DONCASTER LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW
'J' CHILDREN

November 2009

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Serious Case Review Overview Report relating to 'J' Children

This document contains the redacted Serious Case Review overview report relating to the 'J' children. This overview report was written by an independent author commissioned by Doncaster Local Safeguarding Children Board. It was published on 29 March 2012 by the Department for Education. The only editing undertaken by the Department prior to publication is the redaction of information that it is not appropriate to put into the public domain.

The process of redacting the overview report has involved:

- considering the welfare of children involved in the case;
- comparing the executive summary already in the public domain, with the corresponding overview report; no information that is included in the executive summary has been redacted;
- considering the extent to which information in the overview report is capable of being used to identify living individuals whose identity is not already common knowledge;
- considering whether information that is by its nature sensitive personal data under the Data Protection Act 1998 (for example, because it is information about a person's physical or mental health or condition, his / her sexual life, or the commission or alleged commission by him / her of an offence) is likely to have already been made public (for example, as part of a criminal trial) and whether its inclusion in the report is necessary to give a complete picture of events;
- redacting personal data or information which would breach reporting restrictions imposed by any court; and
- redacting any personal or sensitive personal data, including clinically confidential information, that has not already been published and which cannot be justified as necessary or relevant, bearing in mind the overall purpose of publishing the overview reports.

Doncaster Safeguarding Children Board

A Serious Case Review

‘J’ children

The Overview Report

November 2009

Index

1 Introduction and context of the review

1. On the 4th April 2009 a very serious assault occurred that has caused local and national dismay and distress. The victims are V1 [redacted] and V2 [redacted]. Both children live in Doncaster and attended [redacted] at the time of the assault.

2. V1 and V2 were left at the scene having suffered serious injuries and trauma [redacted]

3. [redacted]

4. The assaults were committed by two brothers, J1 and J2. Both boys were looked after by the local authority under s20 of the Children Act 1989 having been placed with foster carers less than [redacted] previously on the [redacted] 2009. [redacted] The boys subsequently pleaded guilty to a charge of grievous bodily harm with intent at the Crown Court on the [redacted] 2009.

5. Prior to this assault they had assaulted [redacted] the previous weekend. [redacted]

6. The J family and the victims of both assaults are all white British.

7. The incident was referred to the serious case review standing panel that met on the 9th April 2009 and agreed that the circumstances of the incident met the criteria for commissioning a serious case review (SCR). This recommendation was endorsed by the chair of the Doncaster Safeguarding Children Board (DSCB) on the 5th May 2009. In accordance with national government guidance and local DSCB procedures a serious case review panel was convened to oversee the review. This panel met for the first time on the 9th June 2009.

8. The review examines the involvement of agencies with the family of J1 and J2 from 1995 to the 7th April 2009.

9. Work began on compiling a chronology in May 2009, which coincided with the appointment of the independent chair of the serious case review panel and of the author of this overview report. The independent chair has previously provided an overview report for an earlier and unrelated serious case review in Doncaster. With this exception, neither the chair nor the overview author has worked for either the DSCB or any of the services contributing to the serious case review. Further information about their experience and knowledge is provided in section 1.8.

1.1 Rationale for conducting a serious case review

10. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires a Local Safeguarding Children Board (LSCB) to undertake a review of a serious case in accordance with procedures set out in chapter 8 of Working Together to Safeguard Children (2006).

11. The LSCB should always consider undertaking a serious case review when a child sustains a potentially life threatening injury [redacted] and the case gives cause for concerns about the way in which professionals and services work together to safeguard and promote the welfare of children.

12. Because of the circumstances of this case the focus of the review is on the involvement of services with the J brothers who the Standing Panel agreed had experienced serious and permanent impairment of their health and development through abuse and neglect.

13. The case has inevitably attracted a high level of local and national media interest and because of the circumstances of the assault there is a significant public interest in this case. This has resulted in a large and persistent range of questions and applications under Freedom of Information procedures from journalists since the incident. This has placed an additional burden on the DSCB manager and [redacted] staff during a complex and difficult review. In view of the extent of public interest in the case, particular attention will need to be given to a media strategy. The Chair of the DSCB will develop a media strategy in consultation with the relevant partner agency press offices.

14. The chair of the panel has ensured that the independent chair of the DSCB has been kept informed of progress on the review. There has also been considerable contact with the relevant officer at the regional government office from the outset of the case.

1.2 Reasons for the review and terms of reference

15. The reasons for undertaking this review are that children sustained a potentially life-threatening injury or serious and permanent impairment of their health and development through physical and emotional abuse; and the case gives rise to concerns about inter-agency working to protect children from harm.

16. The Serious Case Review Panel first met on the 9th June 2009 to confirm the scope and terms of reference. The scope of the review was agreed by the panel and reviewed and updated at each meeting to take account of new information and reflection. The final terms of reference were agreed on the 9th September 2009 prior to completion of the final drafts of IMRs and the first draft of the overview report.

17. The purpose of the review is to establish if lessons are learned from the case through a detailed examination of events, decision-making and action from 1995 through to April 2009. In identifying what those lessons are, to improve inter-agency working and better safeguard and promote the welfare of children in Doncaster.

1.3 The scope of the serious case review

18. The period of the review is from [redacted] 1995 to 7th April 2009. For this period the review includes the J children, their parents [redacted] who are described in section 1.16. For the period that the J children were resident in Doncaster, from [redacted] 2009 onwards, the review also includes their victims insofar as the actions of the J children directly or indirectly impacted upon them.

19. All agency chronologies should include detailed information about when the children were seen, spoken to or observations made about them[1].

20. Agencies that identify significant background histories on family members pre-dating the scope of the review should provide a brief summary account of the significant history. This will be for consideration by the Panel in reviewing the agreed scope.

21. All IMR's should examine the effectiveness of information sharing between Police and the local authority, immediately following the

1 ChronoLator was used as the template for coordinating the very large and complex history of multiple agency involvement over 14 years. It is a computer software programme designed to make the production of the chronology tables needed for serious case reviews more efficient. It ensures that contributing agencies present their data in a consistent format.

incident and up until the application for the court order releasing information.

22. Reviews of all records and materials should be considered including;

- Electronic records
- Paper records and files
- Patient held records.

23. Individual Management Reviews should be quality assured and signed off by the most senior officer of the reviewing agency.

24. All reports should be marked with their date, version number and author. Review reports should be completed in Arial font size 12 and chronologies in Arial font size 10.

1.4 The terms of reference

I. The following agencies to undertake Individual Management Reviews, and be completed in accordance with Working Together to Safeguard Children (2006), Chapter 8 and the associated DSCB guidance and procedures.

Action for Children
Children's Social Care Doncaster Metropolitan Borough Council
Doncaster and Bassetlaw Hospitals NHS Foundation Trust (includes CAMHS)
Doncaster Youth Offending Service which also includes the ABC Plus Team Families First and Family Intervention Project (FIP) and Youth Inclusion Support Service (YISS)
Education (Schools and Learner Engagement) Doncaster Metropolitan Borough Council
Neighbourhoods and Communities Doncaster Metropolitan Borough Council
NHS Doncaster Primary Care Trust
South Yorkshire Police
South Yorkshire Fire and Rescue Service
St Leger Homes (ALMO; Arms Length Management Organisation from October 2005)

II. Keep under consideration if further information becomes available as work is undertaken that indicates other agencies should carry out Individual Management Reviews.

III. To establish a factual chronology of the action taken by each agency;

IV. Assess whether decisions and action taken in the case comply with the policy and procedures of the Doncaster Safeguarding Children Board;

V. To determine whether appropriate services were provided in relation to the decisions and actions in the case;

VI. To recommend appropriate inter-agency action in light of the findings;

VII. To assess whether other action is needed in any agency;

VIII. To examine inter-agency working and service provision for these children;

IX. To establish whether interagency and single agency policies adequately support the management of this case;

X. Consider seeking contributions from family members;

XI. To develop a clear multi agency action plan from the overview report.

1.5 Particular issues identified for further investigation:

25. In addition to analysing individual and organisational practice, the Individual Management Reviews should:

I. Identify the lessons to be learned from this case in relation to the way in which local agencies and professionals worked together to safeguard and promote the welfare of the 'J' children, and their family;

II. Identify the circumstances leading up to and surrounding the incident on 4 April 2009, including whether all the children involved in the incident were treated as children throughout the process.

III. Identify whether there were opportunities for intervention that could have prevented the incident on 4 April 2009 and if so, why these did not prevent those events.

IV. Consider what opportunities were taken, or should have been taken, by agencies to identify and address the risks of permanent impairment to the health and development of the 'J' children [redacted]

V. Identify whether plans developed at multi agency meetings were effective, and met the needs of and provided the best outcomes for the 'J' children [redacted] throughout the period under review.

VI. Identify what other interventions might have improved the outcomes for the 'J' children [redacted].

VII. Consider if agencies assessed the parenting of the 'J' children [redacted], and if so the conclusions reached.

VIII. Summarise any significant issues from the parenting of the adults within the family that are relevant to the events within the scope of the review.

IX. Identify whether the professionals in contact with the 'J' children and their family understood the impact of domestic violence on the children [redacted] of the family.

X. Consider whether [redacted] was, or should have been, recognised within the 'J' children's family and the impact of this on professional involvement with the family.

XI. Consider whether the 'J' children were, or should have been, regarded as posing a [redacted] risk to other children, prior to the incident.

XII. Identify whether information in respect of the 'J' children and their family was shared among agencies to best effect so as to inform appropriate interventions.

XIII. Consider whether practice was sensitive to the racial, cultural, linguistic and religious identities of the all child who are included within the Review and their families.

XIV. Consider whether the wishes and feelings of all children who are included within the Review were ascertained, properly recorded and taken into account when decisions were made by agencies.

XV. Consider whether all single agency and multi-agency procedures were followed.

XVI. Consider whether the policy, procedural, management and resource infrastructure that surrounded each agency's involvement with the 'J' children and their family adversely impacted upon safeguarding and promoting the welfare of children and young people who are the subject of this Review.

XVII. Consider previous Serious Case Reviews conducted by the Doncaster Safeguarding Children Board and take into account any common themes

1.6 The terms of reference for the overview report

26. Provide a multi agency overview report in accordance with the national guidance in Working Together to Safeguard Children.

27. In addition to the requirements of Working Together to Safeguard Children (2006) and taking into account the specific issues identified above, the overview report author should:

28. Comment on whether the Individual Management Reviews have addressed the terms of reference and all relevant issues

29. Examine the inter agency working and communication between all involved agencies

30. Determine whether services which were provided, actions taken and decisions made were in accordance with current policies, procedures and Government guidance

31. Consider, using the benefit of hindsight, whether different decisions or actions may have led to a different course of events

32. Provide an executive summary for publication on behalf of the DSCB.

1.7 Membership of the case review panel and access to expert advice

33. An independent person was appointed to chair the case review panel from the outset. Section 1.8 includes information about his experience and knowledge.

34. The Case Review Panel overseeing this review comprised the following:

Mr Chris Few	Chair, Independent Consultant
Mr Tom Common	Assistant Director Intervention and Support until October replaced by Carol Dunkerly DMBC
Ms Josie Turgoose	Senior Probation Officer (until June 2009) attended one meeting
Ms Marion Corbett	Designated Nurse Safeguarding and Looked After Children
Vicki Lawson	Assistant Director Safeguarding and Vulnerable Children DMBC
Mr Rob McCormick	Head of School Leadership and Management, DMBC
Ms Jane Miller	Director of Neighbourhoods and Communities, DMBC
Mr Peter Maddocks	Overview Author
Mrs Hilary Bond	Director of Nursing, Doncaster & Bassetlaw Hospitals

	NHS Foundation Trust
Mr Pete Horner	Public Protection Unit Manager, Specialist Crime Services South Yorkshire Police
Mr Shaun Kelly	Performance Improvement and Inclusion Manager Action for Children
Ms Judith Jones	Director of Customer Services, St Leger Homes
Ms Dawn Orton	Doncaster Safeguarding Children Board Manager
[redacted]	[redacted]

35. The independent author of the overview report attended every meeting of the panel.

36. The panel had access to legal advice from a solicitor in the council's legal service.

37. Written minutes of the panel meetings were recorded by a member of the DSCB staff team.

1.8 Independent author of the overview report and independent chair of the serious case review panel

38. Peter Maddocks was appointed in May 2009 as the independent author for this overview report. He has over thirty years experience of social care services the majority of which has been concerned with services for children and families. He has a professional social work qualification and MA and is registered with the General Social Care Council. He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to many service reviews and inspections in relation to safeguarding children. He has undertaken agency reviews and provided overview reports to several LSCBs in England and Wales.

39. Chris Few works independently as a safeguarding children consultant and as Chair of Local Safeguarding Children Boards. His background as a police officer includes safeguarding children policy development, leadership of child abuse investigation functions and homicide enquiries. He has degrees to Masters Level in Forensic Psychology. He has chaired serious case review panels, undertaken agency management reviews and prepared overview reports for a number of Local Safeguarding Children Boards and their partner agencies.

1.9 Parental and family contribution to the serious case review

40. The family are aware of this serious case review. The criminal investigation required a delay in seeking contributions from the family. Further complications have arisen as a result of both parents apparently leaving the local area. [redacted]. This has created difficulties in locating [redacted] in order to provide an opportunity for a meeting with the overview author. J1 and J2 will be offered an opportunity to meet with the overview author.

1.10 Time scale for completing the serious case review

41. The case review panel met on seven occasions between June 2009 and November 2009. The chronology of services involvement was complete by September 2009. The first draft agency reviews were complete by September 2009. The first draft of this overview report was completed in October 2009 and the final report presented to an extraordinary meeting of the DSCB on the 18th November 2009.

1.11 Status and ownership of the overview report

42. The overview report is strictly confidential and is the property of the Doncaster Safeguarding Children Board. It is not to be distributed or disclosed to anyone other than members of the DSCB and the relevant officers of the Yorkshire and Humber Government Office and Ofsted unless prior permission has been agreed by the Board. The DSCB is not deemed a public body[2] under the Freedom of Information Act 2000 and as such is not subject to the same disclosure requirements as public bodies such as the local authority. The content of this review is subject to the provisions of The Freedom of Information Act 2000. The report is protected information under section 36 which provides an exemption in relation to information, the disclosure of which would prejudice the conduct of public affairs by inhibiting the free and frank exchange of views[3]. An executive summary is provided at the conclusion of the review for public disclosure. Copies of the executive summary are provided for family members who contributed to the review and to [redacted] assaulted by J1 and J2.

1.12 Previous serious case reviews

43. This is the eighth serious case review undertaken by the DSCB since it was established in October 2005 following the implementation of the Children Act 2004 that replaced the previous structures of Area Child Protection Committees (ACPC).

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[2] Ministry of Justice; July 2009

[3] Freedom of Information Act 2000 (Section 50) Decision Notice Date 23 August 2006

44. Appendix five provides a summary of previous learning identified in earlier serious case reviews that are relevant to this case.

45. Chapters four and five of this review describe in greater detail the specific lessons to emerge from a detailed analysis of this serious case review and include comments on how learning from previous reviews has been used.

1.13 Inspections of services for children in Doncaster

46. The Youth Offending Service (YOS) in Doncaster was established in 1999. The YOS was inspected at the same time as the Joint Area Review (JAR) in 2005. The inspection found a service that was functioning well in all areas of its work, with strong management arrangements, good multi-agency working and proactive interventions with children and young people. The service was rated as good or excellent against the five key judgments.

47. The Youth Service (DMBC) was subject of an enhanced inspection in 2006 when they were judged outstanding. [redacted].

48. Overall services for children in Doncaster were subject of a Joint Area Review (JAR) in the autumn of 2005. The JAR inspectors examined all aspects of work with children against the five key national priorities for English children's services in Every Child Matters and found less satisfactory performance. Arrangements for keeping children safe were judged adequate although the inspectors highlighted some vulnerability. For example the lack of agreed thresholds for intervention caused delays in accessing services for some children. There was a lack of consensus about what constituted a full assessment. The quality of assessment, planning and record keeping for individual children was inconsistent with some being very poor. These are all features of the case examined in this review.

49. At the time of the JAR the council had made progress in reducing vacancies of social workers and there was an anticipation that planned re-organisation of services would be well managed and achieve positive change in delivering better coordinated services in local areas.

50. The re-organisation of council services has been heavily criticised subsequently and is recognised as being a very significant factor in the failure of children's services; the annual performance assessment (APA) of children's services in 2008 describes services for children and

the council's capacity for improvement to be inadequate. This review finds evidence that the reorganisation of services in 2005 is a significant contributory factor to how this case was so poorly managed.

51. Of other relevance to this review is the inspectors' concern that behaviour problems were an issue in some schools and practice was inconsistent. There were more permanent and temporary exclusions than elsewhere. Not all excluded pupils received sufficient time in education. The amount of provision for pupils excluded from school was inadequate as not all young people received their entitlement to full-time education and for too many children the provision for behaviour support was not fully effective. This is a significant factor in this review. [redacted].

52. Almost half of the children surveyed as part of the JAR felt they would do better if classes were quieter and if pupils behaved better. [redacted] The inspectors were reassured that recent action and new appointments in 2005 signaled good capacity for improvements in the coordination and implementation of the behaviour strategy. It seems evident problems still persist.

53. Within the two years following the JAR the quality of services for children had declined to the extent that by 2008 the APA judged that arrangements for safeguarding children were inadequate. This coincided with the Diagnostic Review by Cambridge Education and a decision by the Secretary of State to order an Intervention Team into Doncaster at the beginning of 2009 and the preparation of an improvement plan.

54. Significant concerns highlighted in the APA include;

- The Local Safeguarding Children Board (LSCB) had not ensured the effective implementation of procedure and practice to support the management of child protection allegations;
- The number of new cases subject to a child protection plan and those on a plan was significantly higher than statistical neighbours and those found nationally;
- The number of initial assessments and core assessments completed within timescale was low and significantly worse than statistical neighbours and those seen nationally;
- One in four child protection cases was not allocated to a social worker;
- The council acknowledged weaknesses in the process and practice regarding staff training, the rigour of recording and in case allocation. The council's fostering service was inadequate;

- Standards in the councils own children's homes had deteriorated and nine homes were inadequate in meeting national standards.

55. Against this context, seven previous serious case reviews have also highlighted significant concerns about the capacity of local services to protect children in Doncaster.

56. This review identifies important learning, much of which is consistent with the evidence summarised in relation to inspections and previous reviews. It is apparent when examining this case that the shortcomings are not restricted to recent months.

57. It therefore raises challenges not just about the judgements, decision making and practice of individual practitioners and professionals but more substantially why the corporate and organisational arrangements that are designed to oversee and ensure services are effective in keeping children safe failed to do so, and within such a short time scale since the JAR. This is a theme explored in the final chapter.

1.14 Summary conclusion of the review panel

58. The panel are very mindful that examining events and decision making through hindsight can fundamentally distort how obvious the right or wrong judgements and action looked to practitioners at the time. Nonetheless, the following chapters provide compelling evidence about the extent to which [redacted] 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. These are described in greater detail in section 5.1 of this report.

59. It is not possible to reasonably conclude on the basis of the evidence and information examined that any individual could have predicted the severity and extent of the assaults on V2 and V1 on the 4th April 2009. Neither an expert independent psychological assessment nor the local psychiatric services suggested a heightened risk of extreme violence from any of the children.

60. It was however entirely predictable that the boys would continue to assault and cause injuries to other children (and adults). This is a pattern of escalating behaviour established over many months. For this reason, more assertive and effective action should have been taken and as late as a week before the assault on V1 and V2 and there were opportunities to do this. As such the assault on V1 and V2 was a preventable incident.

61. It is apparent that [redacted], have all displayed escalating violence and disregard for the safety and wellbeing of others. It is also apparent that they are [redacted] for whom the usual sanctions and moral frameworks that guide the vast majority of children and young people have little influence or effect. This reflects the extent to which their emotional and psychological health and development has been neglected and impaired over many years alongside the more tangible evidence of the physical neglect and abuse that they experienced. This is a theme that is explored later in the review.

62. Although the review panel are not privy to the motivation for the assault, it is apparent that it is the behaviour of two boys who [redacted] endured many years of living in a chaotic and neglectful household with regular exposure to high levels of physical and verbal violence. This does not excuse the crime or imply that all children who experience neglect and significant domestic abuse will commit such a serious crime; it does however provide a degree of insight as to why two young boys could be capable of a crime of such premeditation, duration and violence that is beyond the norms of children who are not yet adolescent or indeed older individuals.

63. A central learning point for this review is why it took so many agencies so long to recognise the significance of the boys' family life on their behaviour. This is reflected in several aspects; the failure to recognise and deal with the degree and extent of FJ's threat and actual emotional and physical violence and his harmful influence on the whole family; the degree to which the parenting capacity of MJ in particular was undermined and compromised making her an ineffectual person increasingly unable to exercise her parental responsibility with good effect for her children; the extent to which MJ was unwilling and increasingly unable to prioritise the needs of her children for proper care and control; the extent to which MJ's opposition and manipulation of professional intervention heightened the risk to her children and for others; that professionals were generally ineffectual in planning and executing more effective intervention that could have met their needs better. Collectively they could have reduced both the risk and opportunity for such a serious crime to have been committed.

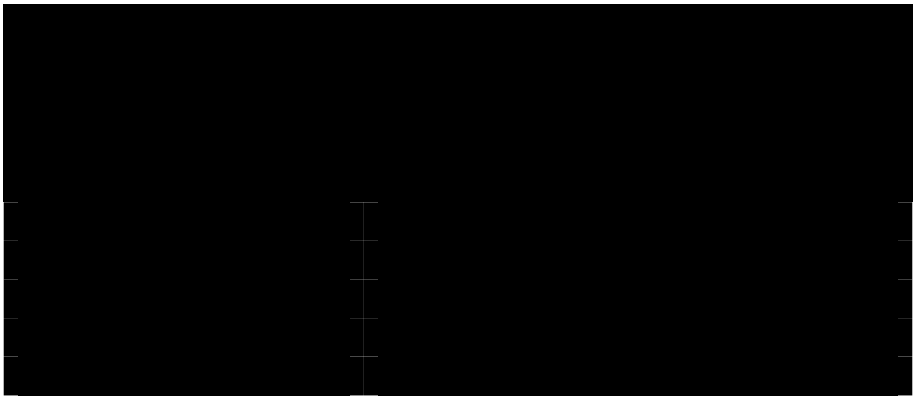
64. Matters are further compounded by the practice of different professionals convening what are in effect parallel planning meetings. The majority of meetings are organised in response to the antisocial behaviour concerns rather than having a clearer focus on the boys as children with complex needs arising from their emotional, psychological and behavioural difficulties. The boys lack effective parenting over many years. This should have been a fundamental starting point for collective intervention. The lack of engagement by children's social care services is an important factor.

65. The single most influential factor in this case is the corporate and organisational inadequacies that contribute to the missed opportunities identified later in this report. It is no coincidence that during the latter months when there is a marked escalation in the boys' problems that children's social care had very high vacancies, and almost a quarter of children subject to a child protection plan did not have a qualified social worker responsible for leading on their safeguarding arrangements. If the most vulnerable children in need do not have access to suitably qualified and experienced staff it will be unsurprising to find other children who have yet to be properly assessed in terms of risks to their physical safety and emotional and psychological well being. The effect on children can be very damaging and enduring. This is such a case.

1.15 The facts

66. A genogram showing membership of the family is included as appendix I of this report.

1.16 [redacted]



67. The negative impact on J2 of [redacted] death is highlighted in the ONSET[4] assessment undertaken by the YISS on the [redacted] 2007. There is no other information about extended family members in any agency records examined during the review. After the review began work the panel was informed that the [redacted] died in [redacted]

[4] The Onset referral and assessment framework was designed by the Centre for Criminology, University of Oxford for the Youth Justice Board. It helps identify risk factors to be reduced and protective factors to be enhanced. It also provides information which might be helpful in selecting appropriate interventions for those identified as needing early intervention.

