The Edlington Case

A Review by Lord Carlile of Berriew CBE QC

at the request of The Rt Hon Michael Gove MP, Secretary of State for Education

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Executive summary

1. On the 4 April 2009, two brothers, [J1] and [J2], aged 10 and 11, committed a very serious assault on two young victims, [V1] and [V2], in Edlington, having assaulted another young victim, [V3], the previous weekend. The perpetrators were subject to a child protection plan for physical abuse and neglect and looked after by Doncaster Metropolitan Borough Council.

2. At the time of the assaults, Doncaster Council was failing to perform adequately its statutory functions for children. It was characterised by poor performance at senior management levels, a demoralised social work profession with unacceptable churn of staff, and inadequate communications between agencies. The Serious Case Review [SCR] that was initiated by Doncaster Safeguarding Children Board after these attacks found that local agencies had failed, over a period of years, to achieve better outcomes for [J1] and [J2] and had therefore failed to prevent the assaults on [V1] and [V2].

3. At the request of the Secretary of State for Education, I have independently reviewed the issues arising from the Edlington Case[1] and the subsequent action taken and improvements made. I found that Doncaster today is not faced with the shambolic situation of early 2009. The Council now has an experienced and stable leadership team. The Doncaster Safeguarding Children Board and the Children's Board[2] have had new independent Chairs (since April and December 2009 respectively) and much more effective partnership work is now evident. I have concluded that, whilst there is a considerable way to go before Doncaster can be comparable with the best performing local authorities, there can be reasonable measure of optimism and a sense of achievable ambition.

[1] I encountered sensitivity about the term 'Edlington Case'. I acknowledge that the boys [J1] and [J2] only lived in Edlington for a very short time, having moved to respite foster care there from another part of the Doncaster area.

[2] Established under the Direction of the (then) Secretary of State in December 2009 to oversee the improvement of children's services in Doncaster.

4. However, there remain weaknesses, which have been highlighted by the consequences of a severely critical report following an Ofsted inspection in October 2012 of the arrangements in Doncaster for the protection of children[3].

5. In particular, there is more work to do to address weaknesses at middle management level, to improve consistency of standards and practice and to develop a performance culture across the service. Furthermore, the involvement and leadership from informed elected members is still not being achieved in a satisfactory or accountable way. It is clear to me that Doncaster Councillors need to have far more opportunity to understand and scrutinise children's services.

6. My review of the Edlington Case has also led me to explore a number of related issues of wider relevance for local authorities and for national policy. These include:

   a. how to make useful and identifiable improvements to the SCR process, building on the recommendations of Professor Munro's review of child protection;

   b. the appraisal of the performance of the Troubled Families Programme and its availability and effect around the country;

   c. the development of the best possible 'triage' arrangements – by which I mean a thorough assessment of a child's needs to inform a diagnosis, leading to resolution or treatment of any identified difficulties the child has;

   d. the retention of responsibility for excluded children in the hands of the excluding school; and

   e. the essential role of health services in effective safeguarding of children, including access to child and adolescent mental health services, basic medical examinations at school and school nurse provision.

7. I hope that my report presents informed and useful observations for people working in Doncaster, the Secretary of State and others. A full list of my recommendations can be found at Annex 3.

[3] *Inspection of local authority arrangements for the protection of children: Doncaster Metropolitan Borough Council*, 8-17 October 2012, Ofsted.

Introduction

8. This independent review was announced on 29 March 2012 by the Rt Hon Michael Gove MP, Secretary of State for Education. It was commissioned following the publication of the SCR overview report on the case of the 'J' children in Doncaster to review the issues and the action taken and improvements made. The review's terms of reference are set out in Annex 1. I agreed a 30 day work programme including the writing of this document. Although this was a short timescale (to which I have adhered), I hope that my report presents informed and useful observations on the evidence base I have been able to establish, including the reading of much material.

9. I acknowledge especially the enormous assistance I have received from Alison Britton, a member of the staff at the Department for Education: she has organised the process of my review, performed research, provided materials (and made no attempt to influence my views in any way). Any errors are entirely mine.

10. In conducting the review I have visited Doncaster, and held meetings there and elsewhere. I believe that I have been able to obtain the frank views of my many interlocutors, whether in Doncaster or elsewhere. I have held discussions with some senior national figures in the field of child safeguarding. I have given undertakings that I shall not identify those who have been remarkably and creditably frank with their opinions and observations. In these circumstances I shall not include a full list of all those whom I have spoken to in preparation of the review. They have included Ministers (including the Secretary of State for Education and successive Ministers for Children), the elected Mayor of Doncaster, a wide range of professional stakeholders in Doncaster, the President of the Family Division of the High Court of Justice and The Rt Hon Lord Justice McFarlane, The Rt Hon Caroline Flint MP, Louise Casey CB, Professor Eileen Munro CBE, Dame Moira Gibb DBE, the Chief Executive of Action for Children Dame Clare Tickell DBE, and the Chief Executive of Barnardo's Anne-Marie Carrey. I was especially assisted by two focus group panels of 15 service managers and front-line practitioners, with whom I engaged in a wide-ranging discussion in Doncaster on the 12 and 13 June 2012.

11. On the 4 April 2009, two brothers, [J1] and [J2] (aged 10 and 11), committed a very serious assault on two young victims, [V1] and [V2], who were left at the scene having suffered serious injuries and trauma. Prior to this assault they had assaulted another young victim, [V3], the previous weekend. The events under consideration became known as the Edlington Case – because they occurred on land at Edlington, near Doncaster. I have visited the scene and other local places referred to in the case.

12. On the 3 September 2009, the brothers pleaded guilty to offences of causing grievous bodily harm with intent. Their case was finally disposed of on the 22 January 2010 before Mr Justice Keith, sitting at the Sheffield Crown Court. In passing sentence he described in graphic detail what they had done to their victims. I consider that a closing extract of the Judge's remarks should be reproduced in this report so that the seriousness of the case is fully understood. He said:

> "The bottom line for the two of you is that you both pose a very high risk of harm to others. ... I've been referred to a number of previous cases ... but none of those cases share all the features which make your offences so serious, the deliberate targeting of your victims, the prolonged attacks on them amounting to torture, the fact that there were two of you and there was more than one victim, the fact that your attack on [V1] and [V2] took place so soon after your attack on [V3], the humiliating sexual acts you forced [V1] and [V2] to perform, the appalling injuries they sustained, the life threatening condition in which you left [V1] and the emotional scarring which they're going to have to live with for so long. Your crimes were truly exceptional."

13. They were sentenced to indeterminate detention for public protection, with minimum terms of five years before release could be considered[4].

14. In other parts of his sentencing remarks the Judge referred to the history of offending by the two boys. In addition to the attacks on [V1] and [V2], they were sentenced for an attack a few days earlier on [V3], another young boy whom they had beaten and humiliated. Further history included attacks on a number of teachers and pupils at the Pupil Referral Units [PRUs] attended by the boys.

[4] This does not mean that they will be released after five years: it sets the first consideration of possible release, which may be much later.

The Serious Case Review [SCR] and SCRs generally

15. At the time of the assaults, the brothers were looked after by Doncaster Local Authority under s20 of the Children Act 1989.

16. A Serious Case Review [SCR] was commissioned in May 2009 in accordance with the relevant regulations and statutory guidance. A SCR panel was convened and met for the first time on the 9 June 2009. The independent author of the SCR overview report was Peter Maddocks CQSW MA, a suitably experienced person in the area of social work and child safeguarding. He was assisted by a twelve member Case Review Panel. His report of 159 pages was produced in unredacted and unpublished form in early November 2009.

17. At the time it was not the practice to publish SCR overview reports. However, following the change of Government in 2010 the Coalition announced (on the 10 June 2010) the intention to publish the overview reports of SCRs. The executive summary of the Edlington SCR was published in January 2010, in accordance with statutory guidance in force at the time. The redacted overview report was published on the 29 March 2012. At the time of publication the Secretary of State for Education Mr Gove said:[5]

> "The redacted SCR overview report published today does not meet my expectations. It is an example of how the current model of SCRs is failing. It documents everything that happened but with insufficient analysis of why and what could have been done differently. In future we want SCRs to focus on why professionals acted the way they did, and what was getting in the way of them taking the right action at the right time....
>
> The policy of publishing SCRs is intended to explain the many difficult decisions that have to be taken on a daily basis when working with vulnerable children. It is not an easy job to predict the future, but in many cases that is what we are asking of professionals every day. I do not want these reports to be used to assign blame where terrible incidents have taken place. People working in these circumstances need to have confidence that they will be backed by their managers when they take difficult decisions with good intent and sound judgement, whatever the outcome.
>
> Publishing factual information about serious incidents helps ensure that all the lessons are learned, nationally and locally, to reduce the risk of repeating mistakes. This will not only help people working at the front line; it will also give the public greater confidence. We want an open, confident, self-regulating system where professionals are continually asking how they can improve rather than a system clouded by secrecy and fear. Where there is clear evidence of failure or incompetence, individuals and organisations need to be held to account. Where there are successes, these should be celebrated and shared."

[5] Letter from the Secretary of State for Education on the publication of the Edlington SCR.

18. The SCR overview report presented "compelling evidence about the extent to which … [the J] children suffered neglect and that different decisions could and should have been taken at several points during the extensive involvement of agencies with this family from 1995 up to April 2009 and that better outcomes could and should have been achieved for the J children." It found that it was "entirely predictable that the boys would continue to assault and cause injuries to other children (and adults) … more assertive and effective action should have been taken and as late as a week before the assaults. As such the assault on V1 and V2 was a preventable incident."

19. A little more background needs to be given about SCRs. These are undertaken by Local Safeguarding Children Boards [LSCBs] for every case where abuse or neglect is known or suspected and either:

- The/a child has died; or
- The/a child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child[6].

20. SCRs should not be confused in their purpose with, for example, inquests. The purpose of SCRs is to establish what lessons are to be learned from the case about the way in which local professionals work individually and together to safeguard and promote the welfare of children. SCRs are not inquiries into how a child died or was seriously harmed or into who was culpable. Nor are SCRs part of any disciplinary inquiry or process relating to individual practitioners.

21. In the two year period from 1 April 2009 to 31 March 2011, there were 184 serious incidents which led to SCRs[7], including the Edlington Case.

22. Until 9 June 2010, LSCBs were only required to publish anonymised executive summaries of SCRs. To improve transparency in the process, the Government amended statutory guidance so that the full anonymised overview reports, as well as executive summaries, of all SCRs initiated from 10 June 2010 onwards should be

[6] Regulation 5 of the Local Safeguarding Children Boards Regulations 2006.

[7] *New learning from serious case reviews: a two year report for 2009-2011*, University of East Anglia and University of Warwick, Research Report DFE-RR226, July 2012.

published (unless there are compelling reasons relating to the welfare of any children directly concerned in the case for this not to happen), suitably redacted and anonymised.

23. The Government has recently consulted on new statutory guidance on learning and improvement[8], including a revised approach to SCRs building on Professor Eileen Munro's Independent Review of Child Protection[9].

24. These changes are intended to bring about a greater level of transparency and accountability; and to enable professionals to understand fully what happened in each case and what needs to change in order to reduce the risk of such tragedies happening in the future. A new model of SCRs is being tested in three pilot areas – Coventry, Devon and Lancashire – and an independent evaluation of the pilots will inform the revision to statutory guidance.

Some general context

25. In December 2010 the Prime Minister The Rt Hon David Cameron MP expressed the ambition to try to turn around every troubled family in this country by the end of the present Parliament.

