence option for children in care proceedings applications states that 'No child should be placed in the care of a Special Guardian without DBS and other necessary checks being carried out'

[6] Bichard Warner Utting et al

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6.17 Harrow contacted Lewisham by email to request the check in November of 2015; the check (although acknowledged by an automated response) was not responded to by a practitioner and was not followed up by Harrow. Lewisham Children's Social Care are unable to explain how the request for information was overlooked. Practitioners and managers were unable to identify any systemic or organisational difficulties at that time which would help to explain it. Similar requests were received via the same electronic system around that time and were responded to appropriately. In view of this the panel concluded that this was likely to have been human error compounded by the lack of follow up from Harrow.

6.18 This is an important learning point, as we know from practitioners and managers that there is significant pressure on them to complete SGO assessments within a very short timescale. The timescale of 6-8 weeks is considerably shorter than assessments for potential foster carers and adopters. This necessitates practitioners to work swiftly, with little time for reflection. The average time a DBS check is returned is considerably longer than this and can take up to three months. This, coupled with an additional pressure on judges and Children's Guardians to complete care proceedings within the prescribed timescale of 26 weeks, is likely to have influenced the amount of time and analysis spent on this case. That said, the court timetable was extended for a short time to allow time for other assessments but the matter of the outstanding checks was not a feature of the extension.

6.19 It was reported in the information provided by Harrow CSC that in their practitioners' experience the courts favoured the making of special guardianship orders if possible to maintain care within the extended family. Further, courts would be prepared to make such orders not infrequently without the results of some checks being received. Although this evidence is largely anecdotal it is important feedback and worthy of further exploration as a result of this review. Harrow CSC have added a recommendation to their action plan to discuss this with the judiciary through their joint meetings with Judges.

6.20 Other opportunities to undertake or chase outstanding checks were also missed, for example;

- Child LH's social worker was advised by her manager to go to Lewisham to view the records especially after doubts were expressed about Ms X that could not be 'pinned down'. This did not happen due to time and workload pressures.

- There is no evidence that the request for information about Ms X, sent to her daughter Y's school by Harrow CSC, was ever received.

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- The SGO assessment in Harrow clearly identified the outstanding checks and despite this acknowledgement they were not chased. The information received by Harrow Children's Social Care provides an explanation in that *the system in place at the time for chasing up the outcome of check requests was somewhat convoluted and reliant on one or 2 business support staff, who were also exceptionally busy.*

- Checks with the police and the Local Authority about Ms X were not undertaken as part of the Child Protection process which began in 2015. This is despite her being part of that process and the youngest two children going to stay with her for an extended period in the summer of 2015.

- Ms X's DBS check came back clear in May 2016 a few days after the final court hearing but this did not prompt practitioners to think about the other checks and the fact that they were still outstanding. The clear DBS check and associated difficulties are explored further in the next section.

6.21 It seems that practitioners relied on the fact that there were no Child Protection Plans and no convictions and this perhaps gave false reassurances about the suitability of Ms X. Positive information such as good personal references and clear OFSTED and health assessments were given more weight and significance than the importance of obtaining the missing information. Information held by Lewisham would almost certainly have precluded Ms X from being approved as an SGO care to Child LH.

The threshold for including non conviction related information on a Disclosure and Barring Service check

6.22 The Disclosure and Barring Service (known as DBS) is the service that processes requests for checks on potential employees (or adults providing home based care such as SGO's) where they care for, work or volunteer with, children, young people and vulnerable adults. The service has been in operation since 2012 when it took over the functions previously undertaken by the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA).

6.23 The importance of including intelligence and/or so called 'soft information' on enhanced employment checks came to the fore in 2002 when a high profile criminal conviction of the murder of two school girls prompted a public enquiry conducted by Michael Bichard. The man convicted of their murder did not have criminal convictions but had had a number of allegations made about him, the sheer volume of which would have raised serious concerns about his suitability to work with vulnerable people.

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6.24 Since the report's publication in 2004 it has been widely accepted that relevant information e.g. not just criminal convictions was disclosable to potential employers and agencies assessing potential carers. In theory this is still the case and the Disclosure and Barring Service website states that;

The (DBS) certificate may also contain non-conviction information supplied by a Chief Officer, if they feel it is relevant and ought to be contained in the certificate.