1.17 The three victims of J1 and J2 assaults

V2	Victim of crime by J1 and J2
V1	Victim of crime by J1 and J2
V3	Victim of crime by J1 and J2

1.18 Cultural, ethnic, linguistic and religious identity of the J family

68. All of the family are white British and speak English as their first language. There is no information regarding any religious or faith based beliefs in any of the families. This reflects the incomplete collation and recording of a social and family history. Very little is known about the various families and therefore little insight as to why MJ is so vulnerable to violent men, the context for FJ's propensity for violence and emotional abuse, or the extent to which either have been prepared through their own upbringing to parent their own children.

69. The absence of a satisfactory social, health and education assessment undermines the ability of all agencies to take clear enough account of the specific cultural, ethnic, linguistic and religious needs of the family. It is a matter of record by the YISS that the death of [redacted] was significant to [redacted]

70. Although the scope of the review is to examine events from 1995 it is worth noting that [redacted] was known to agencies prior to this date and had been [redacted]. MJ is thought to have relatives in [redacted] although none of the agencies involved with the family have any further detail about the family histories of either adult.

71. There is a degree of uncertainty as to whether [redacted] have a disability in relation to their learning. [redacted]. One of the starkest features of the case is the extent to which the educational psychology service is effectively at arms length to [redacted]. Matters are further compounded by the practice of different professionals convening what are in effect parallel planning meetings. The majority of meetings are organised in response to the antisocial behaviour concerns rather than having a clearer focus on [redacted] as children with complex needs arising from their emotional, psychological and behavioural difficulties. [redacted] lack effective parenting over many years. This should have been a fundamental starting point for collective intervention. The lack of engagement by children's social care services is an important factor.

72. [redacted]

2 Overview of agency involvement

73. An integrated chronology of several hundred pages is provided as a separate appendix. This chapter provides the narrative summary.

74. The information summarised in this chapter is taken from the extensive chronology of agency involvement with the family and the individual management reviews.

75. Little is known of the family background prior to 1995 and this was never explored or collated throughout the succeeding years of agency involvement.

76. In January 1995 MJ was distressed [redacted]. She had recently [redacted]. Domestic abuse will be a recurring and consistent feature of domestic life during the following [redacted]

77. On the [redacted] 1995 [redacted] were brought to hospital for a medical examination following an assault [redacted] by FJ in the family home the previous evening whilst MJ was out. [redacted]

2.1 The first child protection conference following FJ's injury of [redacted]

78. A child protection conference on the [redacted] 1995, attended by the consultant paediatrician was advised that the injuries were non-accidental [redacted] The conference decided to not make the children subject of a child protection plan. The conference was advised by MJ that she had stopped contact with FJ although this was not confirmed or challenged. No other plan of support or intervention was agreed although primary care services retained contact through the health visitor and GP. For the most part these routine checks are unremarkable [redacted].

79. In [redacted] 1995 the police arrested FJ for assaulting MJ. Their records show that [redacted]. FJ was charged with assault occasioning actual bodily harm [redacted]

[redacted] DAS were informed but no record was made and no action resulted.

80. By the [redacted] 1995 it is apparent from a home visit made by a nursery nurse that FJ is spending time in the home. Later records suggest he is living at the house. A joint visit on the [redacted] 1995 by the nursery nurse and a social worker is intended to emphasise the 'gravity' of allowing FJ back in to the home. This visit is not recorded by DAS. MJ continues to say the relationship is over but concedes she is frightened of his violence. It is apparent from other recorded evidence that includes FJ being in the house early morning, boots being left in the house and his attendance at clinic appointments that the relationship is not over.

81. In [redacted] 1995 the health visitor is told during a routine clinic check and [redacted] that MJ and FJ are living together and are engaged to marry. A housing application later that month is made in their joint names.

82. In [redacted] 1995 the police arrest FJ for assaulting MJ [redacted] and are charged with actual bodily harm (ABH). [redacted] It seems the information about the offence was not reported to any other agency.

83. By [redacted] 1996 MJ [redacted] and there are reports that FJ is continuing his assaults on MJ although these are not reported to the police. [redacted].

84. A social worker at the hospital provides a short social history in a memorandum [redacted].

2.2 MJ's first disclosure of domestic violence from FJ

85. During MJ's stay in hospital [redacted] she discloses sustained domestic violence from FJ. A telephone referral is made to the emergency duty team (EDT) on the [redacted] 1996 that results in a faxed 'action report sheet' being sent to SW5 describing the history of abuse and an agreement to an 'investigation strategy which will not endanger MJ'. (There are no other records held by duty and

assessment team (DAS) concerning what happened as a result of the referral although on the [redacted] 1996 although it appears an exit plan was developed to help MJ leave the domestic violence.

86. The nursery nurse is told by a social worker that MJ [redacted] are in a hostel having become homeless fleeing FJ [redacted]. She is not re-housed until the end of July 1996 by which time she has resumed her relationship with FJ).

87. According to police records a referral was made by Children's Social Care Services to the dedicated Sexual Offences and Child Abuse Unit (SOCAU) in Doncaster. It was alleged that MJ attended hospital with bruising that had been caused by FJ. She was not making a complaint about the assault on herself but the information states that whilst she was in hospital [redacted] was assaulted by FJ. [redacted].

88. [redacted]

FJ was interviewed for the offence of assault on [redacted]. There is no record of any statement or interview taking place in respect of the injuries to MJ.

89. During a home visit by the health visitor the day following MJ's disclosure of violence at hospital ([redacted] 1996) MJ is described as physically weary and admits FJ has beaten her for weeks. [redacted] FJ has also threatened to throw [redacted] through a window. [redacted]

90. The GP examined [redacted] and the police become involved on the following day. The GP makes a written referral to DAS who have no record of this. MJ wants to make complaints about a series of assaults by [redacted]. FJ is not interviewed until [redacted] 1996, by which time he has resumed his relationship with MJ and denies the allegations. No further action is taken. [redacted].

91. On the [redacted] 1996 MJ presents herself as being homeless [redacted] at DMBC's homeless section. MJ states she is fleeing violence from FJ MJ is placed in a homeless hostel within the borough.

92. MJ is provided with a tenancy on the [redacted] 1996 where she lives until moving in [redacted] 1999 to the address [redacted] where the family live until [redacted] 2009.

93. A health visitor who recently took over the case makes a telephone and written referral to DAS on the [redacted] 1996 reporting [redacted] and MJ's difficulty in exerting care and control. The health visitor requests a child protection conference. There is no record of the referral or request for a conference in DAS. The Child protection Register check on the [redacted] 1996 should have alerted DAS to FJ having resumed the relationship with MJ.

94. A referral by the health visitor to DAS in [redacted] 1996 is not recorded or any of the concerns or action taken. Records of a home visit by the health visitor a week later confirm there has been no contact with by DAS with the family. MJ admits that FJ is staying in the home on three nights a week. He is present during the visit and MJ says there is no reoccurrence of violence.

95. After several follow up phone calls the health visitor is told by DAS a month after the referral that no intervention will be offered but action will be taken "as necessary to referrals from other agencies".

96. From [redacted] 1996 there are regular recorded concerns about the children's development. In [redacted] 1997 [redacted] is subject of a paediatric [redacted] referral. In [redacted] is discharged after two appointments are missed.

97. On the [redacted] 1997 FJ is arrested for a further assault on MJ and another person. [redacted]

98. Although MJ says her relationship with FJ is over, by [redacted] 1997 MJ confirms she is living with FJ [redacted].

99. In [redacted] 1997 [redacted] is causing [redacted] teachers' concern about [redacted] progress at [redacted] school. [redacted] This is the first of [redacted] referrals made to the Education Psychology Service in relation to [redacted]

100. In [redacted] 1998 the health visitor writes in support of the family's application for re-housing. The parents share their bedroom with [redacted], there is no space to play, and home conditions are generally overcrowded. The overcrowding

becomes more acute [redacted]. MJ is frequently described as looking tired (and throughout review period). [redacted]. By 1999 MJ feels low and weepy [redacted]. MJ is opposed to support from DAS. In 1999 MJ attends at the A and E [redacted]. None of this is apparently shared with other agencies.

2.3 First information about FJ's [redacted]

101. In 1998 [redacted]

102. In 1999 [redacted]

103. In [redacted] 1999 the family move to the home they occupy until 2009. FJ is convicted of criminal damage at the property in 2000. [redacted] The hospital assessment was shared with the health visitor who was collocated with the GP at the time prior to their reorganisation. There is no evidence of this information being shared with DAS.

104. [redacted]

105. In [redacted] 2000 FJ leaves MJ who is unsure if he will return. [redacted]. MJ is [redacted].

2.4 [redacted] injury and attendance at A&E

106. On the [redacted] 2002 [redacted] attends the A&E [redacted]. FJ had become so aggressive about waiting for treatment [redacted] that security staff had to intervene. Hospital staff made contact with the family health visitor on the [redacted] 2002 to discuss this. [redacted] The health visitor agreed to follow-up the hospital attendance. [redacted]

107. [redacted].

2.5 Referral for family support

108. In [redacted] 2002 the EWO refers [redacted] to the family centre provided by Action for Children. She recognises that MJ is struggling to manage [redacted] behaviour and [redacted] also have behavioural difficulties. The referral asks for support for the children during the holidays and after school and provide support to MJ.

109. From the first visit to the home by the deputy project manager she observes at first hand chaotic and aggressive behaviour in the home and MJ has little control or understanding about managing their behaviour. Although MJ is accepting of support [redacted] and agrees to their attendance at sessions and activities, she is less willing to be involved herself and begins to display more clearly her determination to control professional involvement with the family that will be an increasing characteristic.

110. [redacted] attend one of six sessions arranged for them over the school holidays. Four sessions are arranged for [redacted] MJ found it difficult during the holidays to get the children to the Family Centre. [redacted]. The centre provides transport for the children to

attend sessions. [redacted]

2.6 Children's disclosure of violence in the home and MJ's reaction

111. During the After School session on [redacted] 2003 [redacted]

112. The deputy manager phoned DAS on the [redacted] 2003. There is no record of this in DAS. A telephone call was made to a social worker in the DAS, 'updating the situation'. A letter was sent to the DAS explaining that the initial referral provided details of mother being a victim of domestic violence for [redacted] and the children had witnessed this. It goes on to say that it had not been possible to speak with either mother or FJ [redacted]. The inconsistencies in the accounts given by MJ were highlighted. [redacted] None of this is recorded by DAS. In [redacted] 2003 the social worker writes a letter to say an initial assessment has been completed, there had been discussion with school and the case was closed. There is no evidence that any action is taken. The family centre closes involvement on the [redacted] 2003. The IMR from Action for Children concedes this was a lost opportunity.

2.7 [redacted]

113. [redacted]

[redacted].

114. [redacted].

2.8 Children's increasingly disruptive behaviour and educational difficulties

115. [redacted]. MJ is described as unsupportive to the school, [redacted].

116. [redacted].

117. In [redacted] 2004 [redacted] assaults a teacher at his [redacted] school. His behaviour throughout the month is very difficult involving daily violent and disruptive incidents [redacted] He is also allocated support from the Behaviour and Interim Tuition Service. [redacted].

118. [redacted].

119. [redacted] J1's behaviour is increasingly uncontrolled and in [redacted] he is referred to the Behaviour and Interim Tuition Service. He is allocated a place at [redacted] from [redacted] 2005.

120. [redacted] J2's behaviour becomes an increasing concern from [redacted] 2005, assaulting other pupils and using offensive language to peers and teachers.

2.9 First complaint under the anti-social procedures

121. On the [redacted] 2005 there is the first complaint of anti-social behaviour. A breach of tenancy letter is sent the same day stating that complaints have been made by neighbours [redacted]. No other agency other than the St Leger Homes is informed.

122. In [redacted] 2005 [redacted] The information was not shared with any other agency.

123. In [redacted] 2005 [redacted] J1 together with [redacted] throws a brick at a moving bus [redacted]

124. By [redacted] 2005 [redacted]

125. J1 [redacted] returns to [redacted] school in [redacted] 2006. [redacted]. At [redacted] 2006 J1 injures [redacted] people. A referral is made to the education psychology service. [redacted].

126. By [redacted] permanent exclusion is being discussed following J1's threats of adults [redacted]; this has similarities with the allegation that FJ [redacted]. A multi agency meeting at the school on the [redacted] 2006 decides to exclude J1 until [redacted] although it is clear they intend for him not to return to the school. The EWO agrees to make a referral to DAS; MJ does not want the referral to be made to DAS. It is unclear if a referral was made. DAS have no record of a referral at this time although records confirm that contact takes place between DAS, EWS and school. There is also a reference to an initial assessment in [redacted] 2006 although there is no recorded assessment. [redacted].

2.10 J1 is injured by FJ [redacted]

127. J1 was seen to have a bruise on his ear on [redacted] 2006 and said that FJ had hit him. [redacted]

[redacted].

128. In mid [redacted] 2006 [redacted].

129. At the end of [redacted] 2006 [redacted]

130. At the end of [redacted] 2006 [redacted]

2.11 [redacted] not in educational provision

131. During the summer of 2006 neither [redacted] is attending any provision. [redacted].

132. At the beginning of [redacted] 2006 [redacted]

133. An initial assessment is undertaken on the [redacted] 2006 with [redacted] J1 by the hospital and interim tuition service. J1 has been placed at [redacted]. The assessment is not faxed to DAS until the [redacted] 2006. J1 is excluded before the end of the month [redacted].

2.12 J2's assault on [redacted] in 2006

134. At the beginning of [redacted] 2006 J2 [redacted] assaults [redacted]. The police are informed and it is treated as [redacted]. No other services are told of this incident. In early [redacted] barely a month later he [redacted]

[redacted] and behaves in an 'uncontrolled and inappropriate manner'.

135. Later in [redacted] 2006 [redacted] J2 is subject of a behaviour agreement at school [redacted]. He is referred to the Family First service by [redacted] at School [redacted] on [redacted] 2006 requesting support with J2's [redacted] behaviour. The work is not allocated until the [redacted] 2006 and then has to be re-allocated to another worker who contacts MJ on the [redacted] 2006. The first meeting with J2 is at school on the [redacted] 2006 when he agrees to attend a friendship behaviour group. He participates well in the six sessions. The case is closed on the [redacted] 2007.

136. On the [redacted] 2006 the [redacted] makes a referral to DAS describing J1's history of violence against other children and staff. The referral includes J1's own disclosure of being hit by FJ. It is unclear whether this is intended to be a referral of a child in need or of a vulnerable child requiring protection. DAS have no record of this referral. There is a record at the end of [redacted] 2006 of J1 being invited to come in to duty to discuss his problems and receive 'advice of appropriate support services they (sic) can access and make appropriate referrals'. A referral is made to Families First by DAS and the case is subsequently closed on the [redacted] 2007 without any further action being taken.

137. [redacted] continue to be disruptive. By [redacted] 2006 J1's placement at [redacted] ends and he is transferred to [redacted]. At the admission meeting on the [redacted] 2006 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.

138. On the [redacted] 2007 [redacted] staff noted a round burn mark on [redacted] J1's shoulder. He provides an inconsistent explanation. No referral or information is shared with other services.

2.13Referral to Families First

139. On the [redacted] 2007 Families First is first contacted regarding J1 in the form of a Request for Service from the DAS. The referral requests support for MJ in managing J1's behaviour. DAS had completed an initial assessment that concluded there was no role for DAS. A home visit did not take place until the [redacted] 2007 when MJ declines the service.

140. In [redacted] 2007 [redacted] J2 punches another pupil [redacted]. This information is not shared with any other service. [redacted].

141. [redacted].

2.14 [redacted]

142. [redacted]

143. [redacted].

144. On the [redacted] 2007 [redacted] beat up [redacted]. Later the same afternoon they threaten [redacted].

2.15 [redacted]

145. [redacted].

146. On the [redacted] 2007 [redacted] throw stones at [redacted] children attending an after school activity. [redacted]. It is

reported to the police and [redacted] are advised with their parents as to their conduct. No other action is taken.

147. The following day J2 throws stones at [redacted] and hits [redacted] several times [redacted]. He is spoken to but the incident is treated as a local problem [redacted]. Four days later on the [redacted] write to the head teacher complaining about J2's violent behaviour and assault on [redacted] while J2 attends the [redacted] school. Exclusion proceedings are initiated soon afterwards.

148. [redacted]. Four days later J1 and J2 assault [redacted] holding [redacted], and hitting [redacted]. On the [redacted] he assaults an [redacted] until [redacted] is able to run away. [redacted]. J1 is arrested, admitted the offence and is reprimanded on the [redacted] 2008. No witnesses are willing to make statements. [redacted] commit criminal damage at [redacted].

149. [redacted]

2.16 Referral to the Family Intervention Project

150. On the [redacted] 2007 St Leger Homes refers MJ to the Family Intervention Project (FIP)[12]. The referral includes information about the [redacted] and the attack on [redacted]. The referral says that MJ is 'grateful for any offer of assistance from agencies to help improve the behaviour of her boys and prevent further tenancy action being taken'.

151. [redacted]

[12] **The FIP** is one of 54 projects established nationally to tackle the most antisocial families.

[redacted].

152. On the [redacted] 2007 a breach of tenancy conditions letter is sent to MJ confirming a Possession Order is to be sought. This is never served and it is unclear why the notice was issued when the decision of the meeting was to [redacted].

153. [redacted].

2.17J2 referred to YISS

154. On the [redacted] 2007 J2 [redacted] is referred to the YISS by the anti social behaviour coordinator. He is subsequently also referred to REMEDI in [redacted] for work in relation to [redacted] and victim awareness. A referral is also made to the FIP and suggestion of undertaking a family group conference.

155. [redacted].

156. On the [redacted] 2007 the GP makes a referral to DAS describing that [redacted], a history of domestic violence and missed immunisations. An initial assessment is completed on the [redacted] 2007.

157. On the [redacted] 2007 the YISS complete an ONSET assessment with J2. This scores the risk of offending as high but does not identify him as vulnerable. It refers to the death of [redacted]. No other agency appears to have information about this.

158. [redacted].

159. On the [redacted] 2007 [redacted] damage the car of [redacted]. Shortly afterwards they assault [redacted].

160. [redacted]

2.18Further information about domestic violence

161. On the [redacted] 2007 there is a home visit by the YISS key worker who only sees MJ. The YISS support plan for J2 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 J2 with the FIP who agree to take the lead role in work with [redacted].

162. [redacted].

163. [redacted].

164. On the [redacted] 2007 a referral is made to DAS by the YISS detailing the anti social behaviour, [redacted]. Apart from a check of the child protection register no other action is recorded by DAS. A follow up phone call by YISS on the [redacted] states the date of referral is the [redacted]. DAS say they have no trace of a referral and request that it is re-submitted by fax. DAS close the case on the [redacted].

2.19Further assaults by J2 in 2007

165. On the [redacted] 2007 J2 [redacted] shoots [redacted] with a ball bearing gun. No injuries are caused and the police speak with [redacted]. A week later J2 assaults a [redacted].

166. On the [redacted] 2007 J1 [redacted] and J2 call at a house to tell [redacted]

[redacted]. Although an argument had taken place the rest of the story was untrue but has some concerning elements given the later events of [redacted] 2009.

167. On the [redacted] 2007 the FIP receive a referral form the YISS on behalf of the Safer Neighbourhood Team (SNT)[14]. This was one of the first referrals to the Doncaster FIP. The family had been living at their current address since [redacted] 1999 and was well known in the area by local residents who had complained extensively to the SNT, particularly about the behaviour of [redacted]. [redacted]. This includes specific reference to assaults on other children [redacted].

168. On the [redacted] 2007 J2 pushed [redacted] into the path of a moving car [redacted]. J1 then punched the [redacted].

169. In addition to the assaults described in this chapter [redacted] are responsible for multiple incidents of verbal abuse [redacted]. Their behaviour in educational placements remains disruptive and physical and verbal abuse of adults and peers are frequent. There are several incidents of damage to [redacted] property. [redacted].

170. A FIP worker begins work with the family from the beginning of [redacted] 2007. A meeting on the [redacted] with mother [redacted] agrees a contract to coordinate FIP and YISS intervention.

171. During a home visit by YISS on the [redacted] 2007 [redacted]. During a further visit the following day mother claims to have no knowledge of [redacted] throwing stones [redacted] or [redacted].

2.20 Growing concern about the safety and welfare of the children in [redacted] 2007

[14] Doncaster has 17 Safer Neighbourhood Teams that operate at a local level to build good links with the communities they serve. They are made up of police officers and council staff aimed at tackling and reducing the causes of crime in those communities.

172. A multi agency meeting that is chaired by Neighbourhood Manager [redacted] on the [redacted] 2007 is attended by all services including a solicitor from DMBC legal services. The main concern of the meeting is the safety and welfare of the children and an inadequate involvement with the family by DAS. The meeting is, according to the IMR from neighbourhood and communities, a result of IDCS at that time requesting an urgent multi agency neighbourhood meeting to look at all aspects of this case. The case had been raised with him by the ward councillor. Despite the request from IDCS, there was no representative from DAS at this meeting.

173. A 'case conference' on the [redacted] 2007 'tasks' [redacted] to pursue the option of a demoted tenancy. It is unclear why this was not allocated to the St Leger Homes.

174. On the [redacted] 2007 the GP makes referral to DAS concerning domestic violence in the 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[15]. This information was in MJ's records but not those for the children.

175. From [redacted] 2007 there are references to the children's physical neglect. On the [redacted] J1 is described as arriving at [redacted]. There is also reference to [redacted].

2.21 Independent psychology assessment is commissioned

176. [redacted].

177. During a home visit by the YISS on the [redacted] 2007 arrangements are made for J2 to be assessed for the mentoring scheme[17]. [redacted] and in any event J2 forgets the appointment.

2.22 [redacted]

178. [redacted]

[15] This is outside national timescales for beginning and completing an initial assessment.

[17] **The Youth Mentoring Scheme** recruits, trains, deploys and supervises volunteer mentors who provide young offenders with a positive adult role model, with the aim of counter-acting the negative peer group pressure to which some young people are vulnerable.

[redacted].

179. On the [redacted] 2007 a GP contacts DAS expressing concern that a referral made in [redacted] 2007 has not been followed up. The referral highlighted the history of domestic abuse, multiple injuries to the children over several months, missed vaccinations, and frequent [redacted]. MJ is too frightened to leave [redacted] the children with FJ, and although denies any physical abuse from him at present MJ is frightened it might occur.

180. A multi agency 'family update meeting' on the [redacted] 2007 discuss concerns about the physical well being of [redacted] who often appear [redacted]. Domestic violence is suspected but not been confirmed. This reflects the extent to which the previous concerns about the family are unknown to the current intervention team. The meeting is told by the YISS support worker that despite continuous engagement there is no improvement in behaviour [redacted]. The meeting is told that DAS are 'in the middle of an initial assessment'. The solicitor who is present at the meeting advises that a suspended possession order could be issued but no action is agreed or carried forward. A subsequent meeting between the St Leger Homes and the solicitor on the [redacted] 2007 confirms that because of the lack of 'proximity' to the anti-social behaviour it cannot be dealt with under a breach of the tenancy agreement [redacted].

2.23 [redacted]

181. [redacted].

182. [redacted] set fire to clothing at [redacted] in [redacted] 2007. DAS are informed four days after the incident by YISS who make a referral to the fire service for fire setter's awareness work. This is provided at the beginning of [redacted] 2008. [redacted]. FIO is subjected to [redacted] during a home visit when mother is present. [redacted]

183. [redacted].

184. At the beginning of [redacted] 2008 FIO tries to encourage MJ to attend a parenting programme. [redacted]. The parenting intervention is therefore targeted on MJ. [redacted]. MJ is not willing to attend the family centre [redacted]. During this visit MJ says that FJ no longer beats her but continually undermines her. [redacted].

185. During subsequent home visits FIO is able to help MJ reflect on the impact that she and FJ have on the children. During a discussion on the [redacted] MJ talks of the effect of the abuse on the children and the extent to which she feels judged as a rubbish parent.

186. In mid [redacted] 2008 J1 and J2 are involved with the 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.

2.24FJ's assault on J2

187. On the [redacted] 2008 J2 tells his mentor that FJ has hit him around the head and banged it on a wall. FJ had been drinking. [redacted].