26. The Government's Troubled Families Agenda led to the appointment in October 2011 of Louise Casey CB as Head of the Troubled Families Programme. We met, and I have read her report '*Listening to Troubled Families*' published online on the 18 July 2012.[10] Valuable progress is being made. There is a demonstrable cost benefit in this kind of work. Figures issued by the Government in December 2010 revealed that troubled families were costing the taxpayer an estimated £9 billion annually, or £75,000 per family, of which over 85 percent was reactive spend, not spent on addressing root problems or preventing such problems from arising. One of the major components of the reactive spending was on criminal justice intervention and meeting the cost of youth crime.

[8] *Statutory Guidance on Learning and Improvement*, June 2012 (draft for consultation).

[9] *The Munro Review of Child Protection: Final Report: A Child centred system* May 2011 (Cm 8062 of 2011).

[10] *Listening to Troubled Families*.

27. The Government pledged to fund a national network of Troubled Family Co-ordinators in each upper-tier local council. These officials would:

- Operate at a senior strategic level
- Get a grip on the numbers, bringing together police, Jobcentre Plus, health organisations and schools and lever in resources locally
- Put a robust plan of action in place to deal with the families – right action at the right time for each family

28. An important part of the impact of the programme is to give councils a clear sense of which families they need to work differently with; acknowledge the extent to which current services and systems are failing these families and act accordingly; and target families with children on the edge of care.

29. The above sets out laudable aims for standards of assessment and better delivery. Put simply, as the table at Annex 2 below makes plain, much earlier intervention in the J family could have been crucially effective.

30. I trust that regular appraisal is made of the performance of the programme, and of its availability and effect around the country. **I recommend that compliance with the Troubled Families Programme should be the subject of an annual report in Doncaster and elsewhere, with a simple scoring system devised so that comparison can be made of the performance of the local authorities included.**

31. A headline conclusion that I have reached is about the importance of what I shall call 'triage'. By this I mean the resolution or treatment of a presenting problem following organised assessment and diagnosis of the material issues. Doncaster has addressed this to some extent, though there remain significant areas for improvement as identified as a result of the October 2012 Ofsted inspection.

32. I regard it as essential and **recommend that Doncaster and all local authority Children's Services should continue to develop the best possible triage arrangements. This will include fast and profoundly co-operative inter-disciplinary co-working, excellent written and electronic document trails,**

and a demonstrable ability to respond to urgent situations efficiently. In that context it is fair to observe that a sudden and unpredicted incident (wholly unrelated to my inquiry) arose on a day when I was in Doncaster, and appeared to be covered very efficiently.

33. Examples of successful triage arrangements can be found around the country – Southend was commended for its co-located family intervention team, with a successful scheme called Operation Stay Safe in which the local police play a significant part. I understand a comparable system is operated in Hertfordshire, where the Family Intervention Project is based in a police station.

34. The Munro Review[11] of May 2011 made 15 key recommendations. I applaud and need not repeat them. Many of the themes that emerge in this review are consistent with Munro, who repeatedly and rightly emphasised the paramount need for early intervention: the absence of effective early intervention is the most glaring failure demonstrated by the Edlington Case.

Child and Adolescent Mental Health Services

35. A further general issue arises from the way in which behavioural and emotional problems in children are approached and assessed in England and Wales. Child and Adolescent Mental Health Services [CAMHS] have an uneven history in this country, though considerable improvements have taken place in recent years. However, my perspective from conducting this review is that CAMHS often become engaged late or too lightly in extremely difficult cases. In comparison the American Academy of Child and Adolescent Psychiatry [AACAP] has for some years conducted AACAP's 'Campaign for America's Kids', with a significant amount of work being devoted to the diagnosis and treatment of conduct disorder[12].

36. Conduct disorder is described in the diagnostic manual ICD-10 as exhibiting some of the following (and other) behaviours:

[11] See footnote 9 above.

[12] Conduct disorder is a diagnosis described in ICD-10 (the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).

- Aggression to people and animals
- Bullying, threatening or intimidating others
- Using weapons that could cause serious physical harm (e.g. a brick)
- Physical cruelty to people or animals
- Forcing sexual activity on others

37. There can be no doubt that the J brothers exhibited some florid symptoms of conduct disorder. AACAP makes clear[13] that children exhibiting conduct disorder should receive a comprehensive evaluation by an experienced mental health professional. They advise that those who do not receive early and comprehensive treatment may develop multiple problems, including law-breaking and anti-social behaviour. Benefits can be gained from multisystemic therapy and, sometimes, medication.

38. In the Doncaster of pre-2009 the recognition of conduct disorder and the desirability of a CAMHS intervention were poorly recognised. Yet the diagnosis described is far from new[14]. Doncaster was not unique in its limited attention towards conduct disorder, and I suspect strongly that even now CAMHS intervention is regarded in many areas as a last resort for children displaying the behaviour described above and shown by the J children.

39. **I recommend that the links between children's services generally and CAMHS should be developed to achieve the best potential effect of full assessments of conduct disorder and the use of available treatment.**

40. This is consistent with the draft consultation paper 'Conduct disorders and antisocial behaviour in children and young people: recognition, intervention and management' issued in August 2012 by the National Institute for Health and Clinical Excellence [NICE] and the Social Care Institute for Excellence [SCIE]. The paper confirms that almost 40 percent of looked after children, those who have been abused and/or those on child protection/safeguarding registers have conduct disorders. It confirms too

[13] American Academy of Child and Adolescent Psychiatry guidance on conduct disorder.

[14] See, for example, 'The Violent Child: Some Patterns Emerge' by Glenn Collins: New York Times 27 September 1982.

that although various interventions have been developed across England and Wales, the uptake of those interventions, and outcomes, is variable. The draft shares my conclusion that greater collaboration across disciplines and professions will result in better access to good services.

41. What has been described to me as the 'Hackney Model' involves bringing in clinicians (for example, psychologists or others with a strong therapeutic background) into the social work team, and skilling up social workers to give them access to a wider range of interventions. This is a good example of the kind of collaboration that can bring benefit.

42. Among those who must recognise their essential role in effective safeguarding are local consultant paediatricians and general medical practitioners. I heard some misgivings about the level of involvement of doctors in Doncaster in the past, though a more encouraging level of commitment now. Simple steps can make great progress – such as doctors giving priority to attending meetings about troubled families.

The role of housing and the Youth Courts

43. Another general observation relates to housing. Information from Shelter and elsewhere shows that housing associations and local authorities provide a considerable quantity of housing. Approximately 8 million households in England live in rented accommodation. Approximately 1.7 million households live in rental housing provided by local authorities, as tenants of their council. Another 2.3 million rented homes are provided by not-for-profit housing associations. The remaining 4 million households live in private rented housing[15].

44. Housing providers carry the responsibility of maintenance of their housing stock. Their staff quickly acquire detailed knowledge of trouble spots and challenging families. Their employers have a vested interest in good order, and many are extremely effective in terms of design and remedial action. One expert described them to me as potentially an 'emergency service' in the lives of troubled families. Yet I have seen little evidence of housing providers being presumed or even recognised as a

[15] Department for Communities and Local Government housing statistics.

normal participant in assessment and triage arrangements where serious issues arise. I hope and **recommend that Ministers and local authorities will consider steps to ensure that the knowledge held by housing providers becomes a standard part of developing intelligent systems for dealing with casework and is recognised by other agencies as an important source of early warning information about families facing problems.**

45. I am concerned too about the limited role played by some Youth Offending Teams and Courts in the strategic approach to children in trouble, and especially children who abuse others. In Doncaster the Youth Court seems not to regard itself as at all involved in broader issues beyond case judgment and disposal. This is to be contrasted with the non-silo approach in, for example, Liverpool[16], where a procedure has been established to deploy key principles and joint working whenever a child abuses (in any way) other children. This is an example well worth following.

46. In addition, I retain long-held reservations as to whether the Youth Courts in England and Wales offer the most effective means of dealing with young offenders. This is beyond the scope of this review. I merely mention the relative success of the very different children's panels system used in Scotland.

[16] For example, see http://liverpoolscb.proceduresonline.com/chapters/p_ch_abuse.html.

J1 and J2's history and the adequacy of action taken

47. In the course of preparing this report I have visited Doncaster. I met a significant number of professionals and others who have been involved in the case. I am grateful for their extensive co-operation and courtesy. I have read many publications on the subject of vulnerable children and how best to confront and deal with the problems they present. I have seen numerous experts with national and even international prestige in child protection.

48. At times I have felt overwhelmed by the weight of documentation and learning given to process rather than the practical business of dealing with cases. Indeed, the subject of child protection and especially that part of it related to domestic and other violence is in my view rampant with documentation and riddled with process. There is a plethora of reports, studies and policies. Less evident are simple and straightforward processes for dealing with critical events. On numerous occasions I have asked, without necessarily eliciting a clear or useful response, what would be done today if (in any local authority area) there came to light another J family. The characteristics of the J family are easily identified and were known, especially:

- Almost certainly, more than one generation of neglect and involvement with social services
- Domestic violence
- The use of drink and/or drugs by the parents
- A large family with multiple paternity
- Poverty
- Poor health
- Inability to manage
- Difficulty and reluctance in dealing with statutory services
- Violence by one or more of the children concerned
- A poor educational record
- Exclusion from school

49. Action speaks louder than process. The lack of meaningful or timely action in this case can be discovered by looking at the timeline of significant events in the lives of [J1] and [J2]. I consider this must be set out quite fully, so that readers may understand the full picture of events as they developed. The table in Annex 2 below is required reading for a full understanding of the case. It summarises over 100 important events affecting them between May 2005 and April 2009. It is simply shocking to reflect that, over 100 events after the first, the two boys were out on the streets uncontrolled to the extent that they very nearly ended the life of a boy of their own age, in the context described by the Judge.

50. With those events in mind, including their sheer volume, it hardly requires a report like this to note with regret that the Doncaster social and other relevant services failed to co-ordinate any realistic attempt to address the problems caused by, and of course faced by, [J1] and [J2].

51. I have asked myself what would happen if today there occurred a similar case limited to the events up to (say) the middle of 2007. Can we be reassured that a comparable and equally disastrous downward spiral would not occur? How much progress has been made in Doncaster to obviate that risk? Have other local authority areas taken more effective steps? What lessons can be learned for general application to provide public confidence?

52. In asking, let alone answering, those and other relevant questions there is an inherent challenge to some long-held assumptions and principles. Those include:

- That for children to remain with a biological parent or parents is in the interests of the child
- That local authority education provision is adequate to deal with extremely challenging children
- That schools should have the discretion to exclude children, even at the primary school stage
- That children's health monitoring is sufficiently managed by the health system
- That necessary information sharing is inhibited by data protection restraints

- That removing children from home to a residential school placement should only be done as a last resort and an expensive one at that

53. **I recommend that we need to take a radical look at the way interventions are assessed and dealt with.** Some old assumptions may not be as sound as has been suggested. There has been a degree of disquiet suggested to me at the length to which the system sometimes acts to uphold a key principle in the Children Act 1989 that a child's best place is with the natural parents wherever possible. I have considered how one might address this. **For example, for cases where there have been three police reports of criminal behaviour (or comparable trigger events) on the part of a child in a given period, consideration should be given to placing the burden on the parents and the child's legal representatives in any ensuing Court proceedings to show that the child's welfare and best interests are served by leaving him/her in the family home.**

Remedial steps in Doncaster

54. There are approximately 69,100 children resident in the Doncaster area, in round figures, making up about 25 percent of the population. In December 2008, well before the Edlington Case events of April 2009, the Chief Inspector for Education, Children's Services and Skills published a performance assessment that was critical of the performance of the Doncaster Metropolitan Borough Council ['the Council'] in its children's services. This was followed by a Diagnostic Review in February 2009. The then Secretary of State for Children, Schools and Families concluded that the Council was failing to perform to an adequate standard certain statutory functions and responsibilities to children.