6.25 The information made available to this review that was held by the police, and therefore available to the DBS, details information that may have been relevant to include on the DBS check, bearing in mind this was a potential carer for a child who had already experienced chronic neglect, and was facing a major separation from his parent. The information includes;

- A strategy discussion in 2008 between the police and Children's Social Care in relation to Ms Z's allegations of physical abuse
- Both children (Ms X's daughters) being taken into Police Protection in 2009 and Ms X's subsequent arrest and then being charged with assault and racially aggravated assault (this did not result in a conviction but is nevertheless significant)
- Ms X reporting her daughter missing in 2012 where officers investigated why she had gone missing and eventually returned her home.
- Ms X called the police in 2015 due to an argument with her then partner which was recorded as a non crime domestic.

6.26 Guidance exists in relation to what can be disclosed on an Enhanced DBS check which includes (among other things) acquittals. The guidance issued in the *Quality Assurance Framework: An Applicant's introduction to the decision making Process for Enhanced Disclosure and Barring Service Checks* issued by the Standards and Compliance unit in 2014, details the circumstances in which non conviction information can be disclosed on the certificate. The decision has to be made by The Chief Officer who has to be satisfied that the information disclosed is relevant, proportionate and consider whether or not there is evidence to believe that the information disclosed *may* be true. The burden of proof is set at a standard below that of it being true on the 'balance of probabilities'. The guidance further states that 'The Chief Officer must also establish whether or not they believe that the impact of disclosure on the private life of those concerned outweighs the potential risk to the vulnerable group from making no disclosure'.

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6.27 It would seem that using the disclosure criteria from this document some of the information in paragraph 7.19 could have been disclosed. It would have been helpful to be included, particularly the incident where Ms X was arrested and charged, as the incident had specifically included her teenage daughter and her much younger sibling.

6.28 The DBS (staff who are employed by the DBS in partnership with the Metropolitan Police Service) were consulted on this matter as part of the review process. They gave the following helpful information in relation to why the information was not disclosed.

6.29 Within the context of this application, the DBS employee reviewing the Ms X's records would not have had full access to the 'softer' information such as the strategy meeting information and missing episodes (though they do now review these records). In relation to the charges of assault and racially aggravated assault in 2009, this was considered to be 'too historical' and there were issues of 'credibility' as the alleged assault on Ms Z was not substantiated by her and there was no significant injury to the child. The racist language was not considered serious enough to warrant inclusion on the check and this was not witnessed by the police at the scene. The rationale for not including the information was reviewed by a more senior Disclosure Officer who ratified this decision.

6.30 The judgements made by staff in the DBS are very complex and as an acknowledgement of this a number of quality assurance measures are in place, including random auditing of cases, as well as the double-checking of certain disclosures by a senior officer.

6.31 As part of this consultation, the reviewers also learned that the staff in this unit process approximately 300,000 checks per annum and there have been times when, because of the excessive volume, there has been a backlog. The backlog did not affect this particular application but is a systemic issue that can be a problem for them at times. Over the past ten years there have been various restrictions placed on the DBS in relation to the intelligence that is disclosed by them on checks. These have been updates in legislation and guidance that have come about partly as a result of Judicial Reviews where applicants have taken exception to information that has been disclosed. In view of this the information disclosed has to be proportionate, have due regard to the Protection of Freedoms Act 2012 and 'reasonably believed' to be relevant. (in addition see para 6.25).

6.32 The reviewers further found that DBS staff have a good understanding of 'home based care' and applied a slightly lower threshold to what was relevant to disclose if the child was going to be in situ with the adult. There are no restrictions as what can be disclosed under legislation such as the Data Protection Act of the General Data Protection Regulation (GDPR).

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6.33 It is difficult to reconcile these factors, which restrict more open and transparent sharing of information, with the protection and safety of children and vulnerable adults. The term 'No Trace' (the terminology used when a DBS is returned clear) is misleading as in actual fact its meaning is much more complex and is more akin to 'no significant trace'. The latter expression is not used, as it would imply that there is other information, which would breach confidentiality and cause an insurmountable amount of further administration for DBS staff. There are similar lessons to other SCRs here, (notably JR; SCR conducted by City and Hackney LSCB, published in 2015) where failure to disclose soft information has resulted in children being harmed.