188. A home visit by FIP on the [redacted] describes MJ as positive about the future but needing much support around confidence and her perception of services. FJ is described as very abusive emotionally.

189. On the [redacted] 2008 a further 'family update meeting' is attended by the St Leger Homes who say that some of the problems are emanating from the tenancy and as such 'enforcement could be actioned'. Liaison and further meetings to plan working together are arranged. There are no complaints from the community for almost three months after this meeting and a NAG meeting on the [redacted] 2008 confirms that 'overall improvements in ASB can be seen in the community'. Some contributors to the review dispute that behaviour had improved. The case will be re-opened on the [redacted] 2008 after further complaints and incidents are reported.

190. [redacted].

191. In [redacted] 2008 it is apparent that MJ wants to leave FJ but is dependant on him for 'practicalities'.

192. [redacted].

193. At the beginning of [redacted] 2008 J2 and J1 have bruising on their faces. J1 speaks openly of getting drunk on vodka bought by [redacted] and [redacted] had hit him [redacted]. J2 says his bruising is from a fight with [redacted]

194. On the [redacted] 2008 MJ tells FIO that she wants to complain about the GP who has given wrong information to DAS about [redacted]. This relates to the referral in [redacted] 2007. She is advised to phone the surgery to get a complaints form.

195. In mid [redacted] FIO is to deliver the triple P parenting course[19] on a one to one basis. [redacted] encourages FJ to commit to the programme. He declines. The programme also includes use of solution focussed therapy[20].

196. During [redacted] 2008 there are no reports of disturbances in the community. However reports begin to accumulate from [redacted] 2008 onwards. FJ is spending time living in [redacted]. MJ becomes low in her mood. By [redacted] there are concerns about the level of disruption caused by [redacted]. Plans to carry out parenting sessions are frequently disrupted. On the [redacted] 2008 J2 assaults [redacted].

19 Triple P is a parenting and family support strategy that aims to prevent severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.

20 Solution Focussed Brief Therapy (SFBT); a method of intervention which attempts to improve the parents' care of their children by emphasising a focus on their strengths. It has a value base as well as its own methods and skills and adherents go through a period of training and their practice skills are mentored.

2.25 Further evidence of arson

197. [redacted].

198. On the [redacted] 2008 J2 refers to both [redacted] smoking cannabis. [redacted]. This information is included in a teacher's report although it is unclear who receives the information.

199. On the [redacted] 2008 an internal management review of the family's case within DAS results in a decision to close the case. The reason for closure is recorded and is based on wrong assumptions. It is made without undertaking any enquiries. The reasons given for closing the case are that all the issues are self reported by MJ; the main issues are anti social behaviour; the reported injuries have not seen by GP; the injuries are confirmed to be self inflicted by children at time of initial assessment; the reports of domestic violence reported by mother are not current and there are no historical reports of domestic violence to the police. This last criterion is factually incorrect.

200. In [redacted] 2008 [redacted]. MJ is distressed to be told about the level of anti-social behaviour caused by [redacted] and agrees to co-operate in encouraging reports being made about incidents. [redacted] continue to be involved in a range of disruptive behaviour in the community and education.

2.26 [redacted]

201. [redacted].

2.27 MJ's disengagement from parenting support

202. A FIP review at the beginning of [redacted] 2008 described MJ as not attending parenting sessions because she knows how to parent her children. The 1.1 work by FIO will continue and forms part of the engagement plan with the family. The same review highlights that [redacted]

[redacted].

2.28 Further disclosures of [redacted] within the family

203. J2 is re-referred to YISS on the [redacted] 2008 by the ABC + team. YISS are reluctant to become involved again due to the number of services already in contact with the family. YISS do become involved in late [redacted] 2009 and a second ONSET assessment provides clear evidence of a marked deterioration in his behaviour since the first assessment. It also includes J2's disclosures of [redacted] who [redacted], of being bullied by [redacted] and that he does things that are dangerous.

2.29 Increasing pattern of assaults by [redacted]

204. On the [redacted] 2008 [redacted] assaulted [redacted].

205. On the [redacted] 2008 the specialist nurse contacts DAS to discuss the outcome of their initial assessment. There is no record of this contact in DAS. She is advised it has been completed and the case closed. The 'plan' is to 'liaise with professionals and input as required'.

206. On the [redacted] 2008 [redacted] approach [redacted]. They threaten [redacted] They attempt to punch [redacted]. One of them tries to hit [redacted].

207. There is a second record on the same day of [redacted] being approached by the same [redacted] boys who try to hit [redacted]. One of them punches [redacted] and [redacted].

208. On the following day, the [redacted] 2008, [redacted] throw a piece of concrete at [redacted]. They hit [redacted] causing minor injuries. [redacted] deny the offence when questioned by police.

209. These offences are discussed at a NAG meeting on the [redacted] 2008 and the family are 'adopted' again by the 'forum'. [redacted] have been involved in other verbal and nuisance confrontation in the park and retail stores. MJ continually defends [redacted] and their action during joint home visit by FIO and police on the [redacted] 2008. A decision is taken to issue 'red warning letters[21]'.

210. At the beginning of [redacted] 2008 and [redacted] are due to start at [redacted] together although this is not a full time placement. There are concerns at FIP that this may be 'over ambitious'. Within the first week J1 had assaulted [redacted]. In spite of a policy to not exclude [redacted], they are both asked not to return to the centre on the [redacted]. This seems to be an informal exclusion.

2.30 Increasing concern about the lack of involvement by DAS

211. On the [redacted] 2008 FIO writes by email to NEMAN asking for advice about how to 'engage' DAS with the family [redacted].

212. On [redacted] 2008 [redacted] are 'trick or treating' and [redacted]. Although the [redacted] reports the incident to the police they do not want the police to take any further action.

213. According a review at [redacted] on the [redacted] 2008 a referral had been made to DAS. There is no record of this in DAS.

214. By the end of [redacted] 2008 J2 has been 'unsettled for several days' needing to be restrained on occasions. He speaks of problems at home, FJ drinking and MJ becoming angry with him. FIO believes that [redacted]. MJ has told [redacted] that has hit J1 for kicking doors and FJ was drunk and abusive over the weekend of the [redacted] 2008.

[21] These are issued when previous warnings about anti-social behaviour have been issued. This can be used as evidence to support further legal action.

215. [redacted].

216. On the [redacted] 2008 J2 and J1 are seen chasing [redacted]. On the same day they set fire to pallets which results in an adjacent building catching fire. The following day J2 [redacted] having threatened [redacted]. Several contacts are made with ABC in relation to J2 [redacted] and therefore service is declined.

217. [redacted].

218. By the beginning of [redacted] FIO believes [redacted]. On the [redacted] 2008 FIO phones DAS to relay [redacted] concerns regarding the family. FIO said a number of multi-agency meetings had been convened, and all the services who were currently involved had done as much as their remit would allow them to do. Despite this, FIO said, the situation was deteriorating, and support was needed [redacted]. FIO was told [redacted] could not voice verbal concerns over the phone, and the family's welfare was [redacted] responsibility until a Common Assessment Form (CAF) was completed. According to DAS records this was received on the same day although FIO's records say it was the following day. FIO also advised the [redacted] to complete a CAF and to send it to DAS. The following day FIO spoke to TLDAS who told [redacted] did not believe that they had a role to play. In correspondence [redacted] says "the case for a social worker and core assessment remains unmade in my view." [redacted] suggests that a CAF be completed. A 'multi-agency meeting' was arranged for [redacted] 2008, but in the event neither TLDAS nor any representative from DAS attended.

2.31 [redacted]

219. [redacted].

220. On the same day J2 makes threats to set fire to the school but FJ confiscates his lighter. When J2 arrives at school he threatens [redacted] and assaults [redacted]. Police support is requested. [redacted].

221. [redacted].

222. On the [redacted] 2008 J2 tells staff at [redacted] that he dislikes [redacted] because FJ [redacted]. He became distressed saying FJ was not telling the truth and not to tell the police or FJ will hit him. ST1 phoned mother who said [redacted] would check [redacted].

223. [redacted].

224. FIO discusses the report with MJ on the [redacted] 2008. MJ says that FJ is much better now and they are getting on much better and he has been looking after J2 while he was off school. FIO believes [redacted].

225. [redacted].

226. On the [redacted] 2008 FIO asks for advice about MJ's situation from IDVA. [redacted] advises continued work on self esteem and to explore alternative avenues with mother. [redacted] says that if FJ is no longer living at the home then this would not be viewed as high risk for support from their service. IDVA advises taking the case to the 'safeguarding team'. No professional appears to know if FJ is in the house or not.

227. On the [redacted] 2008 J1 appears in court [redacted]. MJ is at court and tells FIO that FJ's excessive drinking has increased since the death of [redacted]. She also talks about his social isolation and distrust of all professionals.

228. [redacted].

229. On the [redacted] 2008 J2 is treated at A&E for a head injury. [redacted].

230. [redacted].

231. On the [redacted] 2008 J2 approaches [redacted] and punches [redacted]. The police interview J2 but he is under the age of criminal responsibility.

232. A multi agency meeting on the [redacted] 2008 is not attended by DAS. On the [redacted] 2008 FIO writes by email to SM1 raising [redacted] concerns about the lack of response from DAS to the 'number of concerns' sent through to DAS. The email explicitly describes J2 being taken [redacted] to burgle properties, [redacted], the children being out until late in the evening, the children turning up [redacted] at school, longstanding domestic violence and [redacted] makes clear [redacted] view that 'the children are not safe and we are failing in our statutory duty to protect them'. There is no recorded response.

2.32 Decision to convene a child protection conference in [redacted] 2008

233. On the [redacted] NEMAN circulates an email confirming that DAS will proceed to an initial child protection conference. An email two days previously from the Team Manager for the Urban Team confirmed the intention to proceed to a conference. This is after FIO has met with [redacted] and given hard copies of the referrals sent by [redacted] and FIP since [redacted] 2008. The inference is that the conference is convened under the DSCB procedures. The conference does not take place until [redacted] 2009[23].

234. According to DAS records an 's47 enquiry is completed' on the [redacted] 2008. This is incorrect.

235. The focus of FIP is to continue support to mother and encouraging her to engage more in developing her parenting ability. A home visit on the [redacted] describes [redacted], inability to carry through with instructions to any of the children and the impact of FJ's verbal and emotional abuse.

[23] Working Together refers to a timescale of 15 days between the strategy discussion and the conference.

236. The following morning FIO finds MJ in a fury about a letter addressed to both [redacted] from DAS giving notice of a home visit to discuss concerns that MJ is unable to supervise her children adequately. MJ is threatening to go to DAS reception and demand to see someone. She is dissuaded from this. On a return afternoon visit MJ is still furious and determined that social workers will not see the bedrooms. She feels 'criticised rather than supported'; FIO advises her that 'social workers are there to support her, not blame her'. The letter apparently states concerns about FJ's violence.

237. DAS arrive late for the planned home visit having already gone to the wrong house. MJ is uncooperative [redacted]. There is no record of the visit in DAS although a file record describes an interview took place with FJ on the [redacted] 2008. The social workers are told that MJ and FJ separated [redacted] previously and that he visits daily. This is untrue. [redacted].

238. On the [redacted] NEMAN writes by email to SW14 and SW15 asking that a 'case conference' [24]is convened. An email from SW14 confirms that information will be collated and passed to 'safeguarding' who will make decision about whether a case conference is convened. The case is allocated to SW8 on the [redacted] who is to complete a core assessment.

239. On the [redacted] 2008 J2 is assaulted by [redacted]. Police interview [redacted]. No other service is aware of the assault.

2.33 [redacted]

240. [redacted].

241. [redacted]

[24] This seems to imply convening a child protection conference under the DSCB procedures but is an example of how meetings are unclearly referenced. Case conference is terminology used for the anti-social behaviour meetings. Similarly there is ambiguity about who is 'safeguarding' referred to in the same email.

[redacted].

242. [redacted].

243. On the [redacted] J1 grabs a teacher's shirt and tries to punch [redacted]. He [redacted].

244. A meeting planned for the [redacted] 2008 is cancelled at short notice due to the unavailability of DAS. The status and purpose of the meeting is not clear although in DAS records it is described as a CIN meeting. A NAG Meeting takes place.

245. On the [redacted] 2008 J2 attends [redacted] with bruising on his arms and a scratched neck. He says [redacted] caused the bruise and the dog scratched him. There is no evidence of a referral being made by [redacted].

246. On the [redacted] 2008 J2 attends [redacted] with bruising to his arms. He claims [redacted] is responsible. J2 has rolled up his sleeves to show the bruising which is not his normal behaviour. A referral is made to DAS. This is not recorded at DAS. FIO speaks with the social worker to say that a referral had been sent. SW8 planned to phone [redacted] to advise them to contact [redacted] if there were any further concerns.

247. [redacted]

248. A record made by FIO on the [redacted] 2008 of a meeting with the ABC+ team refers to a worker finding a strong smell of cannabis at the house when [redacted] visited the previous evening ([redacted] 2008). This information is not reported to anyone else.

249. On the afternoon of [redacted] 2008 FIO undertakes a home visit. [redacted].

250. [redacted].

251. A multi agency meeting on the [redacted] 2008 is told that [redacted].

2.34 Concern that expert advice to instigate formal s47 enquiries have not been followed up

252. On the [redacted] 2008 [redacted] FIP emails SW8 asking [redacted] to phone FIO as soon as possible regarding the psychology report. [redacted] reports that the psychologist advises that the report should have 'triggered an immediate s47' and that FJ should be told 'not to enter the property or have contact with the children until a risk assessment has been completed'. There is no record of this email communication on DAS files. There are records in DAS of contact with the police and reference to FJ's schedule 1 offence'. A separate record by FIO on the same day refers to MJ appearing 'to distance herself away from services'.

253. [redacted].

254. On the [redacted] 2008 according to records in DAS they are provided with information from the police about FJ's status as a person presenting risk to children having committed a schedule 1 offence. This apparently relates to a historical caution (and therefore not a conviction) due to his admitted participation in an assault on a child.

255. [redacted].

256. On the [redacted] 2008 there is a 'professionals meeting' that according to YOS agrees that a child protection conference will take

place under the DSCB procedures. There is no record in DAS or elsewhere that they attended the meeting.

257. [redacted].

258. On the [redacted] 2008 J2 is detained at a retail store for behaving in a disorderly manner and spitting at staff. MJ had become involved, [redacted]. FJ had then become involved [redacted].

259. [redacted].

260. [redacted].

261. [redacted].

262. A meeting at [redacted] on the [redacted] 2008 reveals that SW8 will leave DAS on the [redacted] 2008 and TLDAS will leave on the [redacted] 2009. The core assessment is still not completed. [redacted] children are 'felt to be at risk of emotional and physical harm'. The core assessment is to 'follow the Public Law Outline'. [redacted].

263. During a telephone discussion from FIO to MJ on the [redacted] 2008 MJ says that SW8 has told her that the children 'will be going on the at risk register, and that TLDAS was to carry out a core assessment'. During a follow up home visit later that day they discuss how FJ can be kept out of the house. The following day FIO returns with a police officer from the Safer Neighbourhood Team (SNT) and mother agrees to the domestic violence unit being contacted. She says she wants nothing more to do with FJ and acknowledges the situation cannot improve with him in involved. [redacted]

2.35Further disclosures about [redacted]

264. A school log entry on the [redacted] 2008 includes J2, now [redacted], saying he stays alternate nights with FJ [redacted] but MJ denies this. [redacted] This information is not shared elsewhere. [redacted].

265. A meeting on the [redacted] 2008 includes MJ, TLDAS and FIO. TLDAS spoke about mother's expectations and perception of social services involvement. MJ says she will be unable to attend the case conference. The conference will go ahead; TLDAS says in light of MJ's statement that she will have nothing further to do with FJ [redacted] believes a child in need plan would be enough. FIO's note of the meeting records that 'the meeting goes quite well, [redacted].

266. [redacted].

267. [redacted].

268. A meeting of NAG on the same day is told that [redacted] and that FJ has moved to another area of the town. The meeting is advised that the house could be closed for three months by court order if the anti-social behaviour does not end. This would be effectively a temporary eviction.

2.36 Concerns about J2's [redacted]

269. J2's half term report from [redacted].

270. [redacted].

271. In a telephone conversation on the [redacted] 2008 between FIO and MJ, she says that FJ has said that he supposes everyone is blaming him. MJ has told him it is his fault and hers for putting up with the years of abuse. FIO believes that mother has finally accepted the impact that FJ has had on the children and appears adamant that she will not have him back in the house. [redacted].

272. [redacted].

273. TLDAS is 'allowed' to go upstairs and speak with the boys during a home visit on the [redacted] 2008. According to FIO, [redacted].

274. [redacted].

2.37 Child protection conference [redacted] 2009 decides the children are at risk of significant harm

275. The initial child protection conference on the [redacted] 2009 agrees to a plan of protection because of physical abuse and neglect of [redacted].

276. The plan, apart from naming the social work operations manager [25] to be the key worker describes an outline of processes; a chronology to be assembled; FJ is not to access the family home and risk assessment to be completed on him; continuing monitoring of anti-social behaviour; legal advice is to be sought if MJ does not adhere to the

[25] This is a first line manager not a senior operational or strategic manager.

plan; core assessments are to be completed; children's wishes and feelings are to be ascertained; and core group membership (that is not named).

277. TLDAS is named as key worker although [redacted] leaves the service in less than two weeks after the child protection conference.

278. On the same day [redacted]. The first core group meets on the [redacted] 2009.

279. From a home visit on the [redacted] 2009 FIO records that MJ is not happy with the outcome and will not trust social services again. FIO explains that the fact the children are on 'the (sic) at risk register didn't particularly change anything'.

280. A NAG meeting on the [redacted] 2009 reveals lots of concerns about the boys although there have been no recorded incidents since [redacted].

281. [redacted].

282. On the same day J1 [redacted]. The police are informed.

283. [redacted].

284. The first core group on the [redacted] 2009 is told that FJ failed to attend a meeting with TLDAS. Contact between the children and FJ has been left to mother to supervise. [redacted] are not attending education. [redacted]. According to a note on file from the FIO all at the core group agreed that the situation is improving and mother coped with the meeting 'extremely well'. At least one other attendee refers to the meeting as a child in need meeting. [redacted].

285. MJ describes the core group meeting as supportive when FIO visits her the following day. MJ felt that some professionals could be negative.

2.38 Increasing concern about J1's behaviour and mental health

286. J1's behaviour becomes more worrying. He is increasingly undeterred by the police or adult intervention. The FIP [redacted] feel he is not his normal self and are concerned for his emotional and mental health. [redacted] is worried about his and other's safety [redacted] makes a referral to CAMHS on the [redacted] 2009.

287. J1's unpredictable behaviour continues. He is [redacted] and [redacted]. He stays with [redacted] when he is [redacted]. There is no information about who this person is.

288. By the beginning of [redacted] professionals believe he may be trying to [redacted]

289. On the [redacted] 2009 [redacted] J1 until CAMHS complete their assessment.

2.39 CAMHS become involved

290. A meeting of the CAMHS [redacted] Team on the [redacted] 2009 concludes there are no defined mental health problems but acknowledge J1 poses a risk to others. It agrees there is 'a role' for a CAMHS worker. [redacted]. The case is to be open for 'case management, support and consultation to the multi-agency network'. A health advisor at YOS offers individual sessions to J1. The first home visit is undertaken by a student social worker on the [redacted] 2009 after [redacted] had appeared at court [redacted] MJ attributes the recent deterioration of his behaviour to [redacted]. J1 was visibly distressed [redacted]. A 'crisis and contingency plan' was agreed with CAMHS workers. There is considerable involvement and activity between YOS, FIP and [redacted]. A visit by CAMHS on the [redacted] 2009 is classified as a statutory visit [redacted] but J1 fails to attend other subsequent visits. [redacted]. This is not co-ordinated with the Child Protection Plan.

2.40J2 and J1 assault [redacted] in [redacted] 2009

291. On the [redacted] 2009 J2 and J1 approach [redacted]. J2 pushes [redacted] and punches [redacted].

292. On the [redacted] 2009 MJ declines the offer of a housing transfer because it is too close to FJ's address. This is regarded as a legitimate objection[26].

293. On the [redacted] 2009 J2 tells staff at [redacted] that MJ thinks he stayed at a friend's house the previous night but [redacted].

294. J1 is allowed to return to [redacted] on the [redacted] 2009 but MJ has to be called to collect him [redacted]. This information is given to the student social worker, SW10 who had just been allocated the case. [redacted].

295. On the [redacted] 2009 YOS complete a risk of serious harm (ROSH)[27] assessment with J1 that concludes he is assessed as low to medium risk of harm to others. [redacted] The IMR comments there may have been a reluctance to define the risk at a higher level in a child of J1's age but that in any event, appropriate action was taken to address these issues and to reduce the level of risk. This included the referral to CAMHS, alteration to the school timetable and [redacted] at school and at home.

296. On the [redacted] 2009 J2 tells [redacted] staff that he is going to Blackpool during the school holiday with [redacted]. He is accepted at the YISS panel the same day. [redacted]

[26] DAS will place J1 and J2 in the area when they become looked after in March 2009.
[27] This refers to an assessment of risk of harm to others rather than to himself. It is a national assessment tool used by the Youth Justice Board.

[redacted].

297. MJ denies [redacted] During a home visit on the [redacted] mother tells FIO that the children are winding staff up who keep asking them questions [redacted].

298. [redacted].

299. Reports from [redacted] say [redacted] are left unsupervised at home. There are further reports of anti-social behaviour including stone throwing and verbal abuse.

300. On the [redacted] 2009 FIO talks with MJ about the lack of supervision of the children. MJ acknowledges she leaves them [redacted]. MJ wants FJ to become involved in supervising the children. FIO gives MJ [redacted] mobile number for FJ to contact FIO 'for support'. [redacted] subsequently arranges to meet [redacted] on the [redacted] 2009 to 'discuss the reasons for [redacted] being prevented from seeing the boys until the assessment is completed'. In an email to the social worker on the [redacted] 2009 [redacted] says the assessment has to sorted as soon as possible as mother is struggling and refuses to access the support offered by social services. Arrangements for supervising the children will rely on [redacted].

301. J2 hits and kicks [redacted] on the [redacted] 2009. The police have to be called and he is arrested.

302. The second core group meets on the [redacted] 2009. A note of concern recorded at [redacted] describes J2 as showing no empathy for his peers, and showing no respect for police or authority [redacted]. He has no fear of consequences and blocks people trying to help. He shows no emotion. MJ is aggressive towards [redacted] at the core group. The social worker does not attend due to illness.

303. [redacted].

304. At the beginning of [redacted] 2009 MJ has decided to have 'shared care' arranged for J2 and J1. They tell [redacted] staff on the [redacted] 2009 and

also inform them that [redacted]. MJ tells the CAMHS health worker that she has virtually lost control of [redacted] in and outside the home. On the [redacted] she refuses to collect J1 from [redacted].

2.41J2 and J1 become looked after

305. On the [redacted] 2009 J2 and J1 are placed with foster carers in an area close to FJ. [redacted] were not informed by the social worker.

306. On the [redacted] 2009 MJ receives a written alleged breach of tenancy notice relating to J1 causing nuisance [redacted].

307. [redacted] are referred to the Education Psychology Service on the [redacted] 2009. A review child protection conference is told that home conditions are chaotic, that [redacted], and there is a heightened risk of assaults on [redacted] from a community unprepared to accept any continued disruption. Funding is to be considered for a private psychological assessment of J2. Some conference members believe J2 and J1 are subject of a three month care order. The Child Protection Plans are to continue.

308. On the [redacted] 2009 J2 makes verbal threats at [redacted], throwing chairs and leaving the building taking keys and setting off a fire extinguisher. His behaviour is described as being beyond control. [redacted]. Two days later J1 is violent at [redacted] and causes injuries [redacted]. On the [redacted] J2 is [redacted] at [redacted] having [redacted] and punched [redacted]. Staff struggled to restrain him.

309. A third core group meeting takes place on the [redacted] 2009. [redacted]. J2 and J1 are going missing from the foster placement regularly returning home. Their behaviour is deteriorating. [redacted]. YISS involvement is due to end.