55. On the 12 March 2009, the then Secretary of State issued a Direction to the Council pursuant to the *Education Act 1996 section 497A (4B)* followed by a further Direction on the 14 December 2009. The Doncaster Children's Board [DCB], chaired by an independent expert Peter Kemp, was appointed. The effect was to give the Board oversight (through monitoring, advising and making recommendations) of all material direction of children's services in the Council's area. The second Direction was to be

reviewed on an annual basis and to remain in place until the Secretary of State was satisfied that the Council were performing their Children's Services functions to an adequate standard. It is still in place today. I have read all the Board Minutes from Mr Kemp's appointment, to date. This has given me a reasonable opportunity to understand its actions and their product.

56. The Doncaster Children's Trust was established in January 2010. This included representatives from the statutory and voluntary sectors, including youth representatives.

57. On the19 April 2010, an Audit Commission corporate governance report was produced on the Council. It was very unfavourable in a number of aspects of the Council's management and processes. On the 29 June 2010, the Secretary of State for Communities and Local Government gave a further Direction. Three Commissioners were appointed for a period of three years to exercise local authority functions. These included the appointment and determining the terms and conditions of employment of the head of paid service in the Council, the monitoring officer and the chief finance officer.

58. The Directions summarised above are evidence of the Slough of Despond into which Doncaster had fallen. It was characterised especially by poor performance and numerous changes at senior management levels, a demoralised social work profession with unacceptable churn of staff, and (perhaps worst) wretched communications between the various responsible agencies.

59. The Who's Who of currently relevant persons and bodies is a little complicated. It can be summarised thus:

Reporting to The Elected Mayor Peter Davies	Cabinet including Lead Member for Children's Services, Cllr Tatton-Kelly. Council Chief Executive, Jo Miller Director of Children's Services, Chris Pratt Senior management team including Vicki Lawson (Safeguarding) Mil Vasic (Commissioning) Jo Moxon (Education) Local Safeguarding Children's Board [LSCB] Independent Chair, Roger Thompson (reports direct to Director of Children's Services) LSCB members including police, health, CAFCASS[17], and voluntary sector)
Reporting to the Secretary of State for Education (via Minister for Children)	Independent Chair of the Doncaster Children's Board [DCB], Peter Kemp DCB members, including CEO and other officers of the Council, NHS, police, head teacher and some Councillors
Reporting to the Secretary of State for Communities and Local Government	Independent Commissioners Rob Sykes Jessica Crow Julie Kenny

60. On the 12 May 2011, Ofsted and the Care Quality Commission published an inspection report on safeguarding and looked after children services in Doncaster. It described safeguarding services as Grade 3 (adequate), highlighting significant progress since 2009 but considerable continuing deficiencies. The report noted robust

[17] Children and Family Court Advisory and Support Service.

improvements in staff recruitment, retention and training, founded on increased management stability and a fully qualified workforce of social workers. Among the inadequacies identified was poor documentation, following triage of any issues brought to accident and emergency hospital facilities locally. Very positive was the establishment of an effective multi-agency forum (the 'Blue Group') to assess police notifications of domestic violence incidents where children were involved, to determine whether any agency intervention was required.

61. Unfortunately, however, an unannounced Ofsted inspection between the 8 and 17 October 2012 produced a much more disappointing, even dismal outcome. The inspection was of the arrangements for protection of children. The findings in relation to the four relevant competencies were as follows:

Overall effectiveness	Inadequate
The effectiveness of the help and protection provided to children, young people, families and carers	Inadequate
The quality of practice	Inadequate
Leadership and governance	Inadequate

62. These conclusions mean that Doncaster has been found to fall below minimum requirements in every respect. To say that this is disappointing is to minimise the problem. The report[18] recommends no less than 18 areas for improvement within 6 months, 8 of them immediate. These include several aspects of what I describe as 'triage' in this report; and also the essential issue of information sharing. I have no doubt that there will be great concern and disappointment in Doncaster at this latest Ofsted assessment.

63. In relation to leadership and management, the 2011 Ofsted/CQC inspection noted clear evidence that safeguarding services had become well resourced, better managed and were delivering an improved and safe service demonstrated by improvements in the timeliness of responses to referrals, children being seen promptly, better

[18] *Inspection of local authority arrangements for the protection of children: Doncaster Metropolitan Borough Council*, 8-17 October 2012, Ofsted.

communication between agencies and assessments being completed on time. Staff morale was improving and there was increased service user and professional confidence. Nevertheless there were reservations, some of great importance. For example, a glaring shortcoming was the need to pay greater attention to ensuring that key documents were on file and case records were kept up to date: not all case plans contained full records of key decisions and actions due to difficulties with the electronic system. Healthcare provision for looked after children was found to be inadequate overall and the absence of a framework for looked after children and a designated doctor had impeded strategic development such as secure processes for healthcare planning. There was no standard approach about recording the health status of looked after children on their primary health record. Staffing within the healthcare system for looked after children was inadequate.

64. The Ofsted/CQC inspection produced recommendations focused on record keeping, health assessment, sharing information and continuing improvements in management and supervision.

65. In January 2012 the DSCB produced what was described as a Learned Lessons Review, focused on the case of the J children. So far as it went, this was realistic, with conclusions that accord with my own assessment in 2012. They recognised that concerns raised by the case were justified, not least that it was *"entirely predictable"* that the boys would continue in escalating behaviour of causing injuries to other children and adults; and that more effective and assertive action should have been taken and that as late as a week before the indicted attacks there were opportunities to do this. By 2012 the DSCB had taken or encouraged into operation considerable and material steps. These included a key Front Door Service, the Children Multi-Agency Referral and Assessment Service [CMARAS]. This produced an integrated team of social workers, police and health staff to work together. An audit programme had been put in place, but unfortunately even in January 2012, 9 of the 15 agencies in Doncaster were not fully compliant with the required standards. This deficiency requires early rectification. **I recommend that all agencies involved in child safeguarding in Doncaster be required to demonstrate compliance with at least the standards described in the Learned Lessons Review of January 2012; and that there be clear evidence of timely compliance with the**

Ofsted report following the inspection in October 2012.

66. The DSCB was praised by some of those I met for its effective leadership and development. However, the role of voluntary organisations was described as underdeveloped. In the field of child protection there is no doubt that the voluntary or third sector possesses enormous expertise, and can be deployed to great effect.

67. Despite the lack of compliance described above, a determined attempt has been made by all concerned to climb out of a situation that had deteriorated gradually over several years. Although my conclusions contain continuing criticism, I acknowledge efforts that have been made. Pushing large rocks uphill is demanding, and the metaphor is appropriate. There has been real determination, but the extremely low starting point has made the going tough, despite the presence of Intervention Commissioners and a detailed Recovery Plan. There has been proper and necessary attention to detail. The Director of Children and Young People's Service, Chris Pratt, an enormously experienced Director was appointed in 2010 to deal with the renewal of the service. He was previously Director for 10 years in Trafford, which in 2010 had been judged outstanding by Ofsted. In his report written in January 2012 to review the consequences of the Government's intervention, he described and evaluated every aspect of the service. This evaluation has contributed to progress.

68. It is worth noting the value of community policing in relation to repetitive criminal behaviour by children. I visited the Edlington Police Station. A community Sergeant there, with the help of a Police Community Support Officer, demonstrated a wealth of local knowledge founded upon considerable skill and acquired over a number of years of service in the local area. It is not the job of the police to act as social workers or co-ordinate them: however, the lack of employment churn, and the commitment of individuals, demonstrates the advantage of retaining specialist professional skills and providing for promotion and continuing professional development.

69. In Doncaster any sense of a 'children's service culture' had failed. There, and I fear in some other authorities, some of the best social workers were removed from front-line practice too quickly and transferred to middle management. Middle managers had become demoralised by apprehension that they would be blamed when things went

wrong. Generally, in Doncaster and nationally an insufficient burden was placed on parents to prove they were capable – when challenging parenting, the State always took the burden of showing the parenting to be incapable. Also, the State was too reluctant to give troubled families lessons in parenting, especially girls who had been in care and were second generation teenage mothers.

70. Whilst I make no specific recommendations arising from the previous paragraph (apart from issues concerning professional development from paragraph 136 below), I have no doubt that the arguments summarised should command attention from policy makers, academic commentators and professionals. They raise some difficult and fundamental questions, which need to be addressed in order to improve the national standard of parenting.

Problems with the Serious Case Review: lessons for future SCRs

71. I have quoted in paragraph 17 above from the Secretary of State's criticism of the SCR. It made 18 recommendations, following an exhaustive review of the facts. Failings were identified accurately, but in its 619 paragraphs it did not provide clear and generally applicable lessons for the future. A term that has been used repeatedly in my discussions, for the purposes of this report, of this and similar cases is 'triage'. In my view it would have been helpful if the report had identified or recommended a form of triage which should have been triggered once it became clear that the J children were neglected physically and emotionally, represented a serious risk to themselves and others, and that efforts to date had been entirely unsuccessful. At the latest, this point should have been reached by the middle of 2007.

72. In addition, the SCR did not examine in any depth the use or effectiveness (actual or potential) of engagements which did or might have occurred with the Youth Court or Family Courts.

73. Further, the publication of a redacted version of any SCR report that is not written with publication in mind is bound to produce an unsatisfactory outcome. In this case it contained all 619 paragraphs of the original, but with many passages blacked out. The effect of this is to give the impression of concealment, or at best to interrupt the narrative in a way that makes parts impossible to read.

74. I agree with the recommendations of the Munro Review that SCRs should move away from a focus on the specifics of the particular case to identify underlying, often local, issues that influence practice more generally. The preparation of the SCR should include the bringing together of local practitioners (and the family concerned where possible) to understand the local context, and remedy failings. I would expect the process to include consultation with the Crown Prosecution Service, in a case like this where there was a prosecution for serious offences. A prosecutor described to me graphically the impression of *"all these flags waving in the breeze and nothing being done about them. These were clearly very disturbed children and everyone knew it but nothing was achieved in a practical way"*. That observation, by someone who saw a great deal of material, might have informed the SCR.

75. I have considered how useful and identifiable improvements could be made to the SCR process. There can be no doubt that an SCR will have to delve into highly confidential material, for example health records of the individual(s) who are the principal subject of the review, or of others with whom they came into contact. For example, placing in the public domain the clinical details of a mental illness, from which there might be a full recovery, might adversely affect the individual's long-term future; or identifying whistle-blowers who revealed shortcomings might prove very damaging to them. However, there is a real need for a coherent, sequential and preferably uninterrupted narrative, for the better understanding of the case.

76. In some Courts (I would cite as an example the Special Immigration Appeals Commission [SIAC]), it has become common for two complete judgments to be issued in a single case. In the SIAC context, the closed judgment contains material concerning national security, which for a variety of reasons cannot be put into the public domain. The open judgment is unredacted, and no less a narrative than the closed, but is prepared in a form that omits the material that cannot be disclosed, which may be referred to but not detailed. Plainly the production of two versions means a greater burden on the writer. However, I am convinced that a much abbreviated version of the facts could have been devised in the Edlington Case, and that the production of an open/closed SCR need not take longer. **I recommend the production of SCRs in two forms, open and closed: the open version would be a fully informative document, without redactions.**

77. There is a genuine question as to whether SCRs should continue to be commissioned and prepared on the instructions of LSCBs. Whilst this may be a matter for further discussion, if this is to continue there should be verifiable independent scrutiny and moderation of the SCR during its preparation and before publication.

78. In that context, I consider that SCRs would benefit from some oversight or contribution of expertise in the way the Court system could or could not have been used to alleviate the problems which had arisen. In every area of the country there is at least one designated family judge, a Circuit Judge who specialises in family and children's issues. These judges are expert in their field. **I recommend that a designated family judge should be asked to participate as an adviser in every SCR.** Not only would the judge concerned be able to provide expertise as to the role of the Courts. But he/she will have experience of the production of (1) relatively concise and focused narratives of factual assertions and findings, and (2) distilled conclusions of utility for the instant case and as precedents for the future.