6.34 All that said, more detailed information was contained on Lewisham CSC's records and in terms of specifics was more noteworthy in terms of questioning Ms X's suitability. The clear DBS (albeit received after the final court hearing) may also have falsely substantiated the social worker's original assessment that there was no significant external information available that would have been relevant to Ms X's suitability. There is learning for Harrow CSC to ensure that practitioners are aware of the different thresholds applied to information sharing e.g. what information can and will be shared via DBS checks, as compared with police checks through their local teams. The latter will often provide much more soft information and is always an avenue worth exploring for families where the concerns reach the threshold of child protection.

6.35 There are lessons for all agencies / practitioners about an over reliance on DBS checks which may omit significant pieces of information that would be useful to be consider in risk assessments prior to children being placed in their care. It is important to remember that whilst these restrictions prevail, the DBS is only one part of the story in terms of information to be considered.

Advocacy for parents with a learning disability

6.36 Ms W (Child LH's mother) was known to have a learning disability. This was formally assessed within the Public Law Outline (PLO)[7] in Harrow. Although her disability was assessed to be within the mild disabled range, a striking comment in the report told an additional story about how Ms W might process information. '*Ms AW struggles in comprehending new information and processing. Even though she may present as being able to understand what is being said to her she struggles in how she is able to implement or follow through tasks'.* This level of incapacity would put her at a severe disadvantage in trying to understand a Child Protection Plan or the nuances of care proceedings. It is not clear what support

[7] The Public Law Outline (PLO) sets out the duties local authorities have when thinking about taking a case to court to ask for a Care Order to take a child into care or for a Supervision Order to be made. Local authorities are obliged to set out their concerns about children and what parents can do to avoid going to court.

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was put in place to support her learning needs but through the process of gathering information for this review it would appear that there are a number of ways her opportunities were not optimised. It raises the question of how well her learning disability was understood by a range of professionals.

6.37 In Harrow the Child Protection process uses a method known as 'Signs of Safety'[8]. This is an interactive model used in child protection meetings using white boards to map strengths and risks within families. This can result in a huge amount of complex information being generated from the active discussion, particularly in a family such as this with three children with very differing needs. The information may not have been presented in this way before the meeting to a parent. Ms W would have struggled to comprehend the amount of information produced.

6.38 Practitioners in Harrow who were consulted for this review, questioned whether this was the best way to present the information to Ms W in light of her learning disability. The way it was presented may have been intimidating for her especially without any kind of intermediary or advocate. Her manner and personality may have compounded this. Practitioners described her 'as easy to work with' and agreed to do everything that was asked of her, but then was not always able to follow through. The current arrangement for advocacy in Harrow for parents with a learning disability is for an externally commissioned resource to deliver a service where required. In respect of the learning from this SCR Harrow recognised this service would have benefitted Ms W, both for the CP process and the legal proceedings.

6.39 The Signs of Safety model can be adapted for parents with learning disabilities with the use of storyboards, simple language and pictorial representations of the worries and concerns of the professionals as well as the strengths of the family. Preparation for the meeting is key, as is help during the meeting from an advocate, family member or friend to assist. This was not done for Ms W.

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[8] Signs of Safety® is a strengths-based, safety-organised approach to child protection casework developed in Western Australia

6.40 The same may have been true in the care proceedings where although her own solicitor represented Ms W, the question of her capacity to instruct was not assessed separately. Her learning needs were assessed in terms of whether she was eligible for services from Adult Social Care and her IQ assessed as very much below average intelligence. This did not lead to her legal advocate or any other parties to question her ability to take part in the proceedings on an equal footing. In terms of equal opportunities this is poor practice and leads the panel to conclude that her learning needs were not understood sufficiently. From information gleaned through this review about how Ms W functioned and research about adults with learning disabilities, a person with an IQ similar to Ms W, may well lack capacity to make key decisions or give instructions.