310. On the [redacted] 2009 FJ approaches MJ when drunk and warns her to leave the area for her own safety and kicks her car.

2.42J2 and J1's assault on the [redacted] 2009

311. On the [redacted] 2009 V3 is attacked by J1 and J2 and this is a very similar offence to the events of the 4th April 2009. [redacted]

[redacted].

312. V3 did not know the names of [redacted] assailants, but [redacted] was able to tell the head teacher the names of the two boys and details of their foster carers' address. This information was passed on to the police. [redacted]. However, details of [redacted] were not requested until after the assault on 4th April 2009. There were two other opportunities when the head teacher spoke to the police about the assault on V3 prior to 4th April 2009. The informant's name was not requested on either occasion although it is apparent the police were told of J1 and J2's identity.

313. [redacted].

314. J1 and J2 go missing on three occasions from their foster placement on the [redacted] 2009. They are returned to the foster carers' on the [redacted] 2009.

2.43J2 and J1's assault on the 4th April 2009

315. On the 4th April 2009 J2 and J1 carry out a prolonged assault on [redacted]. It this for this offence that they appeared in court on the [redacted] 2009 pleading guilty to causing grievous bodily harm with intent.

316. V2 was found by a member of the public [redacted].

2.44[redacted]

317. [redacted].

318. [redacted].

319. [redacted].

320. [redacted].

321. [redacted].

322. [redacted].

3 Procedures and legislation

323. Agencies have a responsibility to ensure that their staff are aware of the policies and relevant legislation within which they operate. This means ensuring that all staff are appropriately trained, have access to supervision and management guidance, and know how to access and apply the policies, procedures and legislation appropriately.

324. The responsibility of staff who work in public agencies is to apply good professional, managerial and practice skills to ensure that statutory functions are properly and effectively carried out. In some agencies the statutory requirements may be couched in general terms; in those agencies that have responsibilities concerning vulnerable children the statutory functions are detailed and comprehensive.

325. Procedures and protocols are underpinned by and intended to ensure that the statutory functions are properly performed. The following chart devised by David Spicer[29] illustrates this principle.

3.1 Policy to Practice

Government Formulates Policy

▼

Legislation to Implement Policy

▼

Guidance to Assist Implementation of Legislation

▼

Procedures/Protocols

▼

Practice

326. Appendix 4 describes in detail the legislation, policies, procedures and guidance that are relevant to the circumstances examined in this review. This includes reference to legislation designed to control anti-social behaviour. The appendix also includes information regarding the education of children and young people. There is also a summary of relevant national guidance and relevant reports.

327. For policies and procedures to be effective it requires practitioners to have a well informed understanding about the purpose of different procedures. It also requires an understanding as to the degree to which they provide a framework for the checks and balances; this ensures intervention with vulnerable children is based on evidentially

[29] David Spicer is a barrister and former Nottinghamshire County Council Legal Officer. His guidance was used in a Wales Assembly Government circular.

sound judgements that lead to clear well executed decisions aimed at achieving improved outcomes for the child. They should not be regarded as bureaucratic requirements that can be dispensed with unless the circumstances dictate that compelling action to safeguard a child is required.

328. The Lord Laming's progress report[30] in March 2008 emphasises the importance of professionals having a good understanding of their legal responsibilities and the particular responsibility of the Local Safeguarding Children Board and Children's Trusts in ensuring the proper functioning of safeguarding services in their local areas.

329. In this case there is a very concerning level of non compliance with basic procedures and a worrying lack of understanding about key aspects of legislation and national guidance. Chapter two and chapter four provide examples of where practice does not comply with procedures and legal duties.

330. It is an important function of the Local Safeguarding Children Board to ensure that local practice complies with and is consistent with legal requirements and standards of good practice. This is explored further in the last chapter with recommendations.

[30] The Protection of Children in England: A Progress Report; March 2009

4 Evidence and analysis from the individual management reviews.

4.1 Summary

331. After the first meeting of the panel, the chair and author of this overview report provided a briefing session for the agency authors. Not all were able to attend this. All the authors were provided with a template for the completion of the IMR from the DSCB together with guidance from the overview author and chair addressed to each agency for the quality assurance of each IMR.

332. Some of the initial draft IMRs endorsed by a senior manager were inadequate, and required resubmission following review and discussion at the panel. This is an area for development that is included in the final chapter and recommendations.

333. A significant and recurring issue was achieving an adequate level of analysis. The quality of some recording has been a challenge for the IMR authors. Many of the practitioners involved with the family at the start of agency involvement in 1995 are no longer in post to assist with information and analysis.

334. Most IMRs provide a comprehensive account of what happens to the children, and generally give a good account of where practice or decision making can be improved with the benefit of hindsight. However some of the IMRs struggle to provide sufficiently clear analysis about why significant areas of poor practice occurred over and above describing the singular difficulties in children's social care services that have clearly persisted for a considerable time and had an impact on other services.

335. The panel and this author recognise that the poor recording and the historical nature of many events together with the interim nature of people in significant posts currently presented substantial obstacles for the individual agency review authors.

336. The IMRs acknowledge that there was a collective inability to recognise the significance and persistence of neglect and domestic violence in the lives of the family as well as other indicators of risk from issues such as substance misuse; there was insufficient shared understanding about the implications and consequences for the boys in particular; the intervention was insufficiently co-ordinated; and there was a failure to give greater regard and inference to what the boys were disclosing over several years about their domestic circumstances.

337. The panel undertook a detailed critical reading of each IMR and through the relevant agency representatives provided comments to

each of the authors. The panel acknowledge that inconsistencies remain in the quality of the IMRs. The IMR from the PCT has an inadequate level of information or analysis in relation to the involvement of GP services. With this exception the panel are satisfied that the information provided to the review is adequate with some being good.

338. In addition to the critical reading and analytical discussion at two day long meetings of the panel, the chair of the panel and the independent author of this report had separate discussions after which the chair provided detailed comments or requests for amendments or additional information to individual authors. Some of this work had to be completed under very challenging timescales to meet the overall timescale for completing this review.

339. Some authors have undertaken training and had previous experience of providing an IMR. For others this was a new task for which they have had little preparation. Several services commissioned independent people to undertake their IMRs. Not all of these were consistently good. All the authors are independent of the services provided to the family or decision making.

340. All the IMRs have been completed and amended by the panel to produce a final version on 9th September 2009 using the terms of reference set by the DSCB. All the IMRs provide an account of agency involvement although some are more effective in developing a level of analysis that explains why action and decisions are taken or not. Where this clarity is achieved the recommendations made to the agency tend to be better focussed and the outcomes more clearly identified. Some IMRs refer to national guidance, legislation or local procedures. Some provide reference to research or other evidence to inform the agency analysis, although on occasion this is inadequately applied to analysing the specific circumstances of this case. All of the IMRs make recommendations designed to address the important areas of learning for the agency.

341. The judgements about services, practice and decision making that are included in the individual agency reviews are made by the IMR author. Some IMRs provide information about the training given to staff and some make reference to agency procedures. Some also provide comment about expected standards of practice.

342. All of the reviews were completed using ***Working Together to Safeguard Children***. All the agencies use the template for completing their individual reviews provided by the DSCB. All the IMRs include the terms of reference provided for the serious case review. The IMRs include action plans for implementing recommendations. All the IMRs are countersigned by the senior manager for the agency. The agency

recommendations are included in separate appendices at the rear of this report.

4.2 Significant themes for learning that emerge from examining the IMRs

343. The agency reviews identify themes that have implications for policy development and staff training that applies to all services working with children. These include:

- The pervasiveness of neglect and the extent to which services fail to develop effective interventions to address this or the antisocial behaviour and violence within the home;
- The extent to which this chaotic and neglectful family had an impact on both their children and the practitioners and effectively controlled intervention;
- The limitations of enforcement led strategies in the absence of understanding and targeting the underlying factors of need; this included never engaging FJ with sufficient effect through the legal system or other means;
- The lack of critical evaluation and proper enquiry to better understand factors causing the range of problems; although this is a principle function of children's social care other services should have given this higher priority including the education service;
- The children's need and right to satisfactory parental care and guidance and the extent to which nobody exercised sufficient parental responsibility;
- The importance of public agencies collectively understanding the concept and fulfilment of corporate responsibility in respect of keeping children and their community safe;
- The importance of understanding the range and purpose of statutory powers and having access to legal advice that helps develop effective court strategies when necessary; understanding and using the statutory powers available to promote children's emotional, psychological and physical well being and provide protection to others when necessary;
- The challenge of trying to remedy the effects of long term poor parenting and neglect with older children and in particular when they become looked after with entrenched needs and patterns of behaviour;
- The importance of being able to get access to good quality specialist services to help develop informed analysis and reach balanced judgements;
- That good working arrangements between practitioners can be promoted or impeded by organisational arrangements;
- The need to recognise the significance and relevance of self harming behaviour whether it results in physical injury or not;

- The importance of school staff in early identification and securing appropriate support for children presenting with emotional and behavioural difficulties; the importance of ensuring intervention is based on good assessment and clear plans;
- Information sharing, collation and communication that supports identification of trends or patterns of concern or risk as illustrated in the missed opportunities described in a later section of this report;
- The value and importance of well informed social and family history taking to help understand the current situation;
- Recognising and recording information that is relevant and significant for making judgements and decisions;
- Knowledge and theoretical understanding about the relevance of significant harm in relation to young people engaged in anti-social or criminal behaviour;
- The dangers of intervening in complex families without a sufficiently clear and robust theoretical framework within which to understand concepts such as significant harm, conduct disorder, etc in order to develop an appropriate plan of intervention;
- Having strategies, understanding and purpose about engaging with non – cooperative families and young people; the reasons for non engagement can be a result of many different factors that require enquiry and analysis in order to understand the barriers;
- Understanding the purpose of and importance of planning the conduct of key activities which include a sufficiency of enquiries and assessments that reflect the complexity of a child's circumstances;
- The importance of specialist services such as educational psychologists and behaviour support teams to provide support in meeting pupil needs and ensuring access to the minimum statutory educational offering;
- The need for clarity about how to reach sound and well informed judgements that inform subsequent clear decision making;
- Listening to what children say and giving proper inference to their behaviour and symptoms;
- The capacity and ability of managers to oversee practice and service arrangements and make well informed evaluations and decisions and create opportunity for reflection particularly in relation to complex long term cases such as this; to be alert to the erosion of thresholds of concerns about indicators of risk and need;
- Recognising the compromising impact of alcohol or drug misuse on parenting capacity and emotional availability and the implications for assessment and care planning and that it is often hidden;
- The significance of drug and alcohol use by children and their parents or carers for their emotional and psychological well being must not be underestimated or ignored.

344. Further evidence from this review and how it relates to previous serious case reviews and national evidence is included at 5.2. The

remainder of this chapter summarises key evidence relating to the terms of reference established for the IMRs.

4.3 Good practice identified through the review

345. To support the learning from the review the panel looked for examples of good practice. To constitute good practice, the panel looks for action or decision making that goes beyond compliance with local and national policy, procedures and guidance.

346. The examples of good practice include;

- The first child protection conference was attended by the consultant paediatrician who had examined the children at hospital;
- The quality of some individual attention given to the boys clearly engages them on a temporary basis;
- The quality of some referrals are of a high standard; for example the referral to the Action for Children family centre contained good individual information about each child;
- Some individual practitioners worked with exceptional commitment to support mother and the children; in particular the FIP worker showed considerable tenacity and determination;
- Individual teaching staff tried very hard to engage with the boys and prevent permanent exclusion;
- Some services made individual arrangements to encourage engagement and involvement by MJ and the boys such as at the family centre and at one of the [redacted];

4.4 The lessons learned from this case in relation to the way in which local agencies and professionals worked together to safeguard and promote the welfare of the J children, and their family

347. Communication within and between services was problematic especially after 2005. The historical information relating to the first case conference was not available to most of the practitioners working with the family after 2006. For example in health there was no single coordinated family record which should have identified domestic violence and child protection concerns. [redacted]. The hand over system from health visitor to school nurse is not well defined. There are issues for national policy highlighted in the final chapter.

348. Many agencies were in contact with this family, which in itself was a significant logistical challenge and contributes to some of the

incomplete communication between services. It would have represented a very significant challenge for the most experienced practitioner to co-ordinate. This was exacerbated by the confusion that was likely to arise when [redacted].

349. There was confusion around the role of some of the professionals. For example some professionals thought that a referral to the Education Welfare Service would bring the case to the attention of a social worker; others that the service should only be contacted in the case of regular and concerning absence. It is apparent from the education IMR that the confusion continues about the defined role of the service. Other similar issues related to referrals being made to services such as CAMHS who declined to become involved prior to [redacted] 2009 due to the number of services already involved.

350. Some of the services working with the family did not have adequate information about plans agreed at multi agency meetings, many of which had an ambiguous status. Even when the children became subject of child protection plans some agencies such as CAMHS did not have copies of the plans, invitations or minutes of core group meetings.

351. The many incidents involving the police dealing with the family are treated in isolation and the impact of FJ on the rest of the family was insufficiently recognised or shared with other agencies. Without exception all services concentrate their effort on engaging mother and the boys.

352. On the occasions when individual practitioners try to encourage FJ to participate, for example in a parenting session, his refusal is met with acquiescence.

353. According to the education IMR there was 'ongoing contact' with children's services from 2003 although none of that contact prior to the [redacted] 2006 is recorded by that service.

354. There were problems in sharing information effectively between Children's Social Care Services and the Police following the incident on the 4th April 2009. The absence of an effective Children's Social Care Service removed the agency that should have provided a lead professional of sufficient knowledge and experience to co-ordinate

plans and action. The inadequate educational provision had implications for managing the anti-social behaviour of the boys.

4.5 The circumstances leading up to and surrounding the incident on 4th April 2009, including whether all the children involved in the incident were treated as children throughout the process.

355. [redacted]

356. The incident was reported to South Yorkshire Police at [redacted] hours in the [redacted]. It was initially reported by ambulance control who had received a call from a member of the public who had found V2 [redacted]. The identity of the suspects as being J2 and J1 was known early on in the investigation and within a matter of thirty-five minutes; they were located with [redacted].

357. [redacted].

358. [redacted].

359. Children's Social Care Services were informed of the arrest and detention of J2 and J1 for the assault of V2 and V1. By this time the senior investigating officer had decided that the foster carers would be the appropriate adult present when the police first interviewed the two boys. The foster carers had received PACE training. They had previously been asked to act as appropriate adults in relation to the

assault on V3. The children's services IMR states that it is unclear who made this decision in children's social care services. Their IMR is critical saying that it represents a poor decision on behalf of the service and was an inadequate response to the needs of the children in custody not to have their best interests protected and the support of appropriately trained and experienced social workers. The reliance on communicating primarily with the foster carers reflects a lack of understanding about who shares parental responsibility when a child is looked after by the local authority. It is not the individual foster carer.

360. J1 was interviewed in the presence of the foster carer [redacted]. [redacted]. J2 was interviewed in the presence of his foster Carer [redacted]

361. Prior to this very serious assault for which J2 and J1 have been convicted they had assaulted V3 [redacted] 2009. [redacted] reported this incident to the police [redacted]. V3 did not know the names of [redacted] assailants, but [redacted] the names of the two boys and details of their foster parents' address. [redacted]. However, [redacted] were not requested until after the assault on 4th April 2009. There were two other opportunities when the head teacher spoke to the police about the assault on V3 prior to 4th April 2009, but the informant's name was not requested on either occasion.

362. [redacted].

363. [redacted].

364. [redacted]

[redacted].

365. [redacted]. In the meantime arrangements had been made for J2 and J1 to be brought to the police station by the foster carers on the 4th April 2009 to be interviewed. They ran away from foster carers on route to the station and then went on to become involved in the incident that led to the charges for which they were convicted. The delay to the investigation was inappropriate. The decision to have J1 and J2 interviewed prior to interviewing V3 reflects insufficient planning.

366. There was no contact between J1 and J2 or any of the family of V2 or V1 prior to the attack in 4th April 2009; neither was there any prior contact between V3 and the brothers before the alleged attack on [redacted].

4.6 Identify whether there were opportunities for intervention that could have prevented the incident on 4 April 2009 and if so, why these did not prevent those events.

367. No officer actually managed to get to the V3's home the following day due to other incidents taking priority and it was again deferred for another day. An officer eventually attended at [redacted] 2009, three days after the initial call was made.

368. The placement of J1 and J2 in close proximity to FJ by children's social care services reflects an overall lack of planning or assessment of risk.

369. Further detail is provided in the description of missed opportunities included at 5.1.

4.7 Consider what opportunities were taken, or should have been taken, by agencies to identify and address the risks of

permanent impairment to the health and development of the J children [redacted].

370. All of the IMRs acknowledge that opportunities to identify and address the risks to the J [redacted] were largely missed. A separate section at 5.1 of the report provides more detail about the most important missed opportunities identified through a detailed examination of events and decision making.

371. Although it is clear that several individual practitioners try at times to intervene and provide support all are undermined by the inability to get [redacted] to engage in any substantial work. The level of FJ's violence is insufficiently enquired into or understood or the extent to which [redacted] are allowed to effectively control professional contact and involvement with the family. There is also the perverse juxtaposition of an unduly optimistic confidence that [redacted] evident behavioural and emotional difficulties will respond to the provision of increasing levels of support whilst at the same time resorting to the use of sanctions and controls that are generally ineffectual and often poorly executed. Threats of action are made and not followed up.

372. The absence of any comprehensive assessment of the family or individual members is a very serious deficit. The evidence of increasingly compromised parenting capacity combined with the complexity of emotional and behavioural needs of the children required competent assessment.

373. It was apparent for many years that [redacted] are children in need of care and control who are often injured and often place themselves and others at risk of significant harm and yet much of the agency involvement is characterised by reacting to the escalating pattern of concerns and incidents described in chapter two.

374. This contributes to a poor understanding of underlying needs and risks, undermines any sense of clear strategy in the overall approach or sharing a competent theoretical framework for understanding what is driving [redacted] behaviour, and inevitably leads to the rather random approach to constantly referring and involving yet more services and practitioners with the boys. The delay in Children's Social Care Services becoming involved and the delay in undertaking a core assessment until [redacted] 2009 was a significant factor.

375. It is apparent that the FIP worker had an understanding that intervention was inadequate and worked hard to engage children's social care services and senior manager regarding [redacted] concerns from 2008 onwards. However [redacted] was increasingly compromised in [redacted] intervention with mother in particular. This reflected the insufficiency

of appropriate supervision in working with a complex family. The adoption of a family support approach to the children's welfare even when shown to be ineffective and even in the context of the Child Protection Plan was inappropriate and inadequate in responding to the needs of [redacted].

4.8 Identify whether plans developed at multi agency meetings were effective, and met the needs of and provided the best outcomes for the J children [redacted] throughout the period under review.

376. Many meetings discuss the behaviour of [redacted]. In large part these are in response to incidents of anti-social behaviour. It is difficult to discern under which local procedures many of the meetings occur. Often they are referred to as 'multi-agency meetings', as well as case conferences, family update meetings, interagency meetings, a tension assessment meeting, a miscellaneous meeting, a professionals meeting as well as more specific and recognisable meetings such as the Neighbourhood Action Group (NAG) meetings.

377. Different agencies on several occasions record the status of the meeting differently. For example a NAG meeting in [redacted] 2008 is referred to as a 'CIN' meeting by DAS. This is not an issue of pedantry. If practitioners are unclear about the purpose of meetings and the framework under which they take place the status and expectations will not be clear.

378. Many of the meetings are inadequately recorded. This includes meetings of the core group arranged after [redacted] 2009 when [redacted] are subject of child protection plans. The children's services IMR highlights that the child protection plan is of poor quality and merely reflects the work that had been already ongoing with the family by other agencies; this had not influenced the lives of the children and had failed in its efforts to engage children's social care to safeguard the children. It is weak in its interventions to protect and safeguard the children and fails to address and plan actions around the key issues of the case. There is no consideration of the various legal avenues available to secure the welfare of the children. In particular there is no consideration as to whether the local authority should acquire parental responsibility for [redacted].

379. The engagement plan drawn up by the FIP in 2007 focussed on all members of the family except for FJ. This reflected a failure to appreciate the extent to which he has a significant influence on the family. There was also insufficient attention given to the evidence of intimidation within and external to the family.

380. Similar weaknesses exist in the plans to manage the antisocial behaviour. For example the IMR from St Leger Homes reports that on the [redacted] 2005 the first complaint of anti-social behaviour resulting in a breach of tenancy letter the same day [redacted] is not communicated to any other agency. A 'case conference' on the [redacted] 2007 'tasks' [redacted] to pursue the option of a demoted tenancy. As the IMR author queries, it is unclear why this was not allocated to a representative of St Leger Homes.

381. A frequent difficulty mentioned by the IMRs is the absence of involvement by children's social care services. However other services are also not significantly involved in spite of the extent and complexity of behaviour that is certainly evident from 2008 onwards. Behaviour management at school relies heavily on exclusion and use of [redacted] that are increasingly ineffective in managing the challenge from [redacted]. CAMHS only become involved shortly before the assaults in [redacted].

382. Many of the meetings were convened in response to the increasingly antisocial behaviour of the family. By [redacted] 2008 the escalation in offending and violence combined with increasing concern about the physical and mental health of MJ and J1 saw an increased pre-occupation with looking for a court based intervention with the family that was not focussed on protecting J1 [redacted].

4.9 Identify what other interventions might have improved the outcomes for the J children [redacted]

383. The most significant and single intervention that would have improved the opportunity for more successful outcomes would have been the completion of a well planned and structured assessment of the family and [redacted].

384. It remains unclear why this was not achieved in spite of increasing pressure on DAS from other services and an acknowledgement by that service of the need to undertake a core assessment. It reflects the overall condition of the service that is examined in further detail in chapter six. Although this is a significant weakness in the intervention other services could have been better focussed. For example [redacted] increasingly challenging behaviour at school [redacted] demanded specialist support.

385. Only [redacted], were referred to the Education Psychology Service to decide if there was a need for an assessment [redacted]

[redacted].

386. A further referral to an independent education psychologist was made in [redacted] 2007 and the report was circulated in [redacted] 2008. [redacted]. J1 was seen by an Education Psychologist on [redacted] and no further action was taken.

387. Educational arrangements for [redacted] in particular that provided full time education and involvement in structured and supervised activity would have contributed to better outcomes. The level of disruption to their own and other pupil's education is a serious concern for the panel. This is explored in further detail in chapter six and the extent to which statutory duties were not complied with.

388. [redacted].

389. By the beginning of [redacted] 2008 FIO was phoning DAS. Despite all the services who were currently involved doing as much as their remit would allow them to do, the situation was deteriorating, and support was needed regarding [redacted]. FIO was told [redacted] could not voice verbal concerns over the phone, and the family's welfare was [redacted] responsibility until a common assessment (CAF) was completed.

390. FIO completed a CAF pre-assessment check list and sent it to DAS on the [redacted] 2008. FIO also advised [redacted] to complete a CAF and send it to Social Services. The following day [redacted] spoke to TLDAS, who told [redacted] did not believe that social services had a role to play. In correspondence to children's services [redacted] said "the case for a social worker and core assessment remains unmade in my view." [redacted] suggests that a CAF be completed. A multi-agency meeting was arranged for [redacted], but in the event neither TLDAS nor any representative from social services attended.

391. The receipt of the independent psychological report at the end of 2008 reinforced concerns about FJ's contact with the children although this did not result in any meaningful strategy by the agencies to restrict his contact.

392. The effect of FJ's [redacted], his high levels of alcohol consumption, and his generalized mistrust and antipathy towards professionals were significant factors contributing to FJ's attitudes and behaviour. These are not addressed in assessments or interventions with FJ at any stage.

393. An intervention that had given sharper focus on the influence of FJ and his relationship with MJ could have improved outcomes for the children. The FIP probably realised this. However the strategies used were more focussed on support and working with the consensus and agreement of mother and FJ. What was required was a more assertive approach.

4.10 Consider if agencies assessed the parenting of the J children [redacted], and if so the conclusions reached

394. There was no assessment of either parent's capacity to meet the needs of a [redacted] at any time during the 14 years of agency involvement. Very little is known about the family history of either parent. Very little information over and above incidental and anecdotal conversation with mother or [redacted] is gathered regarding their lifestyle.