79. The conclusions of an SCR should form part of a gathering body of knowledge and guidance for practitioners and, where they become necessary, for other SCRs. The use of precedent is of course well established in the Courts. A clear and properly reported decision can change practise considerably. For example, decisions by the Courts on the retail labelling of goods have changed the practice of retailers. This occurs methodically because cases affecting retailers are reported formally and contained in digests of cases. I am concerned that there is no efficient digesting, let alone digestion, of SCRs. **I recommend that under the guidance of the relevant Minister there should be established a Digest of open versions of SCRs. This is likely to lead to improved and recognised formats for such reports, a reduction in their length, and a significantly increased capacity for lessons from one SCR to be learned and applied by the material statutory services in other locations.**

80. If the above recommendations are accepted and put into effect, I am confident that shared learning would be facilitated and that examples of good practice in one area would be more likely to be replicated elsewhere.

Specific and singular issues affecting Doncaster

81. I trust that it will be accepted that no political judgements are made in this section of my report: none are intended. The welfare of children is the paramount consideration underlying my comments.

82. The importance of general involvement and leadership from informed elected members cannot be over-stated. It did not occur in Doncaster before 2009, and is not being achieved now in a satisfactory or accountable way. The almost unchallenged description I have received discloses that in the period 2005-09 there was an unparalleled level of dysfunction in Doncaster. This was caused by an absence of professional leadership resulting from a series of interim Director appointments. Further, a lack of political vision for Children's Services caused by inter and intra Party conflict and the newness of the elected mayoral system provided an inadequate foundation for service management and development. The situation was compounded by high staff turnover, the unregulated and excessive use of agency staff, a breakdown of trust between partners characterised by an inadequate multi-agency safeguarding system, a lack of robust safeguarding policies and procedures to give guidance to staff, and poorly organised 'front door' and triaging arrangements which were unable to deliver even a basic assessment service.

83. The comments and conclusions in the previous paragraph are an accurate and credible summary of the views presented to me by responsible and thoughtful senior staff and others with material knowledge, who have been striving to develop the services since 2009.

84. Doncaster has some unusual political characteristics. It has a directly elected Mayor, who was co-operative with my task and extremely courteous in dealing with my inquiry. In 2012 the continuation of an elected mayoralty received strong majority support from the electorate.

85. In addition to the Mayor, there are 63 Councillors serving 21 wards. The Boundary Commission for England currently is reviewing the size of the Council. Hopefully there will remain a sufficient number of Councillors for elected members to be informed about and accountable for crucial front-line services. Following the 2012

one-third election, 50 of those were elected as Labour, nine as Conservatives, three as Liberal Democrats, and one as Independent. One would therefore logically expect the Cabinet (which includes the Lead Member for Children's Services) to bear some relationship to the proportions of the political parties. In fact the Cabinet of six consists of the Mayor, three Conservatives and two Liberal Democrats. This is a decidedly and evidently odd situation. The Council as a whole is responsible to the electorate for the services it provides. The Council as a whole should be well informed about Children's Services. My repeated questions as to how much attention is given in Council plenary meetings to those services were met with depressing answers, given the importance of those services and the widespread attention and criticism arising from the Edlington Case. I summarise the effect of the answers I was given.

86. The average Doncaster Councillor is poorly informed about the Edlington case and about the improvements or otherwise in children's services. Although there are periodic presentations about those services to the plenary Council, they are brief and little written information is given to members prior to such presentations. The potential for well-targeted, pertinent questioning is extremely limited as a consequence. That there is a Lead Member for Children's Services in the Cabinet is not especially reassuring. Hard as he may work, it is impossible for one Councillor to acquire and retain, with an appropriate critical faculty, all the necessary information and keep the Council as a whole properly informed.

87. An Overview and Scrutiny Schools, Children and Young People Panel has been established by the Council and is chaired by an experienced Labour Party Councillor. Very helpfully, she provided me with a summary of the work done by the Scrutiny Panel in the period 2010-12. Their work programme is well directed and looks closely at issues relating to the safeguarding and welfare of children. The Panel's work is clearly beneficial, and should strengthen political accountability for Children's Services. Although I was surprised to be told that the Panel had not considered the SCR of the J children, nor specifically addressed how such a case would be dealt with in future, this turned out to be incorrect. A report on the SCR was presented and considered by the Scrutiny Panel in private session on the 28 January 2010. This was followed by meetings between Panel members and several social workers and managers, and

actions were set and (I am told) followed. I am surprised that the new Panel Chair was not made aware of these steps on appointment. The Panel has many opportunities to improve its knowledge base, share useful and necessary information, and develop further its already useful role.

88. The above is a factual account of the Council arrangements at present. The level of knowledge of Councillors about their Children's Services, potentially affecting the 72,000 child inhabitants of their area, is extremely disappointing and must be improved. **I recommend that steps be taken urgently to ensure that Doncaster Councillors are given far more opportunity to understand and scrutinise those services. This will involve training, which I am sure will be welcomed by most if not all. At the very least there should be regular and quite detailed briefing sessions to the full Council, with papers in advance. Social workers and senior staff in the service should be encouraged to discuss the service (but not individual named cases) with Councillors where they feel it would assist Members to be briefed in that way. In summary, every Councillor should be given the opportunity to develop a questioning and critical faculty about the services.**

I recommend too that the Doncaster Scrutiny Panel should receive enhanced training, so that it can provide Council colleagues with better informed views and a more rigorous critical faculty.

89. If this can be achieved, Doncaster will bring itself into line with other local authorities, where Children's Services are given a more appropriate ranking among issues discussed by and considered by the Council with a useful knowledge base. I have looked at the practices of some of those Councils. A good deal can be learned from, for example, Liverpool (where much progress has been made since the Bulger Case), Manchester and the London Borough of Newham. All of those are local authorities with difficult demographic issues, in particular the great annual rate of change in their population.

Progress to date

90. It should be emphasised that Doncaster today is not faced with the shambolic situation of 2009. The DSCB has been revitalised under the leadership of an independent Chair appointed in July 2009. Appropriate sub-committees of staff cover the full range of responsibilities. Much more effective partnership work is now evident especially in and combining education, health, policing and social policy. There is a considerable way to go before Doncaster can be comparable with the best performing local authorities, but there can be reasonable measure of optimism and a sense of achievable ambition, despite a rising rate of referrals year on year.

91. There remain weaknesses. The strength of the management team is to an extent dependent on high quality individuality and inspiration rather than embedded systems. Weaknesses at middle management level are hindering progress and obstructing support for accelerated change. There are continuing concerns about the consistency of standards and practice within teams, the quality of supervision and professional support, and the under-development of a performance culture across the service. These issues are being addressed.

92. The DSCB has produced the '*Doncaster Multi-Agency Pathway to Provisions Thresholds Guidance*', more briefly described as the threshold document. This is a short document, intended as a toolkit for practitioners working with children, young people and their parents/carers. It is intended to enable practitioners to identify the level of need, and to enable the most appropriate referrals. Four threshold levels are listed, with indicators of issues triggering the introduction of services. The J boys would have fallen into the most acute category, described as Level 4. This group are described as being in need of specialist services, some needing intensive help and support. Once a statutory assessment has been performed (which can and should happen extremely quickly in acute cases), specialist services should be available.

93. There are various versions of threshold guidance used in different local authorities, and I have seen a few. There may be some need for regional variation, though I find that difficult to envisage. **I recommend that there should be consensus nationally about the most appropriate form of the threshold guidance, which ideally should be adopted nationally for all councils and children, and**

thus would be familiar to professionals wherever they worked. I have no criticism of the Doncaster version: it is an excellent tool, and is familiar to all practitioners.

94. Information sharing is absolutely essential for continuing improvement. The basic requirement is for partner agencies, subject only to necessary gateways, to have arrangements that facilitate the sharing of information to meet the needs and welfare of children. Data protection laws are sometimes cited as an obstruction: where this is believed to be the case, advice should be taken. Additionally, in Doncaster as elsewhere, it is unacceptable for partner agencies to be prevented from necessary information sharing by incompatible computer systems.

95. Information sharing must include the Crown Prosecution Service when prosecution is under consideration. In the case of [J1] and [J2] the senior prosecutor involved had undergone specialist youth training provided by the CPS. She could reasonably have expected co-operation. However, she and her team had to resort to obtaining material from the Council by Court Order, after a policy change by the Council early in the preparation of the prosecution case. This is an example of why **I recommend that, nationally, there be a continuous learning programme on the subject of sharing information in the interests of child safeguarding: this could be achieved by e-learning.**

96. I have repeatedly asked those involved in or with the Doncaster Children's Service to assess improvement, based on 2008 being rated at zero percent and perfection 100 percent. Within a response range from 25 percent to 70, the main consensus is slightly under 50. This shows how far there still is to go.

97. Specific and clearly identifiable improvements have occurred in partnership working. Nevertheless there are weaknesses. In the following sections I address some specific areas in which improvements can and should be prioritised.

School exclusions

98. The exclusion of children, especially primary school children, should be a last resort. Every exclusion imposes an obligation on another part of education services. The result of exclusions, if not correctly managed, can quickly lead to the child concerned not being educated at all. The provision of education to the J boys became vestigial after only a short time. They were roaming the streets, and not receiving anything like the schooling to which they were entitled and upon which such stability as they might acquire could be founded.

99. In this context, since the Edlington Case there have been considerable improvements in the Doncaster local authority area, though I am left unsure how universal and robust they are. My short timescale of 30 days' work did not permit me to carry out more than a useful discussion of this subject whilst in Doncaster.

100. In June 2012, the Doncaster exclusion process required the excluding school to be responsible for providing schoolwork for the first five days of the exclusion. Thereafter responsibility passed to the local authority generally, away from the excluding school.

101. Recently some very useful work has been done on behalf of the present Government which seems to me to provide a template for the future, and to be of general application.

102. On the 1 September 2011, the current Secretary of State for Education Michael Gove, in a speech at the Durand Academy in Stockwell, London, spoke of an 'educational underclass'. He was referring to pupils who are outside the mainstream education world. He asked Charlie Taylor, the Government's Expert Adviser on Behaviour, to review pupil referral units and other alternative provision, taking the high quality education for all pupils and best value as the starting points.

103. Mr Taylor produced two published reports, both admirably short and accessible. They now provide the paradigm for all local authorities wrestling with the undoubted challenges of excluded children and others not able to enjoy standard school

provision.[19] His recommendations included:

Recommendation 1: That AP [Alternative Provision] policy and practice, nationally and locally, has an increased focus on effective assessment and identification of children's needs. This should take place as early as possible and before a child's behaviour has deteriorated to the extent that permanent exclusion is the only option.

Recommendation 2: That information is shared between schools and providers and that locally this leads to clear and realistic plans with baselines against which to measure progress (including towards reintegration into mainstream schooling, further education, or employment). Where children have Special Educational Needs, these plans will link to 'Education, Health and Care Plans' on which DfE is expected to provide more guidance in due course.

Recommendation 3: All children who are referred to AP should continue to receive appropriate and challenging English and Maths teaching. All providers should offer this provision, or arrange it in partnership with other providers or the school if the child is educated in more than one place.

Recommendation 4: That schools, Local Authorities [LAs] and PRUs as commissioners should set up local systems for quality assuring the AP in their area, so they can place children in the right provision.

Recommendation 6: That schools rather than LAs should be responsible for commissioning AP and PRU services.

Recommendation 7: That over the mid-term LAs should work with schools to begin to devolve the funding they currently use for this purpose to schools.

Recommendation 8: That head teachers or senior managers from schools should sit on the management committees of their local PRU.

Recommendation 9: That when schools decide to send a pupil to AP they share all relevant information with providers, agree the nature of the intervention and set targets for the pupil. Progress should be regularly monitored and plans put in place for the next stage in the child's life.