6.41 It is therefore significant that she did not undergo a 'capacity assessment' to determine whether or not she was able to instruct. Had such an assessment taken place she may have benefitted from the protection of the Official Solicitor and this would also have added an extra layer of scrutiny to the proceedings. It is important to note that she was allocated an intermediary through the subsequent set of care proceedings in Lewisham (in relation to Child LH after the incident) and was assisted by the same person to enable her to contribute to this process.

6.42 Ms W expressed her objection to the placement in a letter she wrote to the social worker in Harrow. In it she expressed her strong disagreement with Child LH being placed with her sister. Ms W felt Ms X was financially motivated and there had been a quarrel about Ms X allegedly saying that the children were not welcome at her house. This is somewhat borne out in the SGO assessment when Ms X expressed reservations about Child 1 coming to her house, in case she 'corrupted' Child Y.

6.43 It is significant to note that Ms W's objections were very specific and only in relation to Ms X. She loved her children dearly and her preference was that they remained with her, but she proffered no such objections to the other potential carers for her other children. Another key family member also expressed doubts about LH's placement with Ms X. There is no evidence to suggest that the objections were not taken seriously due to Ms W's learning disability, but it may have been the case that Ms W lacked capacity to follow them up due to this. She did however include her reservations in her final statement. It would seem that these objections were not treated with sufficient professional curiosity, especially given the niggling doubts held by some of the workers.

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6.44 It may also be the case that there were other gaps in the assessments conducted throughout the PLO and court process, in Harrow. Although it was clear that Ms W was unable to care for three children, her capacity to manage one child was never assessed. Given that her preferred option was that Child LH remained with her rather than go to Ms X, assistance within the court arena through the Official Solicitor or intermediary could have been explored. The outcome may have been the same but the process of Ms W having her voice heard in a more visible form would have been beneficial and more in line with the judiciary's practice in protecting adults who lack capacity[9]. She was able to give evidence at both final hearings (Harrow in relation to all three children and Lewisham in relation to Child LH), which demonstrates her strong commitment to her children.

Partnership working for children subject to Special Guardianship Orders

6.45 Child LH was placed with Ms X in Lewisham a few days after the court hearing in May 2016. The transition was well planned from a family continuity perspective – there was contact with his mother a couple of days later and a goodbye party for his sibling who was going to live abroad with her father. Contact with his mother and siblings continued throughout the review period. Arrangements had been made for Child LH to start pre-school and a Lewisham health visitor was allocated.

6.46 The SGO support plan was mainly focused on financial support and contact arrangements for the family. Discussions during the course of the assessment had been had about training for life story work for Ms X and possibly mediation for the family to improve the relationship between the two sisters. In fact neither of these two things were included in the final SGO support plan. Harrow have acknowledged that it should have been tailored more specifically to the child and carer's needs. The author and panel would concur with this view and Harrow have made provision for this to be embedded in practice.

6.47 The plan also lacked a multi agency perspective and it is pertinent to note that despite the transition taking place under the auspices of a Child In Need Plan (and Harrow practitioners believed) a Supervision Order there were no multi agency meetings to provide a Team around the Child (TAC). Given that the child was moving to a new area this is something that was overlooked and would have been beneficial to co-ordinate the work needed to support the placement. Resources within Lewisham would have been different to those available in Harrow and this would have been a good way to integrate Child LH into the borough. When the issues surrounding this SCR came to light, in consulting with practitioners, it

[9] Guidance on adults lacking capacity in family court proceedings can be found at https://www.gov.uk/government/organisations/official-solicitor-and-public-trustee

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became clear that Child LH's pre-school and subsequently school were unaware of the extent of the neglect he had suffered. It would appear that there was no official handover to services in Lewisham, though the social worker did visit Child LH in his pre-school setting.

6.48 The benefits of a TAC approach can be viewed as it being the opportunity for agencies to share information and have a more structured multi-agency response to supporting the placement. A more detailed and specific plan may have been borne out of such a process. Given the chronic neglect Child LH had suffered it should have been anticipated that he may well have some additional needs, especially whilst making the transition to his aunt's who was likely to have had a very different parenting style. Such needs, arising from long-term neglect and the separation from his mother, (his most significant attachment figure) were likely to result in emotional and behavioural difficulties for him.