395. [redacted].

396. [redacted]. It was not until [redacted] 2008 that the CP expressed the view that the children were at risk of harm from

FJ. This prompted FIO to approach the safeguarding team with a view to 'instigating child protection proceedings'. FIO hand delivered copies of the report to key social services personnel. In the event the initial child protection conference did not take place until [redacted] 2009.

397. [redacted].

4.11 Summarise any significant issues from the parenting of the adults within the family that are relevant to the events within the scope of the review

398. There is no structured family or individual assessment of either [redacted]. All professionals have inadequate knowledge about either MJ or FJ's own childhood or information regarding any significant trauma or physical and mental health history.

399. The death of [redacted] is highlighted in J2's ONSET assessment in 2007 as a significant loss. Other than this there is virtually no information about the extended family of either parent.

400. [redacted].

401. MJ met FJ [redacted]. The extent to which these were [redacted] and the emotional and physical impact it has on mother is insufficiently explored or understood although the GP made a referral to DAS and individual workers such as FIO try to provide emotional support and the referral to the family centre in 2003 was an effort to provide practical support.

402. [redacted].

403. The apparent vulnerability of mother to depression is insufficiently explored. [redacted]

404. Information about the level of emotional and physical abuse is not properly collated. Information provided by [redacted] is not given enough apparent significance.

405. The information about excessive alcohol use and suggestion of FJ's alcohol dependency [redacted] is insufficiently recognised.

406. There are several references to the use of drugs from [redacted] 1998 that are apparently given no significance by any service or professional.

407. The vulnerability of MJ in her relationship with FJ and dependency on him and other key professionals is not explored in a structured assessment. The dependency she transfers to FIO is not recognised.

408. The combination of both [redacted] being compromised in their capacity and ability to meet the physical and emotional needs of [redacted] with increasingly complex emotional and behavioural needs is insufficiently recognised. As early as [redacted] 2002 the EWO recognises MJ's [redacted] when [redacted] makes a referral to the Family Centre. From the first home visit it is apparent to the Deputy Manager that there is 'chaotic and aggressive behaviour' in the home and that mother has 'little control or understanding about managing their behaviour'.

409. [redacted].

410. [redacted].

411. This undermines the initiatives taken for example in relation to encouraging participation on a parenting course and the focus in any event remains largely on mother.

4.12 Identify whether the professionals in contact with the 'J' children and their family understood the impact of domestic violence on [redacted] family

412. All the agencies working with the family have information about the domestic violence and as early as 1995 professionals had concerns about FJ's physical threat to MJ [redacted]. A primary reason for deciding not to make the MJ subject of child protection plans at the first child protection conference was their opportunistic and optimistic belief that he had left the home.

413. In 1996 during MJ's admission to hospital [redacted] she discloses violence. Although FJ is interviewed for an assault on [redacted] no other action appeared to have resulted by the police or any other agency.

414. Not all the violence within and external to the home is reported to the police or to other services. Referrals that are made, particularly to DAS are not always recorded.

415. In [redacted] 2003 the deputy manager at the family centre makes a referral to DAS following the disclosure by [redacted]. The result is that MJ withdraws herself and the children from the service and no other action is taken. The Action for Children IMR acknowledges that this should have been followed up more assertively at the time; current training and staff awareness is better.

416. Similar outcomes occur when the GP made a referral in [redacted] of 2007 and education staff reported several incidents to DAS.

417. Education staff knew about domestic violence in the home. Evidence came from [redacted] as well as turning up at school with various injuries. There is little evidence that these concerns led the schools to refer the family for assistance with this. Neither did they appear to understand the potential impact on [redacted] of this violence.

418. The police dealt with several incidents of domestic violence. The author of their IMR acknowledges that domestic related incidents will have undoubtedly have an impact on parenting capacity and the police service recognise this and the policy in place currently is under review. However there is poor use of specific recording for domestic violence. The police have introduced a positive arrest policy in relation to allegations of domestic violence. This contrasts with the response to FJ especially during the early years of the period under review.

419. FIO demonstrates the greatest awareness of the level of domestic violence and the implications for MJ and for [redacted]. Whilst acknowledging the considerable investment made by this practitioner to gain the confidence and to build a relationship with MJ this does not lead to either effective assessments of risk or the development of a coherent strategy; the deficits were recognised by this worker who particularly from [redacted] 2008 was increasingly determined to involve DAS with the family. Appropriate referrals to REMEDI were made to obtain specific support for J1 and J2 to address the issues which they were facing. In addition to work on anger management and victim awareness, they were referred to a pilot project for children who had witnessed domestic violence.

420. Although the Health Visitors up until 2000 were aware of domestic violence within the family and of the previous case conference in 1995, the latter two said they were unaware of domestic violence or of the previous injuries to the children or of the case conference in [redacted] 1995. This was caused by there being no composite family record for the children. Not all health staff with direct contact with children had received training in relation to domestic violence. The health visitors were attached to GP practices which enhanced communication. This structure has changed.

421. None of the school nurses interviewed was aware of the history of domestic violence until the referral by the GP to DAS in [redacted] 2007.

422. National research and data reinforce the importance of universal services such as primary health care professionals, police and education staff having the ability to recognise signs and symptoms of domestic violence and acting on the information.

423. None of the IMR's indicates that any agency routinely sought information about domestic violence. This case reinforces the difficulty that women and children face in reporting violence whether it is physical or verbal. The hospital trust states that it is good practice rather than policy that midwifery staff are now required to routinely document discussion and decisions about domestic violence with all clients, but the review demonstrates inadequate responses to disclosure of domestic violence within past practice and the author remains unclear about the trust staff's current knowledge regarding domestic violence and the impact of this upon children. Training plans are required to address unmet training need within A&E and the family primary care services. Additionally, the IMR believes that staff groups

within the Trust need to be informed of the role of MARAC[31] and the children and adult counselling service REMEDI.

424. The hospital trust acknowledges that it does not have specific tools to assess the emotional impact of domestic violence upon children and emotional support for victims and their children has in the past mostly been dependant upon charitable organisations i.e. Child line, The Hideout and the Samaritans. The local Domestic Violence Forum has introduced a multi-agency assessment tool (SPECCS) utilised when severe domestic violence is identified in order to develop safety plans. This does not yet have the weight of policy commitments from the various agencies locally.

425. There is a new service REMEDI within Doncaster that offers counselling for children and adults aged 5-30 experiencing domestic violence. As anyone can refer victims of domestic abuse to this service there is the potential for assessment of the emotional impact of Domestic Violence upon children. There is however, a need to ensure staff within the borough are aware of the service and its purpose.

4.13. [redacted]

426. [redacted]

427. [redacted]

428. [redacted]

[31] **Multi-Agency Risk Assessment Conferences (MARACs):** The MARAC is a victim-focused meeting, where information is shared on the highest risk cases of domestic abuse between criminal justice, health, child protection, housing practitioners, as well as other specialists from the statutory and voluntary sectors. A safety plan for each victim is then created. Between April 2008 and April 2009, there were over 24,000 cases heard at MARAC nationally, involving 34,000 children. Information about the MARAC and domestic violence strategy in Doncaster is contained in an appendix

[redacted]

429. [redacted]

430. [redacted].

431. [redacted]

432. [redacted]

4.14 Consider whether the J children were, or should have been, regarded as posing a [redacted] to other children, prior to the incident

433. By [redacted] 2009 there is compelling and consistent evidence of the [redacted] risk that [redacted], in particular [redacted] represent to other children and adults and have done so since [redacted]

434. [redacted].

435. [redacted].

436. [redacted].

437. [redacted].

438. The chronology summarised in chapter two provides a picture of escalating violence from J1 and J2. [redacted] should have aroused a higher level of concern than a low level multi agency risk management framework. [redacted].

4.15 Identify whether information in respect of the 'J' children and their family was shared among agencies to best effect so as to inform appropriate interventions

439. This family is subject of many different professionals involvement, some of which is very intensive. For example the FIP and other members of the anti-social behaviour 'team' are particularly involved. FIO is visiting daily and sometimes more frequently for many weeks.

440. It is the anti-social behaviour process that is primarily the framework for meetings between professionals under aegis of the Directorate of Neighbourhoods, Communities and Children's Services (NCCS) until 2007. Much of this activity is in response to the behaviour of [redacted] and the family generally. It is clear that from 2005 onwards there is increasing community distress and anger.

441. The absence of social services from the case and from the meetings is the subject of increasing correspondence and telephone discussion especially from FIO. There is no effective lead professional from Children's Social Care Services with the statutory powers and authority to intervene more appropriately.

442. Formal procedures for using the Common Assessment Framework (CAF), the national assessment framework for children in need or formal safeguarding procedures are not properly invoked.

443. The result is a preoccupation with managing the increasing public concern in response to [redacted] behaviour; this results in an assumption that matters are improving when levels of complaints decline when in reality it more probably reflected a lack of confidence in services being able to sort the problem combined with the very real concerns individuals had for their personal safety.

444. The information that is shared focuses on reports of anti-social behaviour and monitoring activity. Increasingly it is enforcement led that paradoxically does not result in effective enforcement action.

4.16 Consider whether practice was sensitive to the racial, cultural, linguistic and religious identities of the all children who are included within the review and their families

445. All of the children included in the review are white British. There is no evidence that any agency sought information about religious or faith based values or beliefs. The absence of a family history referred to in 1.17 gives very limited understanding about the cultural identity of the family.

446. [redacted]

4.17 Consider whether the wishes and feelings of all children who are included within the review were ascertained, properly recorded and taken into account when decisions were made by agencies.

447. There is variable recording by different agencies of what the J [redacted] say.

448. [redacted] did not really wish to attend school. Their wishes and feelings in terms of what is over and above the antipathy that many children may feel towards school is not explored. However, the use of alternative placements for [redacted] and the emphasis on the work related curriculum was discussed with them, and the results of the discussions recorded and placements sought. [redacted] were consulted as to their feelings about a return to mainstream school and an attempt was made to take their wishes and feelings into account. This was always recorded. For example, they were not forced to attend a new school that they disliked as this was seen as setting them up to fail. This could be seen in action when there was an attempt to send J2 to School [redacted].

449. FIP contact records about involvement with the whole family and references to J1 and J2 have to be seen within that context. When they do occur there is usually a description some action or event in which they have been involved, and their wishes and feelings are not recorded in any detail. However, even without detailed recording it is possible to get a sense of what it must have been like to be a child in the household. [redacted].

450. The deterioration in J1's emotional health following [redacted] 2008 is clearly recorded and appropriate action is taken. J1 is recorded as saying that he wants to be with [redacted], and on one occasion he is said to have said that he "did not want to be here". He is noted to be very sad, [redacted].

451. Perhaps most significantly though is the inability of professionals to give sufficient significance to the disclosures of violence and emotional abuse in the family. Much of this is made to education staff. Although most of this is apparently passed on to DAS both agencies fail to act with sufficient purpose.

4.18 Consider whether all single agency and multi-agency procedures were followed

452. The IMR from children's social care identifies endemic non compliance with procedures. This agency, together with the police, has particular and specific responsibilities to identify children who may be in need and require protection.

453. The procedures regarding the conduct and completion of initial assessments, section 47 enquiries and core assessments are not followed on several occasions. In addition to procedural non-compliance there are examples of poor or inadequate individual and collective practice. On other occasions there are clear misinterpretations or misunderstanding about legal duties and responsibilities. [redacted]. There is no further record contained in the files of any further response to this disclosure or social care actions. On another occasion FIO is told to complete a CAF when trying to refer child protection concerns.

454. [redacted]

[redacted].

455. The IMRs from other agencies describe information sent to DAS although few describe making a formal referral to DAS using the DSCB procedures. Similarly there is poor use of the CAF procedures.

4.19 Consider whether the policy, procedural, management and resource infrastructure that surrounded each agency's involvement with the J children and their family adversely impacted upon safeguarding and promoting the welfare of children [redacted] who are the subject of this review.

456. None of the IMRs initially reported any infrastructure or resource issues contributing to the manner in which this case was managed. It became apparent however that a major reorganisation of council services in 2005 contributes significantly to the shortcomings in case management. Some of this reflected a loss of focus for key services; for example children's services were located within the new neighbourhood and communities service that had a focus on community safety and locally accountable services. There was a loss of key staff.

457. These issues are explored in further detail in the next chapter.

4.20 Consider previous Serious Case Reviews conducted by the Doncaster Safeguarding Children Board and take into account any common themes

458. All of the IMRs have made appropriate reference to previous SCRs published by the DSCB and available on the Board's website.

459. The relevant themes for this review are summarised in an appendix to this report.

4.21 Other information provided to the panel

460. Following the meeting of the panel on the [redacted] 2009 the chair of the panel and author of this overview report discussed what further information was required as a result of the examination of IMRs.

461. In view of the significant level of anti-social behaviour displayed by the family further information was requested from the council's legal

services regarding the advice given and use made of the anti-social behaviour legislation and procedures. No separate report has been provided.

462. The chair and the author were also made aware of an unpublished report by the Audit Commission concerning the re-organisation of council services in 2005. A request for access to this report was made to the chief executive of the council and the report was provided.

463. The author was given access to the council's diagnostic report completed in 2009.

464. The chair and author have been provided with a copy of the council's improvement plan. This is publically available.

465. The author was given access to the independent psychological assessment.

466. The author has consulted other publically available sources of data and information. This includes inspection data and the annual performance assessment data set.

467. The author responded to a request from the ward councillor for a meeting to discuss her concerns about the case.

5 Analysis

468. This is a case where the agency with the lead responsibility for safeguarding children inadequately fulfilled its statutory functions and responsibilities over several years. However it would be wrong to conclude that it is only children's social care services that face significant challenges for improvement.

469. This case illustrates what can happen when those who have lead responsibility for safeguarding children are unable to fulfil that important and statutory role. Every Child Matters was intended to prevent the organisational and system failures that Lord Laming identified in his inquiry following the death of Victoria Climbié. The significant events in this case follow the implementation of the Children Act 2004.

470. The case demonstrates the vital importance of ensuring that strong collective responsibility and commitment from all relevant services to achieving clear and purposeful work with complex families and vulnerable children is securely established. This is a corporate responsibility of the council and of the agencies on the DSCB who share statutory responsibilities for ensuring safeguarding arrangements work effectively. Lord Laming's progress report in March 2008 acknowledges that the responsibility for keeping children safe is the most onerous job in public service and requires the responsibility to be held at the most senior levels in local areas; Lord Laming is clear; "The performance and effectiveness of the most senior managers in each of these services should be assessed against the quality of the outcomes for the most vulnerable children and young people".

471. Children's services continue to rely heavily on a range of interim professionals including key leadership roles within the service.

472. This is a case that shows up very serious shortcomings in the corporate functioning of children's services, a lack of effective leadership, and ineffectual oversight by the local safeguarding board and a statutory children's service failing to comply with legal duties and national standards.

473. There is a persistent inability to intervene effectively with the family over many years. Knowledge about the violence in the family is known from the outset. The physical and emotional neglect experienced by [redacted] is poorly recognised or understood in developing effective strategies for managing their educational needs and behaviour; the level of disruption to their own lives and to the wider community escalates over several years; there is insufficient collation and analysis of history and information through a well organised assessment; professionals are generally overwhelmed and ineffectual and

demonstrate an insufficient understanding of their legal powers and responsibilities; the significance and extent to which [redacted] in particular became increasingly unconcerned about the consequences of their actions or the safety of themselves or others is insufficiently understood by anyone. [redacted]

474. The presence of domestic violence was known about from 1995; there is also physical and emotional neglect; [redacted] are permanently excluded from their [redacted] school and are not offered a satisfactory or legal alternative; the frequency and severity of assaults on children and adults escalates; [redacted] apparently display indication of emotional and psychological difficulties and distress over many months; frequent referrals are made to DAS; the family were responsible for significant persistent disturbance and disruption to their community; these factors should have been an opportunity for a multi agency plan that included assessment of the home circumstances; given the parents antipathy, this should have been within the context of a child protection plan at a far earlier stage.

475. The children are eventually made subject of child protection plans but this apparently makes no impact on addressing the underlying need and difficulties within this family. It was a poor plan and not based on a competent assessment. The plan is not led by a competent professional. No detailed child protection plan is ever developed that focuses on the children.

476. The protection of [redacted] children presents additional complexity and challenge for all professionals. The impact of neglect and inadequate parenting contribute to the emotional and mental health problems that are evident in [redacted] lives. Practitioners apparently felt powerless to influence the family or use their powers more effectively. This is a feature reflected in national studies and research related to families with complex and chronic needs.

477. The powerlessness that practitioners exhibited in this case occurs frequently in cases of neglect and particularly with [redacted] children. It contributes to a collective culture that prevents practitioners identifying opportunities to act as professionals of influence and authority in children's lives.

478. Not enough inference is given to MJ's inability to make appropriate judgements or achieve sufficient resolution to address the factors that compromised the well being of [redacted]; in particular her dependence on FJ as well as other men was a threat to the emotional well being and physical safety of all the family.

479. Even when individual practitioners realise that intervention is inadequate they remain ineffectual in this case. It reflects the cultural and organisational context in which professionals were operating. Children's services in particular but also other corporate services were not functioning appropriately.

480. Identifying the missed opportunities to intervene more effectively provokes reflection on how all professionals share a common responsibility to promote the safeguarding of children's emotional, psychological and physical health.

481. It demonstrates the importance of professionals acting collectively with purpose and sharing relevant and significant information and using this to make judgements that are balanced and lead in turn to purposeful action. This includes ensuring that the right agencies and appropriate professionals are involved commensurate with the complexity and level of need.

482. Simply putting in many services does not necessarily improve outcomes for children; as can be seen from this case it can discourage some of the more appropriate services from getting involved until problems have escalated. For example, CAMHS should have been involved much earlier but were discouraged from accepting a referral due to the number of services already involved.

483. The panel recognise that this is a family with many complex needs and problems and capable of severe anti-social behaviour with a deep antipathy to professionals. As such they would be a challenge to any practitioner irrespective of their experience, training, professional and organisational support and emotional resilience.

484. The implications for the [redacted] are that nobody exercises reasonable parental responsibility, even when [redacted] are looked after from [redacted] 2009; there is insufficient collective recognition of the extent to which the emotional and psychological health of [redacted] are severely impaired and that MJ's capacity to parent effectively was increasingly compromised. This axis of concern should have provoked a more assertive approach.

5.1 Missed Opportunities

485. The panel identify more than thirty opportunities that could, with different and clearer judgement and action have reduced the harm suffered by [redacted] and their harm to others.

486. In listing the most significant missed opportunities that occur between 1995 and April 2009, the panel do not underestimate the

challenge for practitioners trying to engage with this family and [redacted] in particular and recognise that even with clearer purpose and resolution of action it may not have been possible to achieve significantly different outcomes for J1 and J2 by [redacted] 2009. Their needs and behaviour had become very entrenched.

487. Without doubt, the possibility of influencing and achieving better outcomes for them would have been far stronger if some of the earlier opportunities had been properly identified and taken. It would have reduced their propensity for escalating violence that led to the very serious and sustained assault in April 2009.

488. Opportunity to intervene more effectively with the family from [redacted] 1995 include:

I. The child protection conference on the [redacted] 1995 decided not to make the children subject of a child protection plan having been advised that mother had stopped her contact and relationship with FJ. The conference was clearly told that FJ was violent to MJ. No other plan of support or intervention was agreed over and above primary care services keeping routine contact through the health visitor and GP. Having made this decision it would have been expected that professionals would be vigilant about further contact between FJ and [redacted]. In any event the conference gave insufficient attention and analysis to several factors some of which are highlighted by the IMR from children's services;

- The mechanism of the injury and the age of the children;
- Given the injuries it was highly improbable [redacted];
- [redacted];
- MJ was present in the house for a significant period of time with one of her children in severe pain yet no action was taken;
- [redacted]
- Insufficient information about the family history of both adults;
- Little information about the parenting and nurturing ability of either [redacted];
- The disclosure of domestic violence and how this would have influenced MJ's engagement with the investigation of the events

surrounding the injuries and implications for MJ being able to protect the children from FJ.

II. Barely [redacted] months later it is apparent from a home visit made by a nursery nurse on the [redacted] 1995 that FJ is spending time in the home. Later records suggest he is living at the house. A joint visit on the [redacted] by the nursery nurse and social worker is intended to emphasise the 'gravity' of allowing FJ in the house. This visit is not recorded by DAS. MJ continues to say the relationship is over but concedes she is frightened of his violence. Given her vulnerability and the age of [redacted] the apparent lack of any response is inappropriate. It is apparent from other recorded evidence that includes FJ being in the house early morning, boots being left in the house and his attendance at clinic. There is no evidence that a reassessment of risk to [redacted] was considered. Neither is there any interagency action when the police arrest FJ [redacted] It seems the information about [redacted] was not reported to any other agency.

III. In [redacted] 1996 MJ [redacted] and there are reports that FJ is continuing his assaults on MJ although these are not reported to the police. The health visitor is told by MJ that FJ had caused bruising to her eye and lips (although the health visitor did not see the injuries). She is subsequently referred [redacted]. There are no referrals to DAS and no consideration of a multi agency discussion or sharing information.

IV. MJ's disclosure of sustained domestic violence from FJ when in hospital [redacted] in [redacted] 1996 should have been an opportunity to reassess the risk from FJ in a multi agency meeting. A telephone referral is made to EDT on the [redacted] 1996 and there is according to the children's social care services IMR a thorough social work response to this referral. MJ is seen in hospital by a social worker and discloses regular domestic violence from FJ once a week over the last year. This domestic violence occurs in front of [redacted], which she had previously denied. FJ's family has threatened severe violence to MJ if she discloses her beatings to the authorities. Effective multi agency referral and consultation occurred with the Police. A good exit strategy for MJ and her [redacted] was planned. MJ and [redacted] were to be helped to leave. However it is unclear whether the plan was carried out or how effective it was as no other information was contained in any social care record. The information of this disclosed and corroborated evidence of domestic violence is not contained [redacted] social care files to inform [redacted] future assessments

of the [redacted] and parents. The social worker did not consider the events surrounding the child protection conference in [redacted] 1995 but it is not clear if [redacted] would have had access to this information as it is not included in [redacted] social care files.

V. On the [redacted] 1996 mother presents herself as being homeless [redacted] at DMBC's homeless section. She states she is fleeing violence from FJ. She is placed in a homeless hostel [redacted]. However by the beginning of [redacted] 1996 the homeless hostel staff were aware that mother had resumed her relationship with FJ. A register check on the [redacted] 1996 should have alerted DAS to FJ having resumed the relationship with mother

VI. The health visitor who recently took over the case made a telephone and written referral to DAS on the [redacted] 1996 reporting [redacted]. The health visitor requested a child protection conference. There is no record of the referral or request for a conference in DAS. The child protection register check on the [redacted] 1996 should have alerted DAS to FJ having resumed his relationship with MJ. A later referral is made in [redacted] and follows up the phone calls made to DAS. A month after the referral, DAS say that no intervention will be offered but 'action will be taken as necessary to referrals from other agencies'. No assessment is carried out and there is no information to indicate how the judgement and decision was made.

VII. By [redacted] 1999 there were many indicators that this was a family that required support and an assessment regarding [redacted] needs and the parents' capacity to meet them. MJ is feeling emotionally low and weepy [redacted]. There had already been regular recorded concerns about [redacted] development and the [redacted] should have been indicators of a child in need. The house is overcrowded. The parents are unemployed. [redacted] She is opposed to support from DAS. [redacted]. MJ tells the health visitor about [redacted] a week later. None of this is apparently shared with other agencies.

VIII. [redacted]

[redacted].

IX. In 2002 one of the best interventions is made with the family when in [redacted] the EWO refers [redacted] to the family centre. MJ agrees to [redacted] participating in activities at the centre until [redacted] 2003 when [redacted] phone call to DAS on the [redacted] 2003 is not recorded by DAS or the subsequent written information that is sent. In [redacted] 2003 the social worker writes a letter to say an initial assessment has been completed, there had been discussion with school and the case was closed. There is no evidence that any action is taken. The family centre closes involvement on the [redacted] 2003. This was a lost opportunity. The IMR from Action for Children acknowledges that their staff should have been more assertive in following up the referral rather than allowing the case to be closed by both services.