Recommendation 10: That schools look at using money they currently spend on AP to build up their capacity for managing pupils' behaviour.

Recommendation 12: That the regulations on how long pupils can stay in AP are relaxed. Children directed to AP by the school should be able to stay for as long as is necessary, providing the placement is appropriate, is meeting the child's needs and that progress is regularly monitored.

Recommendation 13: That schools work in partnerships with PRUs and LAs to develop funding systems for AP that enable them to use provision flexibly and responsively whilst still supporting sustainability and growth of quality.

Recommendation 14: That the Government should set clear standards for the commissioning and use of AP by schools.

[19] *Charlie Taylor's reports on improving alternative provision and improving school attendance.*

Recommendation 15: As part of the new strengthened section 5 inspection, Ofsted ensures that inspectors continue to pay close and consistent attention to how well schools take account of the needs of children in AP.

Recommendation 16: That when Ofsted inspects an AP provider they look at sufficient provision to evaluate pupils' experiences.

Recommendation 17: That the DfE and Ofsted should consider setting up a more structured approach to monitoring alternative provision as part of Ofsted's survey programme.

Recommendation 18: That as part of the development of the new inspection arrangements for independent schools, Ofsted seeks to ensure stronger alignment with the section 5 arrangements in the reporting and judgements, to assist parents and those commissioning provision for pupils to make suitable choices about AP.

Recommendation 19: Ofsted should ensure that any concerns identified by inspectors regarding alternative provision are fed into the risk assessment for schools.

104. I draw particular attention to Recommendation 6. The key to these recommendations is the retention of responsibility for excluded children in the hands of the excluding school. Under Mr Taylor's recommendations, this includes responsibility for funding. In discussing this matter with head teachers and others in Doncaster, I was assured that the principles underlying them were accepted and being brought into effect.

105. I endorse strongly Mr Taylor's advice. **I recommend the adoption as fully and quickly as possible of Charlie Taylor's recommendations to the Secretary of State on school exclusions.** I understand that this process is under way. In Doncaster and elsewhere, uninterrupted accountability is necessary to ensure what I suggest are the following fundamentals:

(a) All children, including and perhaps especially those excluded from school, should be entitled to continuing and proportionate education, to as near as full-time as is possible;

(b) Where a child is excluded, the excluding school should retain the responsibility for the education of the child, including the cost implications; and

(c) There should be an underlying assumption that special provision outside the mainstream of the school should be provided on the same campus as the school itself, save in exceptional circumstances.

106. Had these and other provisions been in place in Doncaster in 2007-08, I am reasonably certain that a much more structured approach would have been taken to the issues presented by the J children. The seriousness of their and their family's challenge probably would have been recognised, and it is possible that [V1], [V2] and [V3] would not have been attacked and traumatised.

Training of teachers

107. In all postgraduate teacher training there is a component dealing with child development, safeguarding and protection. Inevitably, the content of the teaching varies from course to course.

108. As part of a whole system approach towards children presenting with safeguarding issues, teachers should understand readily that they have an ethical duty to share information. Just as medical practitioners may be held accountable for failures to share material information, so should teachers.

109. In order to ensure that all newly trained teachers have a sufficiently focused view of such issues, **I recommend that teachers should be familiarised with the kind of threshold guidance referred to in paragraph 93 above; and that continuing professional development courses for teachers should be required to include a refresher component on safeguarding at least once in every three years.**

Health

110. An issue that has been of great interest to me in this inquiry has been the monitoring of basic child health. For the older amongst the general population it was commonplace to be lined up for a nurse or doctor to carry out a basic, annual examination. If done correctly, this included weighing and measuring, and looking in the mouth. Pupils were barefoot, so that the feet could be seen. Any statutory or government requirement for such examinations was abandoned decades ago.

111. Current requirements seem to involve only an examination of children on reception at primary school. Although I am unconvinced about the universality of such

examinations, I understand that some areas provide an examination on entry to secondary education, in year 7.

112. One interlocutor from the voluntary sector, a specialist in assisting families and achieving better results for problem families, suggested that many of the most difficult cases could be identified as early as during pregnancy; but that this predictive approach depended on high quality training and co-operation among professionals.

113. I have not seen and am not in possession of the medical records of [J1] and [J2]. I am aware that during 2009 they had been seen once by a member of a CAMHS High Risk Assessment Team, but not for a full clinical assessment of any kind. Nevertheless the background justifies the conclusion that there is no certainty that they were well-nourished, or in good general physical shape, or had sound dental health.

114. Almost every one of the several clinicians at various levels with whom I have discussed the issue, and very senior local authority managers with some responsibility for children, advised me that there would be great benefit and potential substantial value in the introduction of routine, compulsory, annual medical examinations for all school pupils up to at least year 11. Such examinations would include, as well as weighing and measuring, a basic inspection of oral health (which would not necessitate a dentist or qualified dental nurse save on secondary referral), of the feet, and of sight. **I recommend that annual medical examinations at school be introduced for every child up to and including year 11.**

115. The reasons for the above recommendation are in my view self-evident. Poor development is likely to be evidenced by such examinations. Obviously poor oral health is easily observed and may provide evidence of poor nourishment. Poor care of the feet is likely to provide an indication of unsatisfactory family hygiene. Each such examination is unlikely to take up more than five minutes. If it is universal there is no need for embarrassment or any sense of discrimination as between one child and others.

116. Examinations would not be a perfect way of discovering poorly cared for children. They would, however, at least provide an amber light leading to the involvement of other services. A refusal of co-operation by parents would trigger further enquiry.

The relationship between basic physical neglect and poor behaviour is sufficiently clear to justify whatever initial expense is involved. In any event, the discovery in a local authority area through such checks of a single family with issues such as afflicted the J family would justify the cost to the public as compared with the enormous cost of possibly avoidable provision in the criminal justice system and/or mental health services during later life.

117. Linked to this issue is the provision of school nurses. In 2000, I chaired an inquiry and wrote a report on the safety of children in the NHS in Wales[20]. With my expert advisers I found:

> In most areas of Wales, school nurses are employed by the local NHS Trust, and have responsibility for a number of schools. However, in at least one area they are employees of the local authority and funding is found from the education budget. The former course seems much more satisfactory to the Review Panel. Where school nurses function well, they work within the primary health system but are employed by NHS Trusts. For many children, they are the first port of call for physical and mental health issues. The role of a good school nurse has developed far beyond the old notion of a school matron with a cabinet of ointments, unguents and sticking-plasters. A school nurse may be asked to deal with everything ranging from bruises and grazes to eating disorders, pregnancy and the discovery of cancer.
>
> The Review was impressed by the dedication and sense of purpose of school nurses. We were less impressed by the variable knowledge of the presence of a school nurse, and of his or her potential, among pupils in schools. We were shocked by the under-valuation of their role by health organisations, the almost complete lack of a career path for them, and the relatively poor availability of training courses. We are aware that specialist pathways within the Degree in Community Health Studies have been developed recently and this first school nurse graduate should qualify in 2002 from the University of Glamorgan. We are convinced that, if ever there was an area of primary healthcare that can give demonstrable value for money by effective early intervention, this is it.
>
> Unfortunately, ambitious school nurses and those who realistically need to maximise their earning potential tend to move to other jobs in order to do so. A programme in every Trust to ensure the constructive management of this part of the NHS would be beneficial. This should no longer be a Cinderella service.

118. I remain of the broad view expressed there. Since that report there have been significant changes in school nursing, not only in Wales. The school nurse qualification is now well-regarded, and its expertise acknowledged. For the purposes of the present report I have discussed the issue extensively beyond Doncaster. I believe that some local authorities have established sound programmes.

[20] 'Too Serious a Thing'; now most easily found via www.trosgynnal.org.uk.

119. For example, in the London Borough of Newham (which has a similar size of population to Doncaster), the school nursing service is part of an integrated health visiting/school nursing team. They are split into localities. Each of 7 teams in the Borough consists of a clinical team leader, school nurses, associate school nurses, health visitors, community staff nurses, nursery nurses and administrators. Qualified school nurses are linked with associate school nurses, and each school has a named school nurse contact. The service is provided to pupils between reception and year 11. Key performance indicators have demonstrated positive outcomes. All children with a child protection plan receive appropriate health input from a named school nurse. Outcomes have included improved health outcomes for children, including those with complex or special care needs; and improved access and attendance to education for children and young people with additional physical and developmental or cognitive needs.

120. I do not offer Newham as the model. It may be that in Doncaster or elsewhere there can be a higher proportion of fully qualified school nurses, or a lower caseload per nurse than exists in London. In an ideal world, there would be a school nurse available for part of each day in every school. However, the management and team structure in Newham provides an example of a system that is working and can be used as a basis for discussion. What is absolutely clear to me is that the availability of suitably qualified and/or experienced school nurses in all schools increases the prospect of identifying neglected children whose problems merit detailed and urgent attention. **I recommend that further attention be given to developing a good national standard for school nurse provision.**

The roles and responsibilities of Directors of Children's Services and Lead Members for Children's Services

121. Both of these roles are required by statute to be provided by local authorities. In April 2012 the Department for Education issued Statutory Guidance on the roles and responsibilities of the DCS and LMCS[21] to replace previous Guidance issued in 2005 and 2009.

[21] Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services.

122. There are key items in the Guidance, for the purposes of this report. Because of their importance, I set them out fully:

The DCS has professional responsibility for the leadership, strategy and effectiveness of local authority children's services and, as such, this post should be at first tier officer level. The DCS is responsible for securing the provision of services which address the needs of all children and young people, including the most disadvantaged and vulnerable, and their families and carers. In discharging these responsibilities, the DCS will work closely with other local partners to improve the outcomes and well-being of children and young people.

The DCS is responsible for the performance of local authority functions relating to the education and social care of children and young people. The DCS is responsible for ensuring that effective systems are in place for discharging these functions, including where a local authority has commissioned any services from another provider rather than delivering them itself. The DCS should have regard to the General Principles of the United Nations Convention on the Rights of the Child (UNCRC) and ensure that children and young people are involved in the development and delivery of local services.

The Lead Member for Children's Services (LMCS)

Section 19 of the Children Act 2004 requires every top tier local authority to designate one of its members as Lead Member for Children's Services. The LMCS will be a local Councillor with delegated responsibility from the Council, through the Leader or Mayor, for children's services. The LMCS, as a member of the Council Executive, has political responsibility for the leadership, strategy and effectiveness of local authority children's services. The LMCS is also democratically accountable to local communities and has a key role in defining the local vision and setting political priorities for children's services within the broader political context of the Council.

The LMCS is responsible for ensuring that the needs of all children and young people, including the most disadvantaged and vulnerable, and their families and carers, are addressed. In doing so, the LMCS will work closely with other local partners to improve the outcomes and well-being of children and young people. The LMCS should have regard to the UNCRC and ensure that children and young people are involved in the development and delivery of local services. As politicians, LMCSs should not get drawn into the detailed day-to-day operational management. They should, however, provide strong, strategic leadership and support and challenge to the DCS and relevant members of their senior team as appropriate.

Ensuring a clear line of accountability

Integrating education and children's social care services under a single officer and a single member provides both a strategic and professional framework within which the safety and the educational, social and emotional needs of children and young people are considered together. The DCS and LMCS roles provide a clear and unambiguous line of political and professional accountability for children's well-being.

The DCS and LMCS should report to the Chief Executive and to the Council Leader or Mayor respectively as the post holders with ultimate responsibility for the political and corporate leadership of the Council and accountability for ensuring that the effectiveness of steps taken and capacity to improve outcomes for all children and young people is reflected across the full range of the Council's business. The DCS and LMCS (in their respective roles) will also need to work closely with the Director of Public Health as the principal adviser on

health to officials and members.