6.49 The allocated health visitor in Lewisham did some good work in discussing the family at an internal safeguarding meeting and completing a comprehensive assessment. She was aware of the previous child protection plan (having spoken to the Harrow health visitor) and the subsequent care proceedings, but there was no direct consultation with the Harrow social worker so that she could assess the impact of neglect and his needs around his behaviour. It was not known to the network that Child LH was subject to a Child in Need Plan and therefore the health visitor did not seek safeguarding supervision. This may have prompted her to assess the impact of the long standing neglect in terms of Child LH's 'Adverse Childhood Experiences'[10] (in Child LH's case, early neglect) and how they may affect his development. Being separated from his mother without sufficient preparation or support is likely to have added to his distress.

6.50 Further, it came to light in the practitioner consultation events for this review that the network (school, pre-school and some health staff) in Lewisham had very little awareness of what it meant for Child LH to be subject to an SGO and how that may differ from other types of placements.

6.51 It is a familiar theme in Serious Case Reviews that those children, who move from one borough to another, do not always receive a seamless service. This is the case here and a vehicle to assist this may have been by more provision in the SGO support plan to handover to agencies in Lewisham while a Team around the Child was established. This would have supported a smoother transition between boroughs and provided clarity for the network in relation to Child LH's needs. The

[10] Adverse Childhood Experiences (ACEs) are stressful or traumatic experiences that can have a huge impact on children and young people throughout their lives. Early neglect is one such trauma

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London Child Protection Procedures[11] provide some guidance on transferring children who are subject to Child in Need plans. Section 6.3.4 states;

Although there is no formal requirement to hold a meeting to discuss the transfer of a child in need plan, it would be good practice for the receiving authority to hold such a meeting, especially where the family situation is complex or the children have previously been the subject of a protection plan.

6.52 Consideration could have been given to this but it is likely to have been overlooked in this case as the practitioners from Harrow continued to work with the family (albeit from a distance) and so were not transferring it as such. From a statutory perspective Harrow also held the case as the placing authority for the SGO so were obliged to continue to support the placement.

6.53 There is learning for the GP practice in relation to Ms X's presentation at the surgery when she disclosed her assault of Child LH, which should have resulted in an immediate referral to CSC and/or the police in relation to both children in the household. The IMR provided by the GP practice makes a recommendation in relation to this.

Child LH's lived experience

6.54 There is little doubt that Ms W loved all of her children very much, however, she was not always able to provide consistent or 'good enough' care. Caring for three children, as a single parent is a particularly hard task and Ms W felt that practitioners who worked with the family did not always acknowledge this. In the care proceedings Child LH was often portrayed as the most vulnerable due to his young age and his early experiences will have impacted on his physical and emotional development.

6.55 Child LH's earlier lived experience is well documented in the information provided by Harrow Children's Social Care. The chronology (which at times consisted of daily visits) provides a picture of a poor, and sometimes hazardous, physical environment that placed him at risk. Sadly all three children were removed from Ms W's care and assessments carried out which precipitated this concentrated on whether Ms W could care for all three children. The report has noted elsewhere that Ms W's capacity to care for one child (e.g. Child LH) was never tested and this is a missed opportunity.

[11] http://www.londoncp.co.uk/chapters/chi_fam_bound.html#cin

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6.56 Child LH's life whilst with Ms X is less well documented but from the information that is available all professionals that came into contact with him observed that he was happy and settled. It is difficult to reconcile from the observations of a seemingly contented child to just how difficult his life must have been during the months he lived with Ms X. There were some minor behaviour issues noted by professionals during this time (i.e. he bit a child at his pre-school on one occasion) but these were not thought to be out of the ordinary and were managed well to try and reinforce good behaviour.

6.57 It is not clear what Child LH understood about why he went to live with his aunt and there is no evidence provided to the review that preparatory work was undertaken with him to support his understanding of the move, which quickly followed the conclusion of the care proceedings. The final draft of the SGO support plan did not contain recommendations about Life Story Work or other therapeutic interventions (though they had been considered in Harrow's statements to court), which would have helped Child LH come to terms with his circumstances. The plan was not child centred and mainly contained details of financial support. When reviewing their own practice Harrow identified that *the post order SGO support plan could have included more specific and personalised information about services available to Ms X in respect of Child LH's needs, including specific training courses regarding life story work and the actual details of mediation support service offers as well as a list of leaflets addressing commonly arising issues.* Provision for contact with his mother and older siblings was made and those arrangements went well.