X. There are missed opportunities to address the behaviour problems at school. J1 returned to [redacted] school in [redacted] 2006. Although he is low achieving academically [redacted] his behaviour has improved although [redacted] say he needs 'clear, firm boundaries at home as to what is acceptable and unacceptable behaviour'([redacted] 2006). He attends [redacted] for three days a week. There is no evidence of work being done with the family to follow this up.

XI. At the end of [redacted] 2006 J1 injures [redacted] at [redacted]. A referral is made to the Education Psychology Service. The education psychologist notes that the children are afraid of FJ due to his violence but no referral is made to any other service. By the first week of [redacted] 2006 [redacted] exclusion is being discussed following [redacted] J1's threats [redacted]; this has similarities with the allegation that FJ [redacted]. A multi agency meeting at the school on the [redacted] 2006 decides to [redacted] although it is clear they intend for him not to return to the school, [redacted]. The EWO agrees to make a referral to DAS. MJ does not want the referral to be made to DAS. In any event DAS have no record of this referral.

Although there are records to confirm contact took place between DAS, EWS and school and there is a reference to an initial assessment in [redacted] 2006, there is no documentation or written record of an assessment. If an assessment had been adequately carried out this would have been an opportunity to identify more clearly the nature of need within this family.

XII. At the end of [redacted] 2006 the allocation panel decide to seek an out of catchment area school for J1. He is admitted to [redacted] and transfers to [redacted] in 2008 [redacted]. J1 was [redacted] from [redacted] due to his aggression and many assaults on [redacted]. In an attempt to maintain some educational links he was put on a limited timetable, but this encouraged his poor behaviour allowing him more time to go around the neighbourhood [redacted]. The absence of a viable education placement leaves J1 even more vulnerable.

XIII. A referral to DAS on the [redacted] 2006 by the acting head at [redacted] described the history of violence [redacted] and refers to J1's disclosure of being hit by FJ. It is unclear whether this is intended to be a referral of a child in need or of a vulnerable child requiring protection. DAS have no record of this referral. There is a record of J1 being invited to discuss his problems if comes in to 'duty' to 'advice of appropriate support services they (sic) can access and make appropriate referrals' at the end of [redacted] 2006. A referral is made to Families First by DAS and the case is subsequently closed without any further action being taken on the [redacted] 2007.

XIV. On the [redacted] 2007 [redacted] noted a round burn mark on J1's shoulder. He provides an inconsistent explanation. No referral or information is shared with other services.

XV. The referral made to DAS on [redacted] 2007 by the family G.P. was recorded as a contact, then referral and processed to an initial assessment on the [redacted] 2007 that gathered information relevant to the original referral. However the initial assessment is of poor quality, is unacceptably delayed being completed on the [redacted] 2008, and does not explore circumstances around the reason for the original referral; it is descriptive and lacks analysis; actions are planned but not undertaken. The social care IMR acknowledges the failure to follow safeguarding procedures represents a further missed opportunity to safeguard the children.

XVI. On the [redacted] 2007 the YISS complete an ONSET assessment with J2. [redacted]

[redacted]. The completion of the assessment was an opportunity to undertake a structured assessment. It was primarily focussed on risk of offending and demonstrates the extent to which there was insufficient collation of information to more accurately assess risk and achieve balanced judgements about how to respond to his [redacted] behaviour and needs.

XVII. [redacted].

XVIII. [redacted].

XIX. [redacted].

XX. The GP's referral on the [redacted] 2007 to DAS concerned domestic violence in the family and injuries to the children is apparently a follow up to the referral made in [redacted]. According to a file note by the specialist nurse child protection, DAS have categorised the family as high risk and will allocate within two weeks. This delay in the follow up and the allocation was unacceptable given the judgement already made regarding risk.

XXI. [redacted]

[redacted].

XXII. [redacted].

XXIII. An internal DAS management review of the family's case on the [redacted] 2008 could have been an opportunity to identify the poor recording and unsatisfactory decision making and practice. Instead it decides the case will be closed. It was based on flawed assumptions that included that domestic violence was historic and injuries to the children are self inflicted.

XXIV. On the [redacted] 2008 in an attempt to escalate [redacted] concerns about the lack of action by DAS FIO writes by email to NEMAN asking for advice about how to 'engage' DAS with the family [redacted] 'knowing they only respond in a crisis'. This could have been an opportunity to secure clearer direction to the case but this is not forthcoming. The neighbourhood manager had a very broad range of responsibilities for services in [redacted] area that did not include providing supervision to a practitioner.

XXV. Another multi-agency meeting that is not attended by DAS on [redacted] 2008 results in another attempt to escalate the case with a manager. On the [redacted] 2008 FIO writes by email to SM1 raising [redacted] concerns about the lack of response from DAS to the

'number of concerns' sent through to DAS. The email explicitly describes [redacted], and the children being out until late in the evening, the children turning up [redacted] at school, longstanding domestic violence and [redacted] makes clear [redacted] view that 'the children are not safe and we are failing in our statutory duty to protect them'. This could have been an opportunity to secure the engagement of DAS but failed to do so.

XXVI. YISS become involved in late [redacted] 2009 and a second ONSET assessment provides clear evidence of a marked deterioration in [redacted] behaviour since the first assessment. It also includes [redacted] disclosures of [redacted] regularly [redacted], being bullied by [redacted] and [redacted] risk taking behaviour. The completion of the assessment is another lost opportunity to collate and reflect on information and secure inter-agency discussion.

XXVII. On the [redacted] 2008 FIO finds MJ in a fury about a letter addressed to [redacted] from DAS giving notice of a home visit to discuss concerns that she is unable to supervise her children adequately. She is threatening to go to DAS reception and demand to see someone. She is dissuaded from this. On a return afternoon visit MJ is still furious and determined that social workers will not see the bedrooms. She feels 'criticised rather than supported'; FIO advises her that 'social workers are there to support her, not blame her'. The letter apparently states concerns about FJ's violence. Whilst acknowledging the great effort made by [redacted] to establish a relationship with mother this is an example of how MJr's apparently increasing dependency on the FIP became another aspect of mother's control and influence over intervention.

XXVIII. DAS arrive late for the planned home visit having already gone to the wrong house. MJ was uncooperative [redacted]

The information appears to be taken at face value; there is no respectful scepticism.

XXIX. [redacted].

XXX. The initial child protection conference on the [redacted] 2009 should have been an opportunity to develop a clear plan of protection and co-ordinate action with the family. However the information and reports provided by DAS are of poor quality; they are incomplete, fail to address [redacted] or to report on them individually; they fail to inform conference of all past referrals and information held by children's social care; there is a reliance on information received by DAS and not from their own enquiries into any of the concerns, referrals and contacts received. The decision to recommend a child in need plan represents a wholly optimistic and unrealistic view of future engagement by mother and the potential for improving outcomes for the children. To compound the problems further, the social worker and manager leave their posts very shortly after the conference.

XXXI. The decision to look after J1 and J2 in [redacted] 2009 should have been an opportunity to develop a clear plan with purpose. The arrangements proved to be chaotic. The decision to place the boys close to FJ is unexplained. The plan is weak and the placement inadequately supported and supervised. MJ describes the arrangement as one of shared care. In deciding to use section 20 of the Children Act the arrangement was a voluntary agreement where all parental responsibility remained vested in MJ. This was a case that required the local authority to be much more assertive and exercising far more influence and control.

5.2 Previous serious case reviews

489. Appendix five of this report summarises the five previous SCR's published by the Doncaster Safeguarding Children Board. Those reviews have identified areas for improvement and action plans are intended to deliver improvements. Further comment is made in the final chapter about ensuring services and practice improves. The areas that would have been subject of recommendations and action in this review include;

- Insufficient recognition of adult behaviour and lifestyle and its impact on the emotional and physical health of children;
- Giving insufficient attention and significance to what children say and how they present emotionally and physically;
- The risk of managing the children of severely anti-social families not as children in need at the same time as using other legislation and powers;
- Inadequate response to domestic violence and substance misuse;
- Insufficient attention to getting full enough information about a family including their social history;

- Insufficient recognition of disengagement by significant adults from services and the implications for assessment and decision making;
- Reliance in some circumstances to self reported information and the implications for being overly positive and optimistic in responding to the adults;
- Inadequate assessment of the children's needs or the capacity of MJ or FJ to meet their needs; inadequate enquiry into risk factors;
- Recording and sharing information effectively; children's social care are very poor but other services also identify missing or incomplete information;
- Insufficient co-ordination of intervention and support especially when several services and professionals are involved;
- Different thresholds of concern between agencies;
- Understanding the purpose of and complying with procedures in respect of both protecting children and tackling anti-social behaviour.

490. The review identifies other learning, some of which is reflected in national research and the evaluations of other serious case reviews nationally. These are included in appendix 5 and grouped in to three themes of professional knowledge and skills, professional action and resources.

6 Key themes and recommendations

491. This review identifies serious inadequacy in the organisational arrangements and the quality of decision making. If other reviews had not already identified action plans, and if the intervention team was not in place, the panel would have made many more recommendations as a result of this review.

492. The panel are mindful that previous serious case reviews have already instigated a range of work alongside the improvement plan for children's services. Some of that work is at a very early stage and therefore the evidence about impact on improving outcomes is limited. Allied to this is the high reliance on interim appointments in key positions in Children's Social Care Services. This signifies considerable risk to achieving the level of sustained improvement that is required.

Recommendation one

The Doncaster Safeguarding Children Board must ensure that robust systems are in place to monitor and sign off the progress and outcomes achieved as a result of implementing the action plans from this and the previous serious case reviews.

493. The five most important themes agreed by the panel for learning from this review are;

- The consequence for children of sustained exposure to violence and neglect;
- The importance of clear organisational structures for safeguarding children and effective service delivery;
- Coordinating and integrating safeguarding and public safety strategies for work with damaged antisocial and complex families;
- Using expert or specialist help and advice;
- Focussing on outcomes for children.

6.1 The consequence for children of sustained exposure to violence and neglect

494. The impact of domestic violence and neglect on children is increasingly understood by national and international research[32]. The substantial research evidence establishes an association between the issues that compromise the caring capacity of parents and the adverse

[32] The Home Office Development and Practice Report 33 is a helpful summary in relation to domestic violence.

effects on their children's welfare and development through neglect[33]. Prominent among these are domestic violence, alcohol and drug abuse, and mental ill health.

495. It is less clear how this and other research evidence is being used consistently to inform the practice of professionals who undertake assessments with children in need and their families. Some of this probably reflects the manner in which the national assessment framework has been implemented; the focus on improving the timescales for completing assessments has not sufficiently addressed their quality. A timely assessment is important. However practitioners must also have a good grounding in a clear theoretical understanding about children's development, the factors that nurture or threaten it, and have the practical and emotional capacity to undertake what will often be complex work. This is a significant area for development in Doncaster over and above the national difficulties of workforce recruitment and retention.

496. All children will be affected by the effects of compromised parenting although the impact can differ between children for any variety of reasons and factors. Children are affected by fear, disruption and distress in their lives. They may have physical, emotional, learning, behavioural or developmental problems, and their educational performance and achievement can also be detrimentally affected. These symptoms can easily be misdiagnosed or wrongly assessed as illness, permanent learning difficulties or just being naughty. The J children were managed primarily as [redacted] because of their very poor behaviour. In hindsight it seems probable that their behaviour reflected the chaos and violence and lack of adequate parental care they were exposed to in their home over very many years.

497. When tangible evidence of physical injury to [redacted] is observed this does not elicit sufficient response. The focus of work with the adults was on their mother, [redacted]; it pursued an increasingly enforcement led intervention [redacted] when they fail to respond to the sanctions deployed over several years. Plans when they are made provide little detail in terms of what will be done to explore and address the children's needs for safety and guidance.

498. The link between adult domestic violence and neglect and the detrimental impact on children's emotional, psychological and/or physical health is clear. Research about the extremes of behaviour

[33] Cleaver, H., Unell, I,. and Aldgate J. (1999) Children's Needs. Parenting Capacity: The Impact of Parental Mental Illness, Problem Alcohol and Drug Use, and Domestic Violence on Children's Development.

displayed by [redacted] is less developed. Research indicates the importance of developing a collective awareness about the early signs of violent behaviour in children and working to eliminate the sources of violence. Some researchers including Dr Eileen Vizzard and Professor Susan Bailey identify a small group of children who display a callousness and lack of emotion that makes them unconcerned about the consequences of their violence. This was increasingly apparent in the behaviour of [redacted].

499. For a very small group of children who exhibit extreme loss of empathy, who are violent and asocial, they will require the most careful and well informed assessment and intervention. This has implications for developing strategies to work with [redacted] anti-social families. Their level of need can overwhelm individual practitioners, who need to have well developed professional knowledge, skills and access to good support and reflective supervision.

500. Doncaster has made good progress in developing an effective MARAC that has been independently evaluated by CAADA[34]. There is now a well established fast track court process. There is a Domestic Violence Forum and a published domestic violence strategy for the borough.

501. The Doncaster Domestic Violence Strategy 2008-2011 includes an implementation plan that identifies the three key themes of prevention and early intervention, protection and justice. The plan includes a commitment that children and young people will be protected in families where domestic violence occurs. The plans goes on to state that "children's services will work with other agencies to ensure that the needs of children in families where domestic violence is an issue are fully met. In particular those at high risk (sic) dealt with at MARAC" On the evidence of this review this is a commitment that requires careful scrutiny and oversight by the Doncaster Safeguarding Children Board.

Recommendation two

The Doncaster Safeguarding Children Board should request that the Chair of the Safer Doncaster Partnership provides a report on how the implementation plan for the Doncaster Domestic Violence Strategy is being effectively monitored through measurable milestones and outcomes. In particular the report should identify how vulnerable children are identified and how their needs are fully met within national standards and statute.

[34] Co-ordinated Action Against Domestic Abuse Doncaster is one of 14 Multi-Agency Risk Assessment Conferences (MARACs) from across the UK to have successfully progressed through the first ever intake of CAADA's quality assurance programme

The report should be provided within three months. The Board should ensure arrangements are made to receive information on a regular basis to inform judgments about the effectiveness of the strategy in identifying and safeguarding children at risk from domestic abuse.

502. Previous serious case reviews have already made several recommendations designed to improve practice in relation to domestic violence.

6.2 The importance of clear organisational structures for safeguarding children and effective service delivery

6.2.1 Organisational capacity

503. The single most influential factor in this case is the extent to which the organisational arrangements were inadequate to support effective practice and decision making to keep children safe.

504. The death and subsequent inquiry into the circumstances of agency involvement with Victoria Climbié resulted in some of the most far reaching reforms since the Children Act 1989. The introduction of national strategic priorities and standards through Every Child Matters and the implementation of the Children Act 2004 was intended to create stronger organisational arrangements for the delivery of services to vulnerable children in need.

505. Important elements were the creation of Local Safeguarding Children Boards and the establishment of Children's Trusts. These structures, together with specific responsibilities given to the lead elected member and the statutory Director of Children's Services are intended to be the framework for ensuring the delivery of effective services that keep children safe and promotes their emotional and physical development.

506. These structures are not sufficiently established or secure in Doncaster. The Doncaster Children's Trust (the Improvement Board) is only just recently established, the Doncaster Safeguarding Children Board has recently appointed an independent chair and an interim rather than a permanent Director of Children's Services is in post.

507. The organisational context within which practitioners undertake complex and challenging work is highly influential as to whether their practice and decision making is effective and sufficiently focussed on children's needs and outcomes. Turbulent or dispersed service arrangements will undermine the capacity of professional staff to undertake careful, sensitive and reflective practice. This requires the most skilled and knowledgeable practitioners. They need good support

by managers with relevant professional knowledge and personal skills to provoke reflection as well as ensure compliance with legal and professional standards.

508. Such arrangements require a strong and values driven organisation that gives priority to recruiting and retaining individuals with the vocational, intellectual and emotional capacity to undertake this work and to make properly balanced judgements based on good assessment and communication skills. They need access to good training and development opportunities and the support and challenge from supervisors and managers capable of good reflective supervision that helps achieve effective and balanced judgements.

509. If an organisation is not fit for purpose it will quickly lose the most experienced and qualified staff and leave others working in a vacuum. If an organisation such as a statutory children's service is not held to account by an effective Local Safeguarding Children Board or internal scrutiny arrangements, it is in danger of failing to meet the needs of the most vulnerable children and fulfilling its strategic priorities. This was a service that over three years provided a self assessment of its own services. It was service that lacked the leadership and fundamental scrutiny arrangements to recognise that elementary safeguarding and statutory obligations were not being adequately carried out.

510. The foundation for effective joint working between services and individual practitioners is a shared recognition and commitment to joint working. Although many services are involved with the family over many years, they are not sufficiently focussed and co-ordinated. Joint working is not about how many professionals attend a meeting or are party to a plan or agreement. It is about having the right services involved when needed with a shared understanding about strategy, action and outcomes for children. This is especially important when working with families who are not motivated to accept intervention or to acknowledge their own problems or difficulties.

511. Good and effective safeguarding depends on clarity about what represents risk to children, experienced practitioners who have competent knowledge about the necessary procedures for sharing information and assessing risk and need, and are confident and able when necessary to escalate action on a single and multi agency basis. This also requires leadership and co-ordination especially from an effective Local Safeguarding Children Board who understand their role, function and statutory responsibilities.

512. Until [redacted] 2008 [redacted] were subject of contact and involvement from a range of Tier 2 and Tier 3 services. Most of these

services recognised that the needs of [redacted] were more complex and entrenched and required intervention from higher tier services.

513. The powerlessness that practitioners exhibit in this case occurs frequently in cases of neglect and particularly with [redacted] children. It contributes to a collective culture that prevents practitioners identifying opportunities to act as professionals of influence and authority in children's lives. It is why the organisational arrangements within which practitioners work are so important.

514. All of the agencies represented on the panel were asked to consider if resources were a contributing factor to the events examined in this review. None of the agencies have identified this as a factor although there has been an acknowledgement of the impact that the corporate reorganisation had in 2005/06.

515. It falls outside the scope and terms of reference set for the review to undertake a detailed examination of the council's political and corporate structures. It is a matter of public record that aspects of the corporate functioning have been subject of critical examination and comment. It is legitimate to remind the political leadership in Doncaster that the safeguarding of children is a political responsibility enshrined in the specific requirements of the Children Act 2004. Failures in the safeguarding arrangements identified in this review reflect poorly upon the political as well as executive arrangements within the authority.

Recommendation three

The chair of the Doncaster Safeguarding Children Board should ensure that a full briefing is provided to the Children's Trust and the councillor with lead responsibility for children's services in Doncaster. The Mayor should also be included in this briefing. Arrangements should also be made for reporting the key learning from this review to a meeting of the appropriate scrutiny committee. This should be done within three months.

516. It is apparent from this review that a drive to create an organisation delivering improved and more locally accountable services through more influential neighbourhood management teams caused significant disruption and loss of clarity on specific areas of function and activity. This included how the DAS related to a range of new initiatives many of which were created out of national initiatives to tackle public concerns about anti-social behaviour. This contributed to a lack of understanding about the respective roles and functions of different teams and services and a loss of a clear line of sight on key aspects of service delivery throughout the council's structure and within the Local Safeguarding Children Board.

517. Protecting children is the most complex task in public service. Lord Laming makes this point in his second inquiry published in March 2008. It is the aspect of service delivery that requires effective leadership throughout the council structure and needs to be supported by a rigorous and strong Local Safeguarding Children Board that functions without dependence on any one individual or service. The board was chaired by the Director of Children's Services until April 2009 when an independent chair was appointed.

518. The IMR from children's services provides a frank disclosure of poor decision making and practice and offers good analysis about the organisational context that explains why the decision making and judgements were inadequate. It does not however, along with other IMRs, give any insight as to why so many people in important roles of responsibility apparently fail to see that standards of practice had declined dangerously. Several people in children's social care apparently tolerated the poor practice evident in this case. It could be the behaviour of people feeling overwhelmed by the volume and nature of the work, or by the specific challenges of this case; it reflects a worrying lack of understanding about what was required in legislation and good practice.

519. The children's services IMR describes inherent flaws in the organisation of the DAS that resulted in duty social workers being overwhelmed, blocked duty telephone lines and no organisational capacity to make judgements about priority in allocating referrals and assessments. New arrangements have been introduced in July 2009 that has begun to address the deficiencies.

520. The IMR is less effective in developing an insight as to why the scale of difficulties became so acute. A council restructuring should not have that level of impact on a service as critical as DAS. It is probable that the scale of difficulty is attributable to non specialist managers having responsibility for services they had insufficient understanding or capacity to effectively oversee. This applies to teams other than children's social care. For example the work undertaken by FIP requires access to appropriate supervision and support.

521. Following the critical APA in 2008 an independent diagnostic review was commissioned as part of the external support arrangements for the council. The report is highly critical of the restructuring that in their view led to a lack of key resources in children's services, a lack of managerial capacity and capability and difficulties in the overview and scrutiny of services. The same report criticised the Local Strategic Partnership for lacking a clear enough focus on performance.

522. Children's social care services need staff at every level in sufficient numbers and with the knowledge, experience and resilience to undertake the range of work in terms of volume and complexity, to deliver effective services to children in need.

523. This will not be a matter of simply completing assessments in a more timely fashion or ensuring there is a named professional taking responsibility for a child. It requires the capacity to undertake effective assessments, collate and analyse information, coordinate work through other professionals and have access to reflective supervision and when necessary expert sources of advice.

524. At present the council's improvement plan identifies a range of target outcomes for keeping children safe in Doncaster. Unless the council has permanent social workers in sufficient numbers and with the appropriate experience and access to competent practice supervision that is subject to audit, the plan will remain more an aspiration than a plan for action. Lord Laming and the national task force already understand the extent to which nationally there are insufficient numbers of key professionals with the training, experience and resilience to undertake effective work with the most vulnerable children. It is an even higher order of challenge to recruit such staff to a service that is seen to be inadequate.

Recommendation four

The Director of Children's Services should provide a report to the next meeting of the Doncaster Safeguarding Children Board, and on a quarterly basis thereafter, describing what action has been taken to address the shortcomings highlighted in the IMR. In particular the report should include information about the numbers of interim or agency staff employed in the Children's Assessment Service, the size of case load, and the arrangements for allocating referrals and assessments. The report should include information about how the revised arrangements for the Children's Assessment Service are being evaluated.

Recommendation five

The Doncaster Safeguarding Children Board should ensure that a suitably robust arrangement is established for receiving and collating information and data that alerts the Board when safeguarding arrangements are at risk. This should include information about the workforce capacity of critical services, data about referrals and activity, and the quality of practice. The Board should ensure arrangements are made for this information to be reported to the Children's Trust, the lead member and the

Mayor. These arrangements should be in place within three months.

6.2.2 Education

525. This review highlights the fact that [redacted] had virtually no access to education. Although acknowledging the extent to which some individual staff in schools and [redacted] tried to engage [redacted] it is apparent that the range of resources available to meet the needs of [redacted] was insufficient. At times there was a degree of over optimism that was ultimately unhelpful in securing more enduring arrangements that met their needs more adequately.

526. [redacted].

527. The review highlights a lack of capacity in the Education Psychology Service.

528. The guidance to local authorities is explicit in stating that LEAs have a statutory duty "to make arrangements for the provision of suitable education at school (including pupil referral units), or otherwise than at school, for children of compulsory school age who, by reason of illness, exclusion from school or otherwise, will not receive a suitable education without those arrangements[35]".

529. The strategies used in 2005 appeared to rely heavily on behaviour management strategies. With hindsight it is questionable whether these could be effective given the extent of other difficulties in the home. Referrals to the Education Welfare Service did not apparently provide any further information or insight about [redacted] needs and home circumstances.

530. [redacted].

531. [redacted].

[35] Section 19, Education Act 1996.

532. This is an issue that has been highlighted by inspection and reviews of the service. Given the link between sustaining educational participation and keeping young people safe it is legitimate for the Doncaster Safeguarding Children Board to have some oversight of arrangements from a safeguarding perspective.