Local assurance

Local authorities will, as a matter of course, want to ensure their structures and organisational arrangements enable them to:

- fulfil their statutory duties effectively (including ensuring that children, young people and families receive effective help and benefit from high educational standards locally;
- be transparent about responsibilities and accountabilities; and
- support effective interagency and partnership working.

A local authority should carry out effective assurance checks, integrated as part of their usual decision-making and scrutiny work, of their structures and organisational arrangements. Once any new arrangements are in place, local authorities should review their arrangements regularly to satisfy themselves that they continue to be effective.

These assurances should be agreed within the Council. They should be subject to self-assessment within the local authority, and to peer challenge and review, as part of the process of securing continuous sector-led improvement in the quality of services. Where, as part of Ofsted's assessment of the quality and effectiveness of local authority leadership and management, inspectors identify an issue arising from the local authority's arrangements for discharging the DCS and LMCS functions, they may decide to look at the quality and effectiveness of the authority's assurance process.

It is for each local authority to determine the precise nature of its own assurance process and how to provide transparency for local communities about which individuals are fulfilling the statutory roles of DCS and LMCS, taking account of local circumstances. However, in doing so, the following elements are likely to be essential in assuring that effective arrangements are in place:

- clarity about how senior management arrangements ensure that the safety and the educational, social and emotional needs of children and young people are given due priority and how they enable staff to help the local authority discharge its statutory duties in an integrated and coherent way;
- clarity about how the local authority intends to discharge its children's services functions and be held accountable for them from political, professional, legal and corporate perspectives (including where, for example, services are commissioned from external providers or mutualised in an arms length body);
- the seniority of and breadth of responsibilities allocated to individual post holders;
- the involvement and experiences of children and young people in relation to local services;
- clarity about child protection systems, ensuring that professional leadership and practice is robust and can be challenged on a regular basis, including an appropriate focus on offering early help and working with other agencies in doing so; and
- the adequacy and effectiveness of local partnership arrangements (e.g. the local authority's relationship with schools, the Local Safeguarding Children Board (LSCB), the courts, children's trust co-operation arrangements, Community Safety Partnerships, health and wellbeing boards, Youth Offending Team partnerships, police, probation, Multi-Agency Public Protection Arrangements and Multi-Agency Risk Assessment Conferences) and their respective accountabilities.

Roles and Responsibilities of the DCS and LMCS

The DCS and LMCS work together to provide strong, strategic local leadership and development of an increasingly autonomous and diverse education and children's services sector. Working with headteachers, school governors and academy sponsors and principals, the DCS and LMCS should support the drive for high educational standards for all children and young people, paying particular attention to the most disadvantaged groups. They should also ensure that children's services are integrated across the council, for example to support a smooth transition from children's to adults' services. The DCS and LMCS should involve and listen to parents, carers, children and young people. The DCS and LMCS have a key role in ensuring that the local voluntary and community sector, charities, social enterprises, the private sector and children and young people themselves are included in the scope of local authority planning, commissioning and delivery of children's services where appropriate.

Section 10 of the Children Act 2004 places a duty on local authorities and certain named partners (including health) to co-operate to improve children's well-being. The DCS and LMCS must lead, promote and create opportunities for co-operation with local partners (for example, health, police, schools, housing services, early years, youth justice, probation, higher and further education, and employers) to improve the well-being of children and young people.

The DCS will also help join up local commissioning plans for clinical and public health services with children's social care and education, where appropriate, to address the identified local needs through the JSNA and joint health and wellbeing strategy. The DCS will make a key contribution to ensuring effective working relationships between the health and wellbeing board and the LSCB. The DCS is responsible for any agreements made under section 75 of the National Health Service (NHS) Act 2006 between the local authority and NHS relating to children and young people – for example, pooled budgets for commissioning and/or delivering integrated services covering children's health, social care and education.

Safeguarding

Section 11 of the Children Act 2004 requires local authorities and other named statutory partners to make arrangements to ensure that their functions are discharged with a view to safeguarding and promoting the welfare of children. There is a similar requirement imposed on schools.

This should ensure that safeguarding is integral to all that local authorities, schools and other named partners do. The DCS and LMCS should ensure that there are clear and effective arrangements to protect children and young people from harm.

Local authorities are also required to set up a LSCB to coordinate the effectiveness of arrangements to safeguard and promote the welfare of children and young people in that area.

The DCS should always be a member of the LSCB and will be held to account for the effective working of the LSCB by their Chief Executive, including where the LSCB has an independent chair. The LMCS should be a "participating observer" of the LSCB; they may engage in discussions but not be part of the decision making process in order to provide the LMCS with the independence to challenge the DCS (and others) when necessary. The DCS also has a crucial role in ensuring collaboration and dialogue with the family courts so that high quality local authority assessments and other evidence contribute to effective and timely court processes for children.

Vulnerable children and young people

Local authorities should work with partners to promote prevention and early intervention and offer early help so that emerging problems are dealt with before they become more serious. This will help to improve educational attainment, narrow the gaps for the most disadvantaged and promote the wider well-being of children and young people, including at key transition points. They:

- must ensure arrangements are in place for alternative provision for children outside mainstream education or missing education (e.g. due to permanent exclusion or illness) to receive suitable full-time education;
- should ensure there is coherent planning between all agencies providing services for children involved in the youth justice system (including those leaving custody), secure the provision of education for young people in custody and ensure that safeguarding responsibilities are effectively carried out; and
- should understand local need and secure provision of services taking account of the benefits of prevention and early intervention and the importance of cooperating with other agencies to offer early help to children, young people and families.

123. In my judgement this Guidance is of immense value, provided that it is followed in Doncaster and elsewhere. The essential message is clear: the machinery should be in place for closer co-operation between agencies than has existed in many places in the past; and that such machinery should be able to identify, assess and address potentially very serious challenges (as the J family undoubtedly were) before the situation becomes critical.

124. Therefore **I recommend that Doncaster and every other local authority should be able to demonstrate that it is fully aware of and has complied with the April 2012 Statutory Guidance on the Roles and Responsibilities of Directors of Children's Services and Lead Members for Children's Services.**

Fostering and placements

125. One of the most concerning aspects of the Edlington Case is the indifferent application by social workers in the material Duty and Assessment Team [DAS] of the standards within the Framework for the Assessment of Children in Need and their Families (2000) applicable at the time[22]. Despite considerable activity by the local Youth Offending team, and the police specifically, the DAS failed to recognise the high risk of offending. There were plenty of meetings, but wholly inadequate action. When finally it was agreed to activate the care system, the decision was made to place [J1] and [J2] in the foster care of a well-meaning couple, but they were not a suitable placement in the circumstances – not least because they lived near the home of the father who had caused much of the difficulty for the boys but whom they chose to be with if they could gain access to him. There seems to have been an assumption that the boys needed comfortable care, but insufficient attention paid to their escalating pattern of violence.

126. The foster care provided was for respite purposes. Given the nature of the boys' difficulties and behaviour, there should have been a much more effective assessment of their individual needs, and a long-term solution. Nobody in social services had contact with the father, and there was apprehension about contact with the mother. There are lessons to be drawn from the case, about how essential it is to engage with a family however discouraging the prospect. There is merit in following what has been described to me as the 'Hackney Model', referred to at paragraph 41 above.

127. One is left with the clear conclusion that the boys should have been separated, and removed from proximity to either parent, probably to a secure environment (such as a local authority secure children's home).

128. I was told on several occasions, sometimes by seasoned professionals devoted to maintaining family relationships, that the 'care model', involving removing the most troubled children from home, is too often treated as the absolute last resort. In some cases, I was urged, it should be considered and employed at an earlier stage, for the benefit of the child and the safety of the public.

[22] I acknowledge that for this section I was assisted by an article by Hilary Searing, to be found at www.radical.org.uk/barefoot/doncaster.htm.

129. There is a perfectly respectable case, indeed a strong argument, to be made for a greater emphasis to be given by children's services to the interests of victims and potential victims of violent children. A clear message from this case, and I believe from others, is that there has been insufficient challenge by social workers, teachers and others to assurances given by parents in troubled and challenging families. The ability to make effective challenges with authority, and thereby to avoid future disasters, depends on improved co-ordination and information sharing between the agencies.

130. Parents whose children present as abused, neglected or threatening to others, should be made to understand that there is a real limit to tolerance of their failings; and that residential placements away from the family may well be resorted to if identified difficulties are not resolved. Parents must be made to understand their responsibilities, and that sometimes removal from home may be the way to a better life in the interests of the welfare of the children concerned.

131. I have no doubt that prior to 2009 there was a low level of professional assertiveness by social work staff in Doncaster, probably because of the absence of any confidence in senior management. There is a convincing case to be made for senior managers to have a direct involvement in the more challenging cases, with their administrative functions redistributed as necessary. This approach is now understood in Doncaster. Whilst it may be invidious to single out individuals for comment, even brief contact with Doncaster Children's Services brings one into contact with Assistant Director Vicki Lawson. This dynamic senior manager involves herself in individual cases as well as performing her management role, and by all accounts is extremely capable in her overall responsibilities. My concern is that the individual and sometimes unusual approach that she offers successfully is difficult to translate into systemic professional practice. I deal below from paragraph 136 with the social work profession.

132. In making these comments I do not underestimate the difficulties facing practitioners. In Doncaster there are as many as 170 children being educated in PRUs, some of them offering a considerable and difficult challenge. In addition, Doncaster has an unusually high rate of elective home education, so officials informed me, some suspected to be of indifferent quality but far from easy to scrutinise. These and other

topics of concern are being approached on a foundation of good practice and practical thought: for example, the referral and assessment services have been co-located with police, so that combined strategy meetings can occur at very short notice, and serious failures avoided.

A Parenting Code

133. During the preparation of this report a number of people have reflected to me that although local government and the Courts intervene in families in often seismic circumstances, there is very little straightforward and accessible guidance in everyday use for parents. Of course, there are many books on parenting, but few have a mass audience let alone mass appeal. Good parenting does not lend itself as a subject for reality TV shows, yet parenting impacts everyone. To drive a motor vehicle one is required to read and digest the Highway Code, and pass a formal written test before becoming a fully licensed driver. Nothing similar to the Highway Code exists for parents.

134. It would be unrealistic to suggest that there should be a parenting test comparable with the driving test. However, in my view it is sensible to suggest the production of a free, short and accessible handbook analogous to the Highway Code, to be given to every new prospective and actual parent who comes to the attention of the health services. As well as basic advice on feeding, hygiene, development, play, how to deal with distress, education and sexual development, it could include details of statutory and voluntary agencies able to provide assistance. Given that the document would have to be updated periodically, re-issue could be managed via schools and the NHS.

135. Therefore **I recommend that consideration be given to the creation and provision of a concise national Parenting Guide.**

The social work profession

136. In Doncaster there have been considerable improvements in the professional atmosphere in which social workers function. There, as in many other places, clever and well-qualified men and women become and practise as social workers. They have a range of experience, some young and recently qualified, others in a second career.

As a practitioner group they appear to have high potential, and are showing success. Some agency staff are used, and they too are qualified and dedicated. The balance has shifted from temporary agency staff to full-time Council employment. They struggle against a heavy caseload, and the historical baggage of a formerly very poorly performing council and also the lingering effect of the Edlington Case.

137. Particular problems arise because there is considerable churn. The vacancy rate for social workers in June 2012 was 15-20 percent for qualified social workers. Many leave Doncaster after about two to three years, to work elsewhere. Doncaster does not have a good reputation among social work professionals because of past performance and events. I was told that there is an imbalance between newly qualified and more experienced staff. A 'grow your own' training programme has been established, with a university link. 360 degree appraisal of staff has been introduced for senior managers, but not yet for the rest of the professional staff. The 360 degree system, capable of being run online, is a useful method of peer review of performance.