6.58 A missing link appears to be more thought about the damaging effects of LH's experience of neglect and therefore anticipating difficulties which may occur later on in Child LH's life. As we have seen, as there was no handover between boroughs and no provision in the plan to provide a Team around the Child. In addition there was no forethought for any therapeutic support for any members of the family (see next section in relation to Child Y). There is learning for Harrow CSC about how SGO placements are supported, particularly when they are in another local authority.

6.59 Consideration must also be given to Child LH as a black child and his needs arising from this. Practitioners' in Harrow retrospectively contemplated whether or not there was a bias (conscious or unconscious) towards a family placement for him due to the perceived difficulty in placing black children (particularly black boys) for adoption. During the course of this review there was also a suggestion from both the children's guardian and the social worker that Child LH's care plan was the least problematic of the three children. This may have in turn, influenced their thinking that this placement was the best option and in the course of doing so did not place the correct emphasis on ensuring that the checks were completed. These were not considered at the time and would have been worthy of discussion

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prior to submitting the SGO report and care plans to court, particularly in the context of discussing what the alternatives would be.

Child Y's lived experience

6.60 Child Y was 9 years old when Child LH came to live with her and her mother. She knew her extended family well and had had earlier periods when child LH (and his siblings) had come to live in her home. Ms X indicated that they (Child Y and Child LH) got on well and there was no rivalry between them in the way she had observed between Child Y and her older cousins. There is no assessment however, of the impact on her of having Child LH to live with them. Consideration of her position in the family and how this changed once Child LH was part of the household was not assessed. Child LH shared her bedroom and this would have had a direct impact on her life. She was not interviewed as part of the SGO assessment and this would have added an extra dimension to the assessment. It is not clear if she understood that Child LH was coming to live with them permanently. It is not clear how her wishes and feelings were taken into account in the SGO assessment.

6.61 Again, observations made of Child Y tell the story of a happy well adjusted child with some minor issues that were dealt with by school. These did not portray the extent of the emotional abuse she suffered whilst in the household witnessing the abuse of Child LH. It should be noted, however, that the extent of the abuse she witnessed did not come to light until after the critical assault on LH.

6.62 Indeed the witnessing of abuse for Child Y was long standing as her needs in relation to the early Lewisham dealings with the family were overlooked. It is possible that this was her way of life and therefore all she had known. The extent of physical abuse she may also have suffered is not known but as this was a feature of her older sister's life, and subsequently LH's. This is an area, which should have been explored further.

7 Family Contribution

Ms W

7.1 Ms W met with the report author and the Business Manager from Harrow Safeguarding Children Board. Ms W attended the meeting with an Intermediary who knew her well and was able to assist the reviewers in speaking to Ms W in a way that enabled her to contribute fully.

7.2 Ms W was happy to contribute and acknowledged that she made mistakes during the time her children were subject to the Child Protection Plan. She does not however agree that her children should have been removed and she found this

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very painful to talk about. She stated that she knew that social workers had a job to do but found the visits (that at times were daily) too much. She felt pressured by the number of visits during this time and found it stressful. There were at least two changes in social worker and these changes were hard especially on the children who became attached to them and then they would leave.

7.3 Ms W found the Family Support Worker very helpful and liked the way she spoke to her. The Family Support Worker offered practical support and was not intimidating. Ms W compared this to some social workers and said that she did not always like the way social workers spoke to her as she felt disrespected and not listened to. She stated at times 'they heard but they didn't listen'.

7.4 Child Protection Conferences were also hard as Ms W said that she felt judged and there were always lots of people. She did however also feel that she understood the plan that came out of conference as it was broken down into bullet points. Child 2's father was also there sometimes and he helped explain things to her.

7.5 Ms W said that the health visitors were very nice and polite to her and she reported that she does not think that they had any concerns about the children apart from Child LH's speech delay. One health visitor also got him into nursery, which he loved. A support worker from SSAFA (The armed forces charity) also helped with her housing needs though this has been more recently.