Recommendation six

That the Director of Children's Services provide a report to the next meeting of the Board on the number, age and circumstances of children excluded on more than one occasion and/or for more than five days in the last 12 months. The report should also provide information about arrangements for children receiving education other than at school including the number of hours provided on a weekly basis.

6.2.3 Policies and procedures

533. The absence of up to date procedures or clearly agreed frameworks with other agencies for determining how children referred to Children's Social Care Services would be prioritised, further compounded the weaknesses in responding to this family. This is being addressed with the introduction of the Referral Pathway Framework beginning in October 2009.

534. It is apparent that professionals had an incomplete understanding of the role and remit of different services. This in turn led to referrals that were not linked clearly enough with an understanding of the child's needs or why a particular agency needed to become involved. Some of the referrals were outside agency criteria, for example in relation to age. The role of the Education Welfare Service was unclear. Some staff thought a referral to education welfare was a referral to Children's Social Care.

535. The Doncaster Safeguarding Children Board publishes safeguarding guidance that is shared with the three other South Yorkshire safeguarding boards. The procedures are compliant with national guidance in Working Together to Safeguard Children published in 2006. The joint procedures on the Doncaster Safeguarding Children Board website had not been updated since November 2007. This is not acceptable. The board need to ensure that as a minimum there is an annual review of the procedures and they are refreshed as required.

536. [redacted].

537. The procedures make no detailed reference as to which designated officer makes a decision not to proceed to a child protection conference when concerns are substantiated about a child but social workers judge the child is not at continuing risk of harm in spite of continuing concerns from other professionals.

538. [redacted].

539. The procedures make no cross reference to the anti-social behaviour responsibility of the council and the circumstances under which a referral of a child in need or safeguarding will be considered.

Recommendation seven

The Doncaster Safeguarding Children Board must ensure that a fit for purpose copy of Safeguarding Procedures is placed on the Board's website. Additionally the Board should ensure the amendments identified in this review are incorporated in the next updates of the procedures or by January 2010 which ever occurs first.

6.2.4 Training and development needs of practitioners

540. Good and effective safeguarding depends on clarity about who or what represents risk to children; experienced practitioners who have competent knowledge about the necessary procedures for sharing information and assessing risk and need; and self-confident practitioners able when necessary to escalate action on a single and multi agency basis. This also requires leadership and co-ordination especially from an effective safeguarding board.

541. Until [redacted] 2008 the children were subject of contact and involvement from a range of Tier 2 and Tier 3 services. Most of these services recognised that the needs of [redacted] were more complex and entrenched and required intervention from higher tier services.

542. The powerlessness that practitioners exhibited in this case occurs frequently in cases of neglect and particularly with [redacted] children. It contributes to a collective culture that prevents practitioners identifying opportunities to act as professionals of influence and authority in children's lives. It is why the organisational arrangements within which practitioners work are so important.

543. In order for lead professionals to be effective in their assessment and intervention with complex families, they require experience, good training and effective supervision. Attempts to escalate [redacted] concerns about the lack of action by DAS on the [redacted] 2008 [redacted] writes by email to NEMAN asking for advice about how to 'engage' DAS with the family [redacted] increasingly looked to NEMAN for guidance and supervision. This was not the function of that manager's role.

544. Individual practitioners from other services were unable to escalate their concerns with managers and the apparent absence of knowledge within the DSCB concerning the poor levels of practice in relation to referrals, the conduct of enquiries and assessments and working with children in need. Government inspectorates have highlighted concerns about the quality of work with children requiring protection. This case shows the vulnerability of high need complex vulnerable children who have not come within the scope of formal safeguarding measures.

Recommendation eight

The chair of DSCB should commission a report from the chair of the relevant subcommittee as matter of urgency about the arrangements for professionals to escalate concerns about individual children. The report should recommend what further action is required to ensure that information is promoted with all relevant professionals. A report should be provided within three months to the Board and thereafter to each meeting of the subcommittee regarding any concerns raised by professionals and the action taken in response.

Recommendation nine

The Doncaster Safeguarding Children Board should arrange for the formal presentation of learning from this review to relevant practitioner groups and any other strategic partnerships the Board considers appropriate. This should be undertaken within four months.

6.2.5 Making plans effective

545. The decision of the child protection conference in [redacted] 2009 to make [redacted] subject of child protection plans should have marked a watershed in securing a good plan of protection and intervention. The Children's Social Care Services IMR highlights several issues. The social worker's report was incomplete; failed to address each child's needs and report on them individually; failed to inform the conference of all past referrals and information held by Children's Social Care; relied on third party information received by Children's Social Care and not by their actual investigation and enquiries in to any of the concerns, referrals and contacts received.

546. Neither the child protection plans nor the looked after care plans for J1 and J2 had been reviewed when they committed the offence in [redacted] 2009; this complied with legal requirements in respect of timescales. However the poor quality of the information presented to the initial conference was not reported within any effective process of quality assurance.

547. The Children and Young Persons Act 2008 introduced important new arrangements for IROs overseeing arrangements for looked after children. The duties of the Independent Reviewing Officers will be to monitor the performance of the local authority in accommodating children in its care and ensuring that the ascertained wishes and feelings of the child are given due consideration by the local authority. The reviewing officers have the power to refer a case to a CAFCASS officer, with a view to legal proceedings being initiated if the authority is considered to be failing in its duty to a child in need.

548. The reviewing officers must be an important part of ensuring decision making and practice is compliant with legal and national requirements and is focussed on the needs of children.

Recommendation ten

The Director of Children's Services should provide a report to the Doncaster Safeguarding Children Board describing how the independent reviewing officers comply with legal and national guidance for reviewing children who are looked after and/or are subject of plans of protection. Particular regard should be given to the arrangements for;
i) Monitoring assessments and planning between review meetings;
ii) Ensuring that review decisions are carried out and continue to meet the needs of the child;
iii) Arrangements for reviewing officers to be able to require improvements to plans and for escalating concerns if and when they occur.

549. The examination of the initial drafts of individual agency reviews identified inconsistencies in the quality standards used in different services.

Recommendation eleven

In order to ensure greater consistency for future serious case reviews the Doncaster Safeguarding Children Board should ensure that a programme of training is provided for senior officers who have the responsibility for endorsing and/or commissioning a review on behalf of their agency. This should be completed within three months and the need for future refresher training should be included within the Board's training strategy.

6.3 Integrating and co-ordinating public safety and children's safeguarding procedures when working with damaged antisocial and complex families

550. The many professionals working with the family largely ignored the extent and significance to which [redacted]. A better understanding would have assisted in developing a more clearly focussed intervention.

551. Previous serious case reviews have already highlighted the dangers of managing the children of severely anti-social families not as children in need but only as offenders.

552. When families are causing sufficient disruption to individuals and communities to warrant the use of powers under the anti –social behaviour legislation it should be apparent that any children in that household should be assessed as children in need.

553. There is weakness in using the framework of law more effectively. The police IMR describe explicitly a lack of knowledge about the various legal Acts that are available. Nobody seemed to be able to look at the full range of legal powers embracing tenancy law, controlling anti-social behaviour and the measures for safeguarding the children.

554. The limitations of enforcement led strategies in the absence of understanding and targeting the underlying factors of need are very apparent in this case; of most significance is the extent to which FJ is never the focus of intervention or held to account through the legal system or any other means.

555. Decisions are required as to how the authority's safeguarding responsibilities in these circumstances are exercised. The organisational confusion reflected in some of the IMRs doubtless stems from the various separate organisational routes nationally that have implemented a wide range of government programmes over the last twelve years.

556. The introduction of services such as FIP and Families First alongside other higher tier statutory services gives complexity to how professionals and families relate and interact with each other. The involvement of services was often confused and lacked an apparently explicit definition of purpose; more often it seemed the prime motivation was to put as much support as possible to a family with complex needs and problems.

557. It is important that families have one person or agency taking the lead role and who has the authority to co-ordinate activity and intervention. It is equally important that organisational and procedural arrangements provide the same clarity for determining who the most appropriate lead professional is. Linked to this is the need for ensuring there is clarity about the circumstances under which the different services will become involved.

558. CAMHS did not become involved until the [redacted] of 2008 in spite of an earlier referral five years previously. This was on the basis that several services are already involved. This may also have been a contributory reason that DAS did not respond at an earlier time.

Recommendation twelve

The Director of Children's Services undertake on behalf of the Children's Trust a review of the organisational arrangements for the delivery of assessment, support and intervention to families identified as anti-social and have children under 16 in the household.

559. Different professionals use a range of thresholds to reflect their understanding about the degree of need or risk presented to individual children to influence how they try to access to services. It is apparent that DAS operate at a very high threshold of concern when prioritising referrals.

560. Professionals have great difficulty in getting DAS to accept a referral or undertake an assessment. For example in [redacted] 2008 the FIO was told [redacted] could not voice verbal concerns over the phone, and the family's welfare was [redacted] responsibility until a common assessment (CAF) was completed. In 2003 the school made a referral to CAMHS in relation to [redacted] violent outbursts at home and school. CAMHS declined

the referral because a referral has also been made in the same week by school to the Family Action and Support Team (FAST) who declined the referral due to the number of agencies already involved.

561. There was insufficient clarity and understanding between the different services about thresholds; the distinct role and statutory responsibility of different services and the circumstances under which referrals are made to specific agencies or completing a multi agency CAF.

562. The seminars on referral pathways are clearly intended to address this to some extent. The DSCB manager is also undertaking a comprehensive evaluation of training provided on a multi–agency basis.

Recommendation thirteen

The Doncaster Safeguarding Children Board should agree and deliver a training and staff development strategy that describes clear objectives and outcomes for ensuring relevant professionals have access to and participate in training that promotes their effective working with other services and professionals. Priority should be given to ensuring a common understanding about referral pathways to services that includes the use of common assessments, how to assess risk and identify children in need and the frameworks within which judgements and decisions need to be made. The strategy should be agreed and be in place within three months.

Recommendation fourteen

The Doncaster Safeguarding Children Board should ensure that the training and staff development strategy includes specific training for managers and supervisors appropriate to their organisational role and responsibility for overseeing the quality of practice and decision making and providing supervision in relation to vulnerable children in need.

6.4 Working with damaged antisocial and complex families

563. Although the majority of IMRs describe a positive multi agency approach to the anti-social behaviour of the family, it is ineffectual in dealing with the behaviour presented by this family over many months.

564. Most of the IMRs attribute this to the lack of engagement from Children's Social Care Services. Although this is a significant issue in the overall management of the case it is clear that there was confusion

about the legal remedies available, insufficient clarity in developing a plan and a lack of clear leadership in coordinating action. Some of this is attributable to all agencies believing that social care services needed to be involved and assuming that leadership.

565. The lead responsibility for co-ordinating action is located with the Neighbourhood Teams. The team for [redacted], is one of sixteen throughout the borough of Doncaster. They deliver a variety of services that range from community safety (Safer Neighbourhood Teams are a joint service with South Yorkshire Police), through to grounds maintenance and leisure centres.

566. The neighbourhood teams are part of the much wider Neighbourhood and Communities Directorate where responsibilities cover a diverse range of services from Community Safety (that include substance misuse, domestic violence including MARAC support) to waste management and street lighting.

567. Co-ordinating intervention with some of the most challenging families and young people requires good knowledge about a complex range of law and an ability to mobilise appropriate people and services who can work with clarity of purpose and resolve. Recommendation twelve calls for a review of the organisational arrangements for responding to anti-social families.

568. Very anti-social families will be extremely challenging to individuals and to services collectively. This was a family for whom authority and letters of warning had little significance. It was a family willing to test the resolve of individuals and of agencies.

569. The delays in making clear decisions and the subsequent failure to act on many occasions reinforced the family's disregard for any sense of consequences for their behaviour. Particular behaviour such as [redacted] is subject of action to collate monitoring forms and make reports to meetings; it does not result in clear action to tackle the problem for the victim.

570. This was a family who would not have responded to one decisive act. It was a family who required a better co-ordinated and informed strategy to deal with their behaviour.

571. The complaint [redacted] 2005 resulted in a breach of tenancy letter being sent [redacted]. No other services were informed, as was the custom and practice prior to the Anti-Social Behaviour Strategy and Safer Neighbourhood Teams becoming established.

572. Following the first contact with the anti social behaviour warden in [redacted] 2006 it is [redacted] 2007 when the first meeting of the NAG decided to pursue the [redacted]. Less than a month later in [redacted] 2007 St Leger Housing had sent the second breach of tenancy letter following an incident of [redacted] by [redacted]. [redacted] Shortly after this at the beginning of [redacted] 2007 St Leger Homes referred the family to FIP to assist in improving the behaviour [redacted] and prevent further tenancy action being taken.

573. After the third written breach of tenancy on the [redacted] 2007 following further intimidation and harassment by the letter states that a notice seeking possession will be served. The IMR from St Legers is unable to explain why the notice was never served and the anti-social behaviour case conference in [redacted] 2007 had in any event only agreed to seek an [redacted] for [redacted]. [redacted].

574. Following further complaints of harassment a multi agency family update meeting attended by a solicitor from DMBC agrees that some form of enforcement is needed and that the primary concern is the safety and welfare of the children.

575. The subsequent anti-social behaviour case conference on the [redacted] 2007 allocated the task of seeking a demoted tenancy through the FIP rather than St Leger Homes the landlord. The Neighbourhood Manager emailed Doncaster Council's Legal Team requesting to meet them to discuss the lack of enforcement action taken against tenants by St Leger Homes. Subsequent legal advice is that because the incidents are occurring away from the home it does not fall within the scope of legal action against the tenancy.

576. A further family update meeting in [redacted] 2007 attended by the solicitor suggests a parenting order or suspended possession order but neither are taken forward. A further consultation between the solicitor and St Leger Homes results in legal advice to seek [redacted].

577. The [redacted] that continued through to [redacted] 2008 results in monitoring forms being completed by the victims of the [redacted] and sent to the police community support officer (PCSO). By the end of [redacted] there is further discussion at a family update

meeting that problems are emanating from the home; the meeting agrees to convene a further meeting to plan working together in the future.

578. No action is apparent as a result of the meetings. It coincides with a reduction in complaints about anti-social behaviour with the result that further enforcement action is not considered. In [redacted] 2008 the police inform the NAG meeting that ASB by [redacted] is reducing and no recent complaints had been reported on the family. As a result the decision was made to close case discussion at the NAG and MAG.

579. [redacted]

580. When the case is reopened in [redacted] 2008 further meetings result in further monitoring forms being distributed. One of the monitoring forms that is returned includes information [redacted]. Another form alleging [redacted] leads to a 'case briefing' at the [redacted] meeting in [redacted] 2008 but because the victim did not see who was responsible, no action was taken. Further [redacted] incidents continue when [redacted] are identified. [redacted]. Otherwise the 'plan' continues to be 'monitoring ongoing problems' and 'collating details' of incidents.

581. [redacted].

582. [redacted] incident in [redacted] 2008 is not subject to any formal action 'due to insufficient evidence and language difficulties, the police were unable to press relevant charges'.

583. As late as [redacted] 2009 the fourth breach of conditions of tenancy letter is sent following J1's harassment of [redacted].

584. The police IMR reports that staff working in the Safer Neighbourhood Team (SNT) for the area where this family resided has raised previously concerns with regard to the joint process adopted for the [redacted]. The reason for the failings in this area is due to financial constraints and shortage of staffing. The legislation is in place to tackle the very issues identified in this review, yet, no orders have been applied for in the area where this family resided. Good

practice adopted by other local authorities and policing areas does not appear to have been considered at any of the multi-agency meetings.

585. The panel asked for information from legal services regarding why none of the various legislation referred to in the appendix at the rear of this report was used in this case. No additional information has been forthcoming.

Recommendation fifteen

The relevant subcommittee of the Doncaster Safeguarding Children Board should review the strategy for responding to the needs of children living in antisocial families. This should examine the training provided for practitioners working with anti social families. The training should ensure that all relevant staff undertake the appropriate levels of safeguarding training. In addition, they should develop their knowledge and understanding about legal powers available to the council and its partners as well as techniques and strategies for managing intervention with high need families.

586. There are several examples when witnesses are clearly intimidated from providing information about the family. This pattern persists over several years.

587. Some areas of the country have used professional witness schemes to overcome the difficulty of communities being intimidated.

588. The Home Office encourages landlords to have clear written strategies that include the use of trained volunteers from staff and partnership contacts to gather evidence of ASB that they have witnessed and to support witnesses. The schemes allow greater flexibility in the gathering of evidence in court cases, especially when witnesses of ASB are reluctant to provide evidence in court proceedings. If a landlord has a professional witness scheme, then policies relating to the scheme should be included in the Statement of Policy.

Recommendation sixteen

The Chair of the Doncaster Safeguarding Children Board should provide a written briefing to the chair of the Crime and Disorder Reduction Partnership concerning this review and formally request they consider and provide a response on the use of a professional witness scheme in Doncaster. The report should also consider any other measures that may assist more assertive and timely action on combating anti – social behaviour in the future. This should be complete within four months.

6.5 Access to expert advice and commissioning assessments

589. It is apparent that for much of the time and in spite of the number of services and people involved, most people felt overwhelmed by the complexity and range of problems and need presented by this family. This was a situation that developed over many years until the difficulties and level of need was severe and entrenched.

590. The commissioning of an external assessment was done without a clear commitment from all the relevant services and therefore ownership of the assessment was effectively left with a service inferred with a relatively lower level of authority and influence than others.

591. No written terms of reference were agreed at the outset and although the intention was for the assessment to be delivered within three months it was delayed for over a year. This meant that important information relating to the escalating patterns of violence was insufficiently reflected in the assessment of risk.

592. It remains unclear the extent to which the CAMHS high risk meetings were fully aware of the pattern of violence over many months. The police acknowledge that their systems for collating information had limitations in collating intelligence about the children and family.

593. The extent of support to teaching staff in dealing with very challenging behaviour was insufficient to deal with the complexities of [redacted] needs. Increasing reliance was given to exclusion and writing letter to parents who by their action and response to professionals was predictably futile.

594. The premeditated attacks, the willingness to use as well as threaten others [redacted] combined with the disregard of consequences would be beyond the experience and knowledge of many professionals.

595. Under these circumstances children can be exposed to greater risk if those professionals working with them feel out of their depth. Good case supervision that can place behaviour and events within a context of theoretical understanding is essential. If line supervisors are incapable of providing this or senior managers do not have the capacity to understand the significance of expert information or advice, practitioners will not be sufficiently effective.

Recommendation seventeen

The Director of Children's Services, in consultation with other relevant services should agree a local protocol for the

commissioning of expert or external support. This should establish minimum requirements in respect of identifying and verifying appropriate people and organisations to provide such services; it should ensure clear terms of reference are established at the outset that describe to what purpose the work has been commissioned and its relationship with statutory assessments and plans for children in need. Arrangements should ensure compliance with agreed timescales and national standards.

Recommendation eighteen

The Doncaster Safeguarding Children Board should agree a strategy and development plan to provide training for managers and supervisors providing case supervision or clinical support to practitioners working with vulnerable children in need. The plan should provide ongoing training that develops the capacity and ability of managers to offer appropriate and theoretically informed supervision and case management oversight. The plan should be agreed within four months.

6.6 Focussing on outcomes for children

596. Throughout the years of intervention with the family there has been insufficient focus on achieving improved outcomes for [redacted]. Their poor and violent behaviour provokes reaction from a variety of services. The extent of their antisocial behaviour was insufficiently analysed within a context that developed a clearer understanding about the extent to which their emotional and psychological development had been impaired. The fact that nobody exercised adequate parental responsibility for [redacted] was not recognised by the agency that had the legal power to address this.

597. The solutions focused therapy approach mentioned in paragraph 196 and 570 has a place in family work and a value in emphasising the strengths of parents. It is not compatible when a more assertive and authoritative approach with parents is required. The whole approach to working with MJ was to build a relationship of trust and support; when this failed to achieve real engagement to addressing the problems of [redacted] a different approach should have been developed. This can be difficult for practitioners to recognise and to achieve.

598. The panel acknowledges the effect that years of domestic abuse will have had on MJ but the needs of her children should have been paramount in developing a better strategy for intervention. Practitioners have to be confident that parents are giving their cooperation; that the needs of their children are genuinely prioritised; and there is tangible evidence that children's needs are being met. None of these were factors were met sufficiently in later months.

599. Research and academic evaluations of serious case reviews are providing better understanding about the extent to which families with complex and entrenched needs seek to influence and control involvement and intervention by professionals. In particular when professionals are seen to be influential they can be subjected to a range of behaviour ranging from high dependency, disguised compliance to outright hostility. FJ was never willing to accept intervention by services. MJ would only do so on her terms.

600. The extent to which both parents effectively controlled professionals was evident from very early on. FJ has never been held to account for his behaviour in the family. Even when the threat he posed was eventually realised it was largely left to MJ and [redacted] to control and manage his contact [redacted].

601. Although some of the professionals and in particular FIO understood the extent to which mother was dependant on FJ, it is apparent that MJ used a range of behaviours to manage and reduce any threat of intervention from DAS or other services including FIP.

602. On the one occasion when MJ was helped to leave FJ in 1996 it was poorly recorded and FJ is allowed back in to the family with the knowledge of several professionals.

603. In [redacted] 2008 mother tells FIO that she wants to complain about the GP who has given wrong information to DAS about the children being bruised relating to the referral in [redacted] 2007. This and other examples show the degree to which professional roles can be undermined. The following month [redacted] was advocating the use of solution focussed therapy. It is questionable whether this was appropriate given the clear evidence of compromised parenting combined with the increasing complexity of [redacted] behaviours.

604. In [redacted] 2008 the DAS manager is 'allowed' to go upstairs and speak with [redacted] during a home visit on the [redacted] 2008. The FIP observed MJ no longer fears social services and realises they are there to support her.

605. The complexity and difficulty facing practitioners working with some of the most challenging families in the community is not to be underestimated. This is emotionally and professionally difficult work that requires good and regular training and access to good sources of professional support.

606. Section 11 of the Children Act 2004 places a duty on the key people and bodies described in the Act[36] to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The application of this duty varies according to the nature of each agency and its particular functions. The Section 11 duty means that these key people and bodies must make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children and this includes any services that they contract out to others.

6.7 Issues for national policy

Implications for national research

607. The level of violence displayed by J1 and J2 in April 2009 is rare. None of the professionals including child psychiatry services and an independent expert predicted or anticipated such a violent assault.

608. [redacted] had been involved in an escalating pattern of violence over many months.

609. Research by the Home Office and cited by Dr Eileen Vizzard identifies a small but significant group of children capable of extreme violence. There remains relatively little research or guidance to help practitioners identify factors that may heighten concern or identify potential risk factors.

610. Several leading child experts are calling for additional research to be commissioned. It is hoped that information from this review is used to inform judgements at national and government level regarding further work. This should include consideration of what further guidance can be added to Working Together that is specific to children with a propensity for more extreme levels of violence to themselves or to others.

611. A better understanding about the needs of this small group of high need children will assist in developing a more clearly focussed intervention.

School nursing services

612. School nursing services have little national guidance in terms of their role or range of responsibilities. They can be an important part of identifying emotional and psychological needs.

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[36] Local Authorities, including District Councils, the Police, National Offender Management Service, NHS bodies, Youth Offending Teams, Governors/Directors of Prisons and Young Offenders Institution, Directors of Secure Training

613. None of the school nurses are aware of the history of domestic violence in the family. The hand over system from health visitor to school nurse is not well defined.

614. Further national guidance in relation to Working Together and to local health trusts would be helpful. This should also consider the range of work and remit for school nursing services.

Holding juveniles in police cells overnight

615. The Code of Practice under the 1984 Police and Criminal Evidence Act discourages the prolonged detention of juveniles in police cells.

616. [redacted]

617. There is no data locally or nationally as to how many occasions a juvenile is held in a police cell or for how long.

618. There are implications for how the police, in partnership with other services, respond to the complex needs of a small number of troubled and troublesome young people who present risk to themselves and to others.

619. A police cell is an inappropriate place for a [redacted]. It requires adequate provision of other more appropriate accommodation. In the absence of any national data, it is not possible to judge the extent of need.