138. It is interesting to contrast the very low mobility of the police as compared with social workers: of course, police force structure and conditions of service contribute to their stability. It does lead to local officers, as in Edlington, being the holders of the most reliable narrative concerning local problem families and children.

139. In the light of the above reflections **I recommend that the following improvements should be made a high priority in Doncaster:**

(a) The career structure of social workers in Doncaster should encourage workforce stability. This could be achieved in part by motivating the best staff to stay by an encouraging regime of grading and salary promotion.

(b) Promotion should not mean the automatic reduction in casework responsibilities for those promoted. It should be possible to reach a senior grade of management whilst still dealing entirely or mainly with casework.

(c) The existing mentoring arrangements should be improved so that every social worker, however experienced, has a mentoring partner

with whom there should be freedom of discussion about cases and other aspects of the work.

(d) Every Children's Services manager, without exception and up to Director level, should hold some direct casework responsibilities. One would reasonably expect the most senior staff to be dealing with some of the most difficult cases.

(e) Continuous professional development for social workers at all levels should be active, with the occasional possibility for secondment and/or sabbatical leave for the purpose of broadening experience and skills.

(f) Partnership with academic institutions, such as a nearby university, should be developed further, to ensure the integrity and appropriate range of CPD.

140. The Social Work Reform Board [SWRB], Chaired by Dame Moira Gibb DBE, has been working nationally for two years to implement earlier recommendations by the Social Work Task Force. Shortly there will be recruited the first Chief Social Worker for England, who can be expected to provide significant professional leadership. The College of Social Work is newly established. In September 2012, the Assessed and Supported Year in Employment [ASYE] for newly qualified social workers was introduced. These and other changes highlight the drive towards real professionalism, in which social workers justifiably can assert that theirs is a profession as much as any other. However, in the SWRB report of June 2012, Dame Moira regretted that the progress on the ground was slower than desired, with a profound impact being caused by a significant reduction in available resources.

141. The SWRB report supported the view that social work calls for a particular mix of analytical skills, insight, common sense, confidence, resilience, empathy and use of authority. Social workers were said to be unlikely to develop these skills unless provided with high quality education and training that continues throughout their careers; access to research and its practical applications; high quality working conditions with appropriate coaching, mentoring and supervision, and respect. The

SVVRB supported Professor Eileen Munro's Review of Child Protection[23] and update, in which Professor Munro called for the development of training and career pathways for those working in child and family social work.

142. I agree entirely, and recommend that Doncaster should regard itself as an exemplar and pioneer in the development of steps towards a stable, expert and respected career professional workforce.

Cases from elsewhere

143. For the preparation of this review I sought examples of comparable cases in the recent past. There were fewer than 10 of comparable seriousness, and no geographic focal point. Such information as I received provided two conclusions:

(1) the worst criminal acts by children almost inevitably are perpetrated by children who have been neglected and/or abused; and

(2) the most notable and consistent failure was the absence of effective early intervention.

144. Those two conclusions in my view assist in justifying my recommendations set out in Annex 3 below.

[23] See footnote 9 above.

Annex 1: Terms of reference

Objective, scope and methodology of the review

The review's main **objective** is to give assurance that all the necessary lessons arising from the `J children' case have been identified and appropriate and sufficient action taken to ensure that all necessary improvements are embedded in the practice of the Council and its partners; and, in the event of further remedial action being required, to make recommendations accordingly.

We would expect the review to draw out the **key improvements** needed in the Local Authority, the Police, NHS, the Local Safeguarding Children Board and other relevant agencies. The review would then test whether, and how effectively, these improvements have been made (in each individual organisation and in how they work together) through:

(i) discussions with senior colleagues in the relevant organisations and, as appropriate, with relevant family members;

(ii) reviewing the `J' SCR documentation, including progress reports prepared by Doncaster on the SCR's eighteen recommendations, and minutes of relevant meetings, including those of the Local Safeguarding Children Board (LSCB) and the Children's Board;

(iii) reviewing actual files, systems and policies;

(iv) examining the practice of social workers, police and health workers on the ground; and

(v) considering the wider improvement context, including the statutory interventions in children's services and where appropriate in corporate governance, and Ofsted inspection and other reports on Doncaster's performance since the `J children' incident.

A **written report** to the Secretary of State would assess progress and make recommendations for further action to secure and embed the necessary improvements. The LSCB and the Children's Board (both of which include Council members or officers and partner organisations) would have an opportunity to comment on the report before it is finalised. However, the report is owned by the reviewer and does not require sign-off from any other body or individual. We would expect the report to be published on a suitable date after completion.

The Secretary of State will consider the report when it is submitted and take such action as he deems appropriate at that stage in light of its recommendations. The report would also inform the wider review of progress in Doncaster due to be undertaken later in the year as part of the Department's statutory intervention to secure safeguarding and children in care service improvements and help to determine any further action. DfE officials will discuss with the Council and the independent reviewer how to do that in practice.

In the event of the report making recommendations applicable to future cases concerning the safeguarding of children generally, the Secretary of State will give full consideration to such advice.

The estimated time for completion is 30 days.

The review will start in April and report by 30 September 2012.

Annex 2: Scheduled events referring to [J1] and/or [J2]

List of acronyms:

ABC	Anti-social Behaviour Contract
ABC+	Anti-social Behaviour Plus programme
CAMHS	Child and Adolescent Mental Health Service
DAS	Duty and Assessment Service (part of Doncaster Children's Social Services)
DCSS	Doncaster Children's Social Services
DMBC	Doncaster Metropolitan Borough Council
FIO	Family Intervention Officer working with the J family as part of a Family Intervention Project
FIP	Family Intervention Project – one of 54 projects established nationally at the time to tackle the most anti-social families
FJ	Father of [J1] and [J2]
MJ	Mother of [J1] and [J2]
PRU	Pupil Referral Unit
SW8	Social Worker 8
TLDAS	Team Leader, Duty and Assessment Service
YISS	Youth Inclusion and Support Service (part of Doncaster's Youth Offending Service)
YOS	Youth Offending Service

All events in this schedule relate to [J1] and/or [J2]. At the time of the assaults in April 2009, they were aged 10 and 11.

2005

Agency/ Professional contact	Details of event
School	J child's behaviour becomes an increasing concern from the summer term, assaulting other pupils and using offensive language to peers and teachers.
Police	In the autumn, J child, together with another child, throws a brick at a moving bus, shattering a window. No criminal prosecution is pursued as J child is not yet ten years of age.

2006

Agency/ Professional contact	Details of event
School, Education Psychology Service	J child returns to school (having been in a PRU) but a few weeks later he hurts five people in a day. The school make a referral to the education psychology service and he is subsequently visited at school around one week later.
School	Discussion about permanent exclusion of J child following threats to adults with a baseball bat. Multi-agency meeting decides to exclude J child for the remainder of the term although it is clear they intend for him not to return to the school. An out of catchment area school is sought.
PRU	The following day, J child was seen to have a bruise on his ear and said that FJ had hit him. This information was not passed on to any service.
PRU	Nearly six months later, an initial assessment was undertaken because of concerns about J child's violence against other children. J child excluded from PRU before the end of the month due to his 'extreme behaviour'.
Police	J child assaults another child. The police are informed but no other services are told of this incident.
School	J child subject of a behaviour agreement at school and referred to the Family First (Early Intervention) Service to support the school with his behaviour. The work is not allocated until just over three weeks later and then has to be re-allocated to another worker who contacts MJ. The first meeting with J child takes place at school a month after that; he

	agrees to attend a friendship behaviour group. J child participates well in the six sessions and the case is closed approximately five months later.
Hospital and Interim Tuition Service – PRU	PRU makes a referral to DAS describing J child's history of violence against other children and staff. Referral includes J child's own disclosure of being hit by FJ. Less than three months later, J child is transferred to another setting. At the admissions meeting, MJ claims she can control him at home and his disruption only occurs in school. This is apparently not challenged in spite of the extensive evidence to contradict this assertion.
School	J child makes sexualised comments to an adult and behaves in an 'uncontrolled and inappropriate manner'.

2007

Agency/ Professional contact	**Details of event**
PRU	Staff note a burn mark on J child's shoulder. He provides an inconsistent explanation. No referral or information is shared with other services.
Doncaster Children's Social Services (DCSS)	Two weeks later, Families First is contacted regarding J child in the form of a Request for Service from the Duty and Assessment Service (DAS). The referral requests support for MJ in managing J child's behaviour. DAS had completed an initial assessment that concluded there was no role for them. A home visit did not take place until approximately seven weeks later when MJ declines the service.
Police/RSPCA	J child and another child reported taking ducklings from their nest, standing on them, dropping bricks on them. Reported to police; police records show RSPCA speak to family but RSPCA have no record of this.
School/Police	Over the next two months, there are a number of incidents of the J children assaulting other children, including threatening the use of a knife, throwing stones at children attending an after school activity and hitting one child with a golf club. They also threaten an adult with a knife causing a small cut to the hand.
School	Following a complaint to the school about J child's violent behaviour and assault on another pupil, exclusion proceedings are initiated before the summer break.
Police	J child assaults another child, hitting him with a pole until the other child is able to run away. J child is arrested and reprimanded having admitted the offence.

Youth Inclusion and Support Services (YISS)	A few weeks later, J child is referred to the YISS by the anti-social behaviour coordinator. A referral is also made to the FIP and suggestion of undertaking a family group conference.
General Practitioner (GP)	Around the same time, the GP makes a referral to DAS describing the J family's history of domestic violence and missed immunisations. An initial assessment is completed.
YISS	YISS complete an ONSET[24] assessment with J child. This scores the risk of offending as high but does not identify him as vulnerable. It refers to the death of a family member but no other agency appears to have information about this.
YISS/DCSS	A month later, there is a home visit by YISS key worker who only sees MJ. YISS support plan for J child is discussed and a series of weekly appointments are arranged. There is reference to 'current and previous' domestic violence although this is not followed up. MJ apparently says that the violence 'is not as bad at the moment'. The worker discusses J child with the FIP who agrees to take the lead role in working together. This is followed by a referral from YISS to DAS detailing concerns about the J children.
Police	Over a three month period, the J children are involved in a number of incidents including damaging a parent's car and the use of a ball bearing gun. On one occasion, they call at a house to tell a parent that they have stolen their child's bike and thrown the child in the pond where the child has died. Although an argument had taken place, the rest of the story was untrue. Two days after this, J children push another child into the path of a moving car (that avoids hitting the child) and then punch the child.
GP	GP makes a referral to DAS concerning domestic violence in the J family and injuries to the children. According to a file note by the specialist nurse, DAS had categorised the family as high risk and would allocate within two weeks. This information was in MJ's records but not those for the children.
YISS	A few days later, arrangements are made for J child to be assessed for the mentoring scheme but he forgets the appointment.
GP	GP contacted DAS expressing concern that previous referral relating to J children from almost three months ago has not been followed up.

[24] The ONSET referral and assessment framework was designed by the Centre for Criminology, University of Oxford for the Youth Justice Board.

Doncaster Directorate of Neighbourhoods and Communities	A multi-agency 'family update meeting' discusses concerns about the physical well-being of the J children. Domestic violence is suspected but not confirmed. This reflects the extent to which the previous concerns about the family are unknown to the current intervention team.
Police	Two weeks later, J child sets fire to clothing at a retail store. DAS are informed four days after the incident by YISS who make a referral to the fire service for fire setter's awareness work which is provided a couple of months later.