7.6 In relation to Child LH going to live with her sister (Ms X) she was opposed to this and talked about the letter that she had written to the social worker to state that she did not want this. The reason for this was because her sister was not very nice to her i.e. would send her horrible text messages and call her names like 'narcissist'. Ms W understood that to mean that her sister thought that she was attention seeking and only worried about herself. Ms X would also tell Ms W that her children would not like her when they are older and was generally nasty. In the end when it came to the decision the judge had to make, Ms W preferred Child LH to go to her sister because 'no one wants their child fostered or adopted'.

7.7 Ms W did not receive any help during the Harrow care proceedings and found it hard to completely understand the process. She was however able to give her instructions (i.e. she wanted the children to remain with her). It was better in the most recent (Lewisham) set of care proceedings, as an intermediary was able to help her and stood in the witness box with her. Ms W thought the judge was very kind.

7.8 Contact with Child LH was important and she saw him a lot after he moved to Ms X's. He always seemed happy and bubbly although he did sometimes get upset at the end of the contact. Ms W has found it difficult to see him recently as she finds it very painful if he gets upset.

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7.9 When Child LH was injured she heard this initially from Ms X. Ms W hadn't heard from her in a while and contacted her to see how Child LH was – Ms X rang her and told her what had happened. This was very upsetting for her. She stated that she did not hear officially what had happened until the Lewisham court hearing. She now understands that Ms X had been horrible to her own children and that this wasn't known about.

7.10 One message that she would like social workers in Harrow to have would be to treat people with respect and listen to them.

Ms X

7.11 The two lead reviewers met with Ms X just prior to the report being finalised. Ms X expressed remorse about what had happened and stated that it was never her intention to hurt to Child LH. She gave a number of reasons as to why things got out of hand.

7.12 Ms X felt that she had been honest in disclosing the information about her past contact with social workers and the police in Lewisham during the assessment in Harrow and was surprised when she found out that they had not been aware and that no information about her from Lewisham was accessed. She said that at the time it wouldn't have surprised her if the assessment had come out negatively because of these things and that she would have been fine with that. She said some members of her family (including Child LH's own mother) didn't want her to take on Child LH and so there was a lot of pressure associated with the decision.

7.13 Around the time of care proceedings and the time that Child LH was placed with her, she was distracted by a man she was in a relationship with. His behaviour became problematic and would come to her house uninvited. He sometimes came to the children's school to try and meet up with her, and this was very stressful. She acknowledges that she took her eye off the ball during this time. She did not disclose any of this to professionals though she did on one occasion call the police about him. Social workers in Harrow did speak to him as part of the assessment process.

7.14 Once Harrow CSC closed Child LH's case Ms X did not feel that she had any support. Child LH's behaviour (which had been good to start with) began to deteriorate especially after contact with his mother and when this happened she suspended the contact for a little while. Contact was difficult for Child LH and he did become upset when it was time to say goodbye. There was also contact with the other siblings to think about – one of which was in the United States so this was another thing to organise. Ms X stated that she did try and contact Harrow at this time but was not successful. She tried to manage Child LH's behaviour by talking to him and at one point she did not allow him to go to nursery but this did

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not improve the situation. She described his behaviour as destructive saying that he ruined her washing machine and tried to pull her skirting boards off. She relied on support from her friends and family at this time rather than talking to professionals. She believed that LH's mother encouraged LH to behave destructively during their contact visits.

7.15 Ms X could not recall what had been said to either her or Child LH in terms of preparation for the move but she said that she did not think it was very much. She does recall being promised respite care for Child LH but this never materialised. As Child LH's behaviour got worse she struggled to manage but not seek any help until she was at the end of her tether and had assaulted Child LH.

7.16 According to Ms X, Child Y was happy to have Child LH come to live with them and was pleased to have a 'little brother' figure. She (Ms X) was shocked to hear subsequently that Child Y's relationship with Child LH in placement was somewhat problematic and they did not remain together.

8 Lessons

8.1 There are lessons to be highlighted for all the organisations involved in this review in relation to the importance of background checks for SGO assessments. Without triangulating information provided by potential carers, the assessment lacks the essential rigour required to ensuring placements are safe and are made in the best interests of children.