2008

Agency/ Professional contact	**Details of event**
Family Intervention Officer (FIO)	Early in the year, the J children are involved with the Anti-social Behaviour Plus (ABC+) programme and sign an Acceptable Behaviour Contract. MJ is keeping the children in the house at night in an effort to keep them out of trouble.
PRU	The following day, J child tells his mentor that FJ has hit him around the head and banged it on a wall. A few weeks later, the J children are observed with bruising on their faces. J child speaks openly of getting drunk on vodka and being hit with a golf club. J child says his bruising is from a fight.
Police	J child assaults another child and produces a pen knife.
Police	The J children approach a parent with their children, attempt to punch and hit one of the children with 'an instrument'. Later the same day, the J children approach another parent with their children and try to hit one of the children with a piece of plastic tubing. The following day, J child throws a piece of concrete at young children playing, causing minor injuries to one.
PRU	J child is due to start at PRU at the beginning of the term although this is not a full time placement. There are concerns at FIP that this may be 'over ambitious'. Within the first week J child had assaulted a pupil and teacher. In spite of a policy to not exclude, J child is asked not to return to the centre. This seems to be an informal exclusion.
Police	Whilst 'trick or treating', one of the young people with J child is seen holding a knife. Although the incident is reported to the police, the householder does not want the police to take any further action.

FIO	The same month, J child is noted as being 'unsettled for several days' needing to be restrained on occasions. He speaks of problems at home, FJ drinking and MJ becoming angry with him. MJ has told FIO that FJ has hit J child for kicking doors and FJ was drunk and abusive over the weekend.
FIO	J children set fire to pallets which results in an adjacent building catching fire. The following day J child is temporarily excluded having threatened staff at the PRU with a knife. Several contacts are made with ABC in relation to J child but the service is declined because of the child's age.
PRU/Police	One week later, J child makes threats to set fire to the school but FJ confiscates his lighter. When J child arrives at school he threatens staff with a metal pole, makes racist remarks, kicks another pupil and assaults a member of staff. Police support is requested. J child is temporarily excluded.
FIO	The following month, J child appears in Court and is made the subject of a three month Action Plan Order[25].
Police	J child approaches another child and punches them. The police interview him but he is below the age of criminal responsibility.
FIO	FIO sends email to DAS raising concerns about their lack of response to the number of concerns being sent. Email states J child is being taken to burgle properties, J children are out late in the evening, long standing domestic violence. FIO makes it clear that 'the children are not safe and we are failing in our statutory duty to protect them'. No recorded response.
Doncaster Directorate of Neighbourhoods and Communities	Three days later, Neighbourhood Manager circulates an email confirming DAS are going to hold an initial child protection conference in relation to J children.
PRU	J child grabs teacher's shirt, tries to punch the teacher and is suspended.

[25] An Action Plan Order is a community sentence which is available for any juvenile who has been convicted of an offence which the court considers serious enough to merit a community sentence. It aims to provide a short, but intensive and individually tailored response to offending behaviour.

PRU/DAS	J child attends PRU with bruising to his arms, claims the other J child caused it, and a scratch on neck caused by a dog. Rolled up his sleeves and showed the bruising which is not his normal behaviour. A referral is made to DAS, but this is not recorded at DAS. FIO tells SW that referral sent and SW8 planned to phone PRU to advise them to contact SW8 if any further concerns.
FIO	Record of meeting with ABC+ team regarding J children refers to a worker finding a strong smell of cannabis at the house. Not reported to anyone else.
Doncaster Directorate of Neighbourhoods and Communities	Towards the end of the year, a multi-agency meeting is told that J child has been involved in a sexualised assault. It was agreed he would be referred for an Acceptable Behaviour Contract (ABC). Not reported to police.
DCSS/Police	Police informed DAS that FJ had received an historical caution due to admitted participation in an assault on a child.
Police	J child detained in a retail store for behaving in a disorderly way and spitting at staff; MJ and FJ involved, assaulting and abusing staff.
DCSS/FIO	At a meeting at the PRU, it is revealed that SW8 and TLDAS (Team Leader, Duty and Assessment Service) are to leave the Department, the core assessment is still not completed and the J children are 'felt to be at risk of emotional and physical harm'. One week later, a meeting about J children included MJ. Child protection conference will go ahead; mother says she won't be able to attend. TLDAS says in light of MJ's statement that MJ will have nothing further to do with FJ, TLDAS believes a child in need plan would be enough
PRU	J child reports staying alternate nights with FJ but MJ denies this. This information is not shared elsewhere.
PRU	PRU report describes J child as a boy who has no fear of the police or consequences of his actions.
DCSS	At the end of the year, TLDAS 'allowed' to go upstairs to speak with J children during a home visit.

2009

Agency/ Professional contact	Details of event
DCSS	At initial child protection conference at the beginning of the year, J children become the subject of a child protection plan – categories of physical abuse and neglect. TLDAS becomes the key worker although due to leave the service in less than two weeks.
Criminal Court/PRU	J child appears in Court on charges relating to a previous assault and is made the subject of a supervision order. He is allowed to return to PRU but mother was called to collect him.
DCSS	First core group meeting is held the following week. J child not attending education. FIO recorded that core group agreed situation is improving and mother coped extremely well with meeting.
PRU/FIO/Police	During the same week, J child has a knife at the PRU on two occasions. The police are called. PRU is worried about staff and other's safety and refers to CAMHS. J child continues with unpredictable behaviour and is subsequently excluded until CAMHS complete their assessment.
Child and Adolescent Mental Heath Service (CAMHS)	A meeting of CAMHS later that month concludes there are no defined mental health problems but acknowledges J child poses a risk to others. Statutory visit to J child by CAMHS required under supervision order but J child fails to attend subsequent appointments. This is not co-ordinated with Child Protection Plan.
DCSS	Student social worker undertakes first home visit after J child appeared at court for an assault on a teacher and had his supervision order extended. J child was visibly distressed and became verbally angry but agreed to cooperate and a further appointment was arranged.
PRU	J child tells staff his mother thinks he stayed at a friend's house the night before but he had been out stealing with two other young people.
Youth Offending Service (YOS)	Risk of serious harm assessment concludes J child is low to medium risk of harm to others. It includes information about his behaviour at school and use of knives. Action taken to reduce the risk included: referral to CAMHS, alteration to school timetable, securing knives at school and home.
PRU	J child reports he is going to Blackpool in school holiday with MJ's boyfriend to beat people up and steal money.
YISS	J child accepted at the YISS panel having been the subject of eight anti-social reports.

Police	J children arrested for breaking into retail premises and causing damage.
PRU	J child appears in new clothes which he says are stolen. He has money from stealing jewellery with which he plans to buy cannabis.
Not specified	Reports that J children are left unsupervised at home; further reports of anti-social behaviour including stone throwing and verbal abuse.
PRU/Police	Later that month, J child arrested by police at PRU having kicked and hit three staff.
DCSS	Second core group meeting about J children held approximately one month after the first – social worker does not attend due to illness.
DCSS	Two weeks later, the J children are placed with respite foster carers in an area close to FJ. PRU were not informed by social worker.
DCSS	The following week, a review child protection conference is told: home conditions are chaotic, heightened risk of assault on J children from community unprepared to accept continued disruption. Funding being considered for private psychological assessment of J child. Child protection plans continue. Referral to Education Psychology Service of J child.
PRU	Over the next few days, J children are violent at PRU causing injuries to a teacher and pupils. One makes verbal threats, throws chairs, leaves the building taking keys, and sets off a fire extinguisher; behaviour described as beyond control and he is excluded for a day.
DCSS	Third core group meeting one month after the second. J children going missing from foster placement regularly returning home. Behaviour is deteriorating. YISS involvement is due to end.
School of V3/Police	A few days later, J children attack V3.
DCSS	J children go missing from foster placement on three occasions and are returned.
Police	One week after their attack on V3, the J children assault V1 and V2.

Annex 3: Recommendations

1. I recommend that compliance with the Troubled Families Programme should be the subject of an annual report in Doncaster and elsewhere, with a simple scoring system devised so that comparison can be made of the performance of the local authorities included.

2. I recommend that Doncaster and all local authority Children's Services should continue to develop the best possible triage arrangements. This will include fast and profoundly co-operative inter-disciplinary co-working, excellent written and electronic document trails, and a demonstrable ability to respond to urgent situations efficiently.

3. I recommend that the links between children's services generally and CAMHS should be developed to achieve the best potential effect of full assessments of conduct disorder and the use of available treatment.

4. I recommend that Ministers and local authorities consider steps to ensure that the knowledge held by housing providers becomes a standard part of developing intelligent systems for dealing with casework and is recognised by other agencies as an important source of early warning information about families facing problems.

5. I recommend that a radical look be taken at the way interventions are assessed and dealt with. For example, for cases where there have been three police reports of criminal behaviour (or comparable trigger events) on the part of a child in a given period, consideration should be given to placing the burden on the parents and the child's legal representatives in any ensuing Court proceedings to show that the child's welfare and best interests are served by leaving him/her in the family home.

6. I recommend that all agencies involved in child safeguarding in Doncaster be required to demonstrate compliance with at least the standards described in the Learned Lessons Review of January 2012; and to respond effectively to the Ofsted report on its inspection of October 2012.

7. I recommend the production of SCRs in two forms, open and closed: the open version would be a fully informative document, without redactions.

8. I recommend that a designated family judge should be asked to participate as an adviser in every SCR.

9. I recommend that under the guidance of the relevant Minister there should be established a Digest of open versions of SCRs. This is likely to lead to improved and recognised formats for such reports, a reduction in their length, and a significantly increased capacity for lessons from one SCR to be learned and applied by the material statutory services in other locations.

10. I recommend that steps be taken urgently to ensure that Doncaster Councillors are given far more opportunity to understand and scrutinise those services. This will involve training. At the very least there should be regular and quite detailed briefing sessions to the full Council, with papers in advance. Social workers and senior staff in the service should be encouraged to discuss the service (but not individual named cases) with Councillors where they feel it would assist Members to be briefed in that way. In summary, every Councillor should be given the opportunity to develop a questioning and critical faculty about the services.

11. I recommend that the Doncaster Scrutiny Panel should receive enhanced training, so that it can provide Council colleagues with better informed views and a more rigorous critical faculty.

12. I recommend that there should be consensus nationally about the most appropriate form of the threshold guidance, which ideally should be adopted nationally for all councils and children, and thus would be familiar to professionals wherever they worked.

13. I recommend that, nationally, there be a continuous learning programme on the subject of sharing information in the interests of child safeguarding: this could be achieved by e-learning.

14. I recommend the continued adoption of Charlie Taylor's recommendations to the Secretary of State on school exclusions.

15. I recommend that teachers should be familiarised with the current threshold guidance; and that continuing professional development courses for teachers should be required to include a refresher component on safeguarding at least once in every three years.

16. I recommend that annual medical examinations at school be introduced for every child up to and including year 11.

17. I recommend that further attention be given to developing a good national standard for school nurse provision.

18. I recommend that Doncaster and every other local authority should be able to demonstrate that it is fully aware of and has complied with the April 2012 Statutory Guidance on the Roles and Responsibilities of Directors of Children's Services and Lead Members for Children's Services.

19. I recommend that consideration be given to the creation and provision of a concise national Parenting Guide.

20. I recommend that the following improvements should be made a high priority in Doncaster:

(a) The career structure of social workers in Doncaster should encourage workforce stability. This could be achieved in part by motivating the best staff to stay by an encouraging regime of grading and salary promotion.

(b) Promotion should not mean the automatic reduction in casework responsibilities for those promoted. It should be possible to reach a senior grade of management whilst still dealing entirely or mainly with casework.

(c) The existing mentoring arrangements should be improved so that every social worker, however experienced, has a mentoring partner with whom there should be freedom of discussion about cases and other aspects of the work.

(d) Every Children's Services manager, without exception and up to Director level, should hold some direct casework responsibilities. One would reasonably expect the most senior staff to be dealing with some of the most difficult cases.

(e) Continuous professional development for social workers at all levels should be active, with the occasional possibility for secondment and/or sabbatical leave for the purpose of broadening experience and skills.

(f) Partnership with academic institutions, such as a nearby university, should be developed further, to ensure the integrity and appropriate range of CPD.

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