8.2 Furthermore, it is important that practitioners are aware that information from a DBS check may not contain significant pieces of information that should be included in any assessment prior to placing a vulnerable child.

8.3 During the course of the review Harrow CSC have acknowledged that their SGO assessments did not receive any independent scrutiny via their care planning processes. This means that such assessments have not been scrutinised by the organisation to ensure that they are fit for purpose and this is a systemic issue that needs to be address.

8.4 The review has underlined the importance of ensuring that SGO placements are supported by a robust plan that is tailored to the individual needs of the children (including any children who are existing members of the household) and their potential carers. This is especially important when placing a child 'out of borough' so that the receiving authority and local services can step in to assist in supporting the placement.

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8.5 Children in Need are best served by a Team around the Child who can work as a team to ensure that the family are linked into to the local network of services that can help them. A formal handover between local authorities with an exchange of relevant information would be optimum practice to safeguard this and this was missing in this case.

8.6 There was a lack of understanding of the impact of chronic neglect in early childhood and therefore there was no provision made to address this once Child LH was in placement. There is learning for practitioners from both authorities in how best to identify and address this. The lack of a formal handover mentioned above meant that services in Lewisham were unaware of the extent of Child LH's needs.

8.7 The rights of parents with learning disabilities to have equal access to statutory processes such as child protection and court proceedings is essential. There are lessons for all the agencies in recognising the needs of vulnerable parents in being supported properly by advocacy or other mediums, which allow them to play as full a part as possible.

9 Recommendations

These recommendations should be considered in conjunction with agencies' own action plans which should be monitored via the respective LSCBs.

Harrow LSCB

9.1 Harrow LSCB need to assure themselves that Children's Social Care in Harrow have made provision for SGO assessments and associated support plans to be presented to the local authority permanency panel for quality assurance purposes. This will ensure that assessments have been undertaken with sufficient rigour, and that special guardianship support plans are targeted to meet the identified physical and emotional needs of the child/ren placed on a permanent basis with their guardian/s.

9.2 Harrow LSCB to ensure that practitioners across a range of agencies are aware of the needs of vulnerable adults including mental capacity assessments within statutory processes and where to access advocacy services to assist them.

9.3 In light of the above, Harrow LSCB to oversee a multi agency review of how Child Protection Conferences are convened in Harrow to ensure that they are cognisant of parents who have additional needs.

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Harrow and Lewisham LSCBs

9.4 Both Lewisham and Harrow LSCBs to review their training programs to ensure that there are briefings, information and/or training available for frontline services, including universal services such as schools and pre-school on;

- the impact of Adverse Childhood Experiences (ACE).
- The legislation governing, and the meaning of different types of placements that are open to LA's when considering the future of children who are unable to live with their birth parents

9.5 Lewisham and Harrow LSCBs should reassure themselves that when Harrow CSC are undertaking prospective SGO assessments, the needs of children already living in the household, and their wishes and feelings are fully considered

9.6 The respective LSCBs to oversee a multi agency review of current arrangements for Children In Need that are also subject to SGOs. This is to ensure that the needs of children in SGO placements are met wherever they are placed.

9.7 The respective Boards to seek assurances (with evidence) that the individual agency action plans have been completed and embedded in practice.

Lewisham SCB

9.8 Lewisham SCB may wish to seek a review of special guardianship assessment processes in the light of the lessons from this review.

9.9 Lewisham SCB to ensure that Lewisham Children's Social Care provides assurance on how it logs, tracks and meets requests for Local Authority checks on adults from other authorities; this to be with particular regard to safeguarding and family placement assessments.

Further Recommendation

9.10 The National Chiefs' Police Council, The Home Office, Department For Education and The National Child Safeguarding Review Panel should review the lessons in this SCR. This, to be undertaken in light of recommendations and actions taken as a result of the FC Review, **The sexual abuse of children in a foster home**, 2015 by City and Hackney Safeguarding Children Board[12] in relation to guidance and decisions to exclude soft information from DBS checks.

Jane Doherty
Independent Social Work consultant
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[12] http://www.chscb.org.uk/wp-content/uploads/2015/12/CDM-16569311-v1-CHSCB-Case-FC-Overview-report-FINAL.pdf

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