Peter Maddocks, CQSW, MA.
Independent author
8th November 2009

7 APPENDICES

7.1 Appendix 1 – [redacted]

Appendix 2 – The educational history [redacted]

Appendix 3 - Procedures and guidance relevant to this serious case review

7.2 Legislation

7.2.1 The Children Act 1989

Section 17 imposes a duty upon local authorities to safeguard and promote the welfare of children in need.

Section 25 describes the circumstances under which a local authority can seek to restrict the liberty of a child by placing them in secure accommodation.

Section 46 provides the police with powers of removal and accommodation of children in cases of emergency to take children into police protection where a police officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm.

Section 47 requires a local authority to make enquiries they consider necessary to decide whether they need to take action to safeguard a child or promote their welfare when they have reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. These enquiries should start within 48 hours. The local authority is required to consider whether legal action is required and this includes exercising any powers including those in section 11 of the Crime and Disorder Act 1998 (Child Safety Orders) or when a child has contravened a ban imposed by a Curfew Notice within the meaning of chapter I of Part I of the Crime and Disorder Act 1998.

Section 31 (9) defines harm which was extended via section 120 Adoption and Children Act 2002 implemented in January 2005 that now includes ‘impairment suffered from seeing or hearing the ill-treatment of another’ recognising that children who witness or hear abuse suffer, or are likely to suffer, significant harm as a result.

Section 46 provides Police Powers of Protection to take children into police protection where a constable has reasonable cause to believe that a child would otherwise be likely to suffer significant harm.

7.2.2 Family Law Act 1996

Part IV of the Family Law Act 1996 provides single and unified domestic violence remedies in the county courts and magistrates' courts. Two types of order can be granted:

- A non-molestation order, which can either prohibit particular behaviour or general molestation;
- An occupation order, which can define or regulate rights of occupation of the home.

7.2.3 Protection from Harassment Act 1997

The Protection from Harassment Act 1997 (PHA) makes it a criminal offence to pursue a course of conduct which amounts to harassment of a person. A court may issue a restraining order against someone found guilty of such an offence. Amendments to the PHA introduced by the Domestic Violence, Crimes and Victims Act 2004 will gives courts the power to issue a restraining order in certain circumstances against a defendant acquitted of a charge of harassment.

In addition to the criminal offence, the PHA also creates a civil statutory tort of harassment, which enables a person to obtain a civil court injunction to stop harassment occurring and to claim damages where appropriate.

This legislation can provide protection in neighbourhood disputes, cases of racial harassment and can also potentially apply in cases of domestic abuse.

7.2.4 The Crime and Disorder Act 1998

The Act contains provision for preventing crime and disorder. Section 1 gives powers to the relevant authority to apply for an Anti Social Behaviour Order (ASBO) when a person aged 10 or over is acting in an anti-social manner. Amendments are also made to section 47 of the Children Act and the duties of the local authority to conduct enquiries in specified circumstances.

Section 11 of the Crime and Disorder Act 1998 allows a magistrate to impose a 'child safety' order on a child under 10 years of age and place them under the care of the local authority. Such an order cannot be granted unless notification has been given by the Secretary of State that arrangements for implementation are in place in the area where the child is to reside. It is the responsibility of the Local Authority to make such an application.

7.2.5 The Education Act 2002

Section 175 puts a duty on all LAs, maintained (state) schools, and further education institutions, including sixth form colleges, to exercise their functions with a view to safeguarding and promoting the welfare of children (children who are pupils and students under 18 years of age, in the case of schools and colleges). The same duty is put on Independent schools, including Academies by regulations made under s157 of that Act.

Section 19(1) requires every local education authority to make arrangements for the provision of suitable education at school or otherwise than at school (EOTAS) for those children of compulsory school age who by reason of illness, exclusion from school or otherwise, may not for any period receive suitable education unless such arrangements are made for them.

7.2.6 The Anti-Social Behaviour Act 2003

In March 2003 the government published a white paper outlining proposals for tackling antisocial behaviour. The report, Respect and Responsibility – taking a stand against antisocial behaviour recommended the government provide local authorities and the police with a wider, more flexible range of powers to tackle nuisance crime and low-level criminality. The bill was designed to target what the home secretary, David Blunkett, described as "a yobbish minority" who could make "the lives of hard-working citizens a living hell" and includes a wide range of sanctions such as parenting orders and contracts, curfews, and fixed penalty notices. The act also strengthened and extended the application of antisocial behaviour orders first introduced in England, Scotland and Wales by the Crime and Disorder Act 1998. The demoted tenancy, introduced by the Anti-Social Behaviour Act 2003, enables Local authorities and housing trusts to deal more effectively with anti-social behaviour. It instigates a two-stage regime entitling

such St Leger Homes to apply to demote an otherwise secure tenancy; and then, during this demoted period, the St Leger Homes may seek possession of the property as of right (provided it follows the statutory procedure.)

7.2.7 The Sexual Offences Act 2003

Part 1 of the Act includes provision in section 13 making it an offence for a person aged under 18 to do anything that would be an offence under any of sections 9 to 12 if he were aged 18 or over. The purpose of this section is to provide a lower penalty where the offender is aged under 18. In practice (although there is no provision about this in the Act) decisions on whether persons under 18 should be charged with child sex offences will be made by Crown Prosecutors in accordance with the principles set out in the Code for Crown Prosecutors. The code states explicitly that the public interest requires the prosecution of an offence of unlawful sexual intercourse with a girl under 13 unless exceptional circumstances exist (The Sexual Offences Act 1956 defines sexual intercourse with a girl under 13 as a felony). In deciding whether it is in the public interest to prosecute these offences, where there is enough evidence to provide a realistic prospect of conviction, prosecutors may take into consideration factors such as the ages of the parties; the emotional maturity of the parties; whether they entered into a sexual relationship willingly; any coercion or corruption by a person; and the relationship between the parties and whether there was any existence of a duty of care or breach of trust.

7.2.8 The Children (Secure Accommodation) Regulations 1991

These regulations describe the circumstances under which a child or young person may be placed in secure accommodation upon the application of the local authority. Regulation 4 prevents the placement of children under 13 without the prior approval of the Secretary of State.

7.2.9 Review of Children's Cases Regulations 1991

These Regulations provide for the review of the cases of children who are looked after by a local authority.

Schedule I includes elements to be included in every review.

1. Keeping informed of the arrangements for looking after the child and of any relevant change in the child's circumstances.

2. Keeping informed of the name and address of any person whose views should be taken into account in the course of the review.

3. Making necessary preparations and providing any relevant information to the participants in any meeting of the responsible authority which considers the child's case in connection with any aspect of the review.

4. Initiating meetings of relevant personnel of the responsible authority and other relevant persons to consider the review of the child's case.

5. Explaining to the child any steps which he may take under the Act including, where appropriate-

(a) his right to apply, with leave, for a section 8 order (residence, contact and other orders with respect to children),

(b) where he is in care, his right to apply for the discharge of the care order, and

(c) the availability of the procedure established under the Act for considering representations.

6. Making decisions or taking steps following review decisions arising out of or resulting from the review.

7.2.10 The Review of Children's Cases (Amendment) (England) Regulations 2004

These Regulations impose new obligations on the "responsible authority" in England (a local authority, voluntary organisation or a person carrying on a private children's home) to appoint an independent reviewing officer ("IRO") in connection with the review of each case of a child who is looked after or for whom accommodation is being provided.

Provision for requiring local authorities to appoint IROs was inserted in section 26 of the Children Act 1989 (review of cases) by section 118 of the Adoption and Children Act 2002.

Regulation 2 amends the Review of Children's Cases Regulations 1991 by -

(a) inserting a new regulation 2A requiring IROs to be appointed in each child's case and providing for the description of persons that may be appointed as IROs and the manner in which the IROs should carry out their

functions;

(b) substituting a new regulation 3, providing for timing of reviews (including provision for reviews to be held when the IRO so directs);

(c) inserting a new regulation 8A requiring the responsible authority to inform the IRO about a failure to implement decisions of a review or a significant change of circumstances following a review.

7.2.11 The Children Act 2004

Section 10 requires each local authority to make arrangements to promote co-operation between it, each of its relevant partners and such other persons or bodies, working with children in the authority's area, as the authority consider appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes. This section is the legislative basis for children's trusts arrangements.

7.2.12 Domestic Violence, Crime and Victims Act 2004 (implemented 1st July 2007)

Civil injunctions (under Part IV of the Family Law Act 1996) offer temporary protection through non-molestation orders or occupation orders. However, breach of injunction by the perpetrator was often not effectively enforced. New provision under section 1 of the DVCVA 2004 is intended to address this issue. Until now a breach has only been punishable as a civil contempt of court,

When a non-molestation order either made after July 1st 2007, or an earlier order which has been varied is breached it will be treated like any other criminal offence, meaning that the perpetrator can be arrested, charged and brought before the magistrates' court. The victim, who was the applicant in the original civil process, becomes the key witness in a criminal case. As in other criminal cases, the decision whether or not to prosecute will be made by the Crown Prosecution Service (CPS) in conjunction with the police, where there is sufficient evidence and it is in the public interest to do so. The maximum custodial sentence for breaches dealt with as a criminal offence is five years.

7.2.13 The Children and Young Persons Act 2008

The Children and Young Persons Act 2008 received Royal Assent in November 2008 makes changes to local authority duties for helping children in care. The Act extends the statutory framework for children in care in England and Wales to ensure that such young people receive high quality care and services which are focused on and tailored to their needs. Of particular reference to these circumstances are reforms relating to;

- The securing of sufficient and appropriate accommodation for children in local authority care
- An amendment to the duties of local authorities to enable them to appoint Independent Reviewing Officers, such Officers to be independent of the local authority

The 2008 Act does not define who may be an Independent Reviewing Officer. It will be the duty of the "appropriate national authority" presumably the Secretary of State for Children to define in regulations what the qualifications and experience of such officers must be. The Secretary may also (under s.11 (1)) by order, establish a new national body of Independent Reviewing Officers to carry out the reviewing functions. An order made under this section may provide for the training, accreditation and management of independent reviewing officers.

The duties of the Independent Reviewing Officers will be to monitor the performance of the local authority in accommodating children in its care and ensuring that the ascertained wishes and feelings of the child are given due consideration by the local authority. The officer has the power to refer a case to a CAFCASS officer, presumably with a view to legal proceedings being initiated if the authority is considered to have erred in some way.

7.3 Safeguarding Procedures

7.3.1 The Doncaster Safeguarding Children Procedures

The procedures provide advice and guidance on the recognition and referral arrangements for children suffering abuse. This includes emotional abuse that involves causing children to feel frightened or in danger. The procedures also cover physical abuse of children. The procedures also describe abuse involving the neglect of children that includes failing to protect children from physical harm or danger or the failure to ensure access to appropriate medical care or treatment. This includes describing distinct action to be taken when professionals have concerns about a child, arrangements for making a referral, and the action to be taken. The procedures cover arrangements for the ACPC (now superseded by LSCB) to ensure there are effective arrangements that promote good interagency working and sharing of information and training. The procedures describe specific responsibilities for all agencies contributing to this serious case review. According to the DSCB website the procedures have not been reviewed and updated since November 2007.

7.4 Local strategies

7.4.1 The Doncaster Domestic Violence Strategy 2008-2011

The Doncaster domestic violence strategy acknowledges that the borough has the highest rates of reported incidents per head of population within South Yorkshire. Over 3,300 incidents were reported to the police in 2008. A small proportion of victims report incidents to the police, and then on average only after 35 incidents have already occurred. MJ did not report all the violence she suffered from FJ. Domestic violence accounts for some 25 per cent of all violent crime in Doncaster. There are around 60 reported incidents to the police each week. Of these about ten are assessed as high risk of further injury. Over 4,000 children in Doncaster lived in a household where domestic violence was reported.

The Safer Doncaster Partnership commissioned a report from Expanding Futures in December 2007 into services for victims of domestic violence. Their recommendations were incorporated in to the implementation plan. As part of the Local Area Agreement the national indicator of reducing repeat incidents of domestic violence in cases managed by the MARAC has been adopted as a key indicator.

7.5 National guidance

7.5.1 Working Together to Safeguard Children

The national guidance to interagency working to protect children is set out in Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. The guidance includes safeguarding and promoting the welfare of children who may be particularly vulnerable. There is no specific guidance in relation to young people vulnerable from gang related violence. There is no mention of Osman warnings.

Framework for the Assessment of Children in Need and their Families 2001

The guidance in respect of *the Framework for the Assessment of Children in Need and their Families* is issued under section 7 of the Local Authority Social Services Act 1970 and is therefore mandatory.

The framework sets out the framework for ensuring a timely response and effective provision of services to children in need. It makes clear the importance of achieving improved outcomes for children through effective collaboration between practitioners and agencies. The framework sets out clear timescales for key activities. This includes making decisions on referrals within one working day, completing initial assessments within seven working days and core assessments within 35 working days. As part of an initial assessment children should be seen and spoken with to ensure their feelings and wishes contribute to understanding how they are affected. If concerns regarding significant harm are identified they must be subject of a strategy discussion to co-ordinate information and plan enquiries. Child protection procedures must be followed.

Assessments should be centred on the child, be rooted in child development that requires children being assessed within the context of their environment and surroundings. It should be a continuing process and not a single or administrative event or task. They should involve other relevant professionals. The outcome of the assessment should be a clear analysis of the needs of the child and their parents or carers capacity to meet their needs and keep them safe. The assessment should identify whether intervention is required to secure the well – being of the child. Such intervention should be described in clear plans that include the services being provided, the people responsible for specific action and describe a process for review.

7.5.2 Common Assessment Framework (CAF)

The CAF is a key part of delivering direct services to children that are integrated and focused around the needs of children and young people. The CAF is a standardised approach to conducting assessments of childrens' additional needs and deciding how these should be met. It can be used by practitioners across children's services in England.

The CAF promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development. Practitioners are then better placed to agree with children and families about appropriate modes of support. The CAF also aims to improve integrated working by promoting coordinated service provisions.

All areas were expected to implement the CAF, along with the lead professional role and information sharing, between April 2006 and March 2008.

7.5.3 Multi-Agency Risk Assessment Conference (MARAC)

The MARAC model of intervention involves risk assessment in all reported cases of domestic abuse to identify those at highest risk so that a multi-agency approach may be taken. Evidence suggests that this reduces recidivism even among those most at risk. It was first used in Cardiff in April 2003.

It is an intervention that combines risk assessment and a multi-agency approach to help very high risk victims of domestic abuse.

Doncaster is the only area in South Yorkshire operating a MARAC panel each fortnight. An independent domestic violence advocacy service has two specially trained officers providing services to over 800 high risk victims of domestic violence referred to MARAC. MJ was judged not to be a high risk victim of domestic violence or subject of a referral to MARAC.

7.5.4 Children missing from education

The cost of young people missing out on education is very high both to the young person and their families and to society as a whole. According to the Audit Commission, nearly half of all school age offenders have been excluded from school. Government policies and strategies, particularly since the publication of the Laming Report have required local authorities to develop procedures that are effective in establishing the identity and whereabouts of all children and young people aged 0-16 in their area. Priority is given to ensuring that effective information sharing protocols are in place and there is support for children who are excluded from school.

Prior to Lord Laming's report, the government published the green paper, *Every Child Matters*, which subsequently informed major policy development. The government's aim is to ensure every child has the opportunity to fulfill their potential, and that no child slips through the net.

Ofsted published the report '*Key Stage 4: Towards a More Flexible Curriculum'*, in June 2003, which highlighted the large proportion of unsatisfactory provision for pupils who were not at school. The report recommended that the exchange of information on the attainment and needs of pupils involved in alternative programmes out of school should be improved to secure better monitoring of and accountability for their progress. It also recommended that better systems for tracking pupils missing from school rolls should be put in place and maintained.

In July 2004 the government published a good practice guide for local authorities, '*Identifying and maintaining contact with children missing, or at risk of going missing from education (CME)* '.

In October 2005 the revised national guidance in *Working Together* to safeguard children requires local authorities to have a named CME point of contact. The guidance highlights that when children go missing from education they can be at risk of significant harm.

In October 2005 the school's white paper '*Higher Standards, Better Schools for All* ' include proposals to introduce a statutory duty on local authorities to make arrangements to identify children missing from education. This also becomes a specific area of examination by the Joint Area Reviews (JAR) that start in 2005.

In February 2007, clause 4 of the **Education and Inspections Act 2007** makes it a statutory requirement that local authorities must establish the identity and whereabouts of children missing education in their area.

7.5.5 Improving Behaviour and Attendance: Guidance on Exclusion from Schools and Pupil Referral Units

In 1998 the Social Exclusion Unit published a report on truancy and exclusion, highlighting the damage that sustained absence from education inflicts on children and on society. It recommended a range of measures, including a reduction of one third in permanent exclusions to 8,400, and provision of full-time education to all permanently excluded pupils, by September 2002. These were subsequently adopted in the white paper that subsequently becomes the **Education Act 2002**. Since September 2002 all local authorities have been committed to providing full time educational provision for excluded children and young people.

In September 2006 the DfES publishes guidance in '*Improving Behaviour and Attendance: Guidance on Exclusion from Schools and Pupil Referral Units'.* The priority now is to ensure excluded pupils get a full-time education and schools can manage disruptive pupils outside the classroom. In order to ensure minimum disruption to a pupil's education, local authorities are required to plan as soon as they become aware of the exclusion to provide suitable full time education for a permanently excluded pupil from the 16th school day following the head teacher's decision to exclude. The authority should work with the school during the first 15 school days while making arrangements for longer-term provision. 'Full time' means supervised education equivalent to that provided by mainstream schools in the area and will be different for each Key Stage (KS). The recommended minimum hours per week of taught time are as follows:

KS1	21 hours
KS2	23.5 hours

KS3/4	24 hours
KS4 (Y11)	25 hours

These hours are set out in guidance in the *Management of School Day Circular 7/90*.

Suitable full-time education does include contact time and, as appropriate, activities like breakfast clubs where there is structured interaction. However, it is not the case that every child in a Pupil Referral Unit (PRU) should receive 25 hours education per week; some will have educational time specified in a statement, an individual education plan (IEP) or an education plan.

The requirement that LEAs provide a suitable full-time education is focused on pupils excluded for 15 days or more, with a particular focus on those who have been permanently excluded.

Full-time education for permanently excluded pupils is provided through various routes.

Although educational provision must meet the number of hours required for the school day, the timetable of an excluded pupil may look significantly different to the timetable in a mainstream school. For example, a pupil may spend the entire school week at one site, or alternatively arrangements for that pupil may require attendance at a combination of sites throughout the week. Either approach is valid so long as the total number of hours provided add up to the minimum hours outlined above.

Where possible the authority and schools should ensure that full time education for excluded pupils covers core national curriculum subjects (outlined in the national curriculum handbooks), but in addition time should be used to meet specific needs such as improving basic skills or strengthening emotional literacy. PRUs are also required to include Personal, Social & Health Education (PHSE), ICT and Citizenship within their curriculum. Whatever programme is provided there must be a clear structure to each day and rules, boundaries and expectations must be understood by all, especially the pupil.

There should be good links between schools and full time education providers over the curriculum, particularly for KS3/4 pupils, so that they are working towards eventual reintegration (usually to a mainstream school) otherwise time spent in alternative provision

can itself become a barrier to reintegration. It is best practice for PRUs to include working towards exams or accreditation of some sort.

The educational needs of individual pupils will vary, and the authority should aim to meet these by having a range of alternative provision available to permanently excluded pupils. To help the authority, schools need to pass on a record of the pupil's educational achievements; the steps being taken to address the pupil's behavioral problems including information about other agencies involved; whether the pupil is on the SEN Code; and an initial assessment of needs, against which the LA can plan the most appropriate provision to meet individual needs. The range can include:

a) Schools

b) Pupil Referral Units (PRUs)

c) Voluntary or community organisations

d) Private sector providers

e) Further education colleges or work experience placements

f) IT provision with appropriate supervision.

7.5.6 Guidance for LEAs – PRUs and Alternative Provision (LEA/0154/2004) and Commissioning Alternative Provision– The Role of the LEA (LEA/0155/2004)

The government published guidance in 2004 based on the work of pathfinder authorities. It advises authorities in arranging provision for young people in education other than at school (EOTAS). The guidance is explicit in stating that LEAs have a statutory duty “to make arrangements for the provision of suitable education at school (including pupil referral units), or otherwise than at

school, for children of compulsory school age who, by reason of illness, exclusion from school or otherwise, will not receive a suitable education without those arrangements[37]".

In discharging their legal responsibilities for arranging education for pupils who cannot be educated in mainstream or special schools, LEAs will need to:

- Assess pupils' needs
- Arrange suitable placements at Pupil Referral Units (PRUs) or other alternative education centres
- Check that the provision is of acceptable quality
- Monitor pupils' attendance and achievements
- Review the impact of local policies on admission and reintegration

It is not an option for LEAs to decide not to arrange any education, or to make arrangements that do not provide suitable education for pupils out of school who are resident within the local authority area. Although the nature of these arrangements varies from LEA to LEA depending upon local circumstances and policies, there are minimum standards that all LEAs are expected to meet. This is true of arrangements for any pupil; in addition, arrangements for pupils in vulnerable groups or for pupils whose previous family, social or educational experience has been characterised by difficulties should take account of these difficulties. This may mean taking additional steps to ensure that the individual needs of pupils are met or providing access to appropriate support services.

The guidance makes clear that authorities must have 'robust procedures' that means:

- Undertaking an assessment of suitability before placing pupils with new providers

[37] Section 19, Education Act 1996.

- Drawing up a contract / service level agreement with every provider that details the nature of the arrangement, makes clear the LEA's expectations and reinforces statutory requirements
- Undertaking a risk assessment for each pupil
- Ensuring adequate arrangements are in place in relation to insurance cover
- Fulfilling health and safety responsibilities
- Ensuring attendance
- Keeping track of pupil attainment and progression
- Overseeing curriculum content[38]
- Monitoring patterns of placement in Alternative Provision
- Collecting data and management information.

The guidance recommends that a named senior officer has responsibility for overseeing EOTAS provision.

7.5.7 The Social and Emotional Aspects of Learning (SEAL)

This is a curriculum resource published as part of the national primary and secondary education strategy to help schools develop children's social, emotional and behavioural skills. It is a discretionary programme. It includes assemblies and follow-up ideas for work in class. Schools that have identified the social and emotional aspects of learning as a key focus for their work with the children will use it. These will be schools who know that the factors holding back learning in their setting include children's difficulties in understanding and managing their feelings, working co-operatively in groups, motivating themselves and demonstrating resilience in the face of setbacks. These will not necessarily be schools where behaviour and attendance are poor. The materials help children develop skills such as understanding another's point of view, working in a group, sticking at things when they get difficult, resolving conflict and managing worries. They build on effective work already in place in the many primary schools that pay systematic attention to the social and emotional aspects of learning through whole-school ethos, initiatives such as circle time or buddy schemes, and the taught PSHE and Citizenship curriculum.

[38] DfES guidance, Access to Education for children and young people with Medical Needs, 2001

7.6 National reports and strategies relevant to this review that are not mentioned in chapter 3

7.6.1 National Domestic Violence Delivery Plan

The Home Office has also developed a National Domestic Violence Plan 2005 which states that, in relation to children, the issue of domestic violence should be mainstreamed and integrated throughout the children's agenda

The intended outcomes of the National Domestic Violence Delivery Plan are:

1. To reduce the number of domestic violence-related homicides.
2. To reduce the prevalence of domestic violence, particularly in high-incidence areas and/or communities.
3. To increase the rate of reporting for domestic violence, particularly in high incidence areas and/or communities.
4. To increase the rate of reported domestic violence offences that are brought to justice, particularly in high-incidence areas and/communities, as well as in areas with high attrition rates.
5. To ensure that victims of domestic violence are adequately protected and supported nationwide.

7.6.2 Specialist Domestic Violence Court (SDVC) Programme

The SDVC Programme has been the centrepiece of the National Domestic Violence Delivery Plan. The model as set out in the National SDVC Resource Manual[39] contains 12 core components – including Multi-Agency Risk Assessment Conferences (MARACs) and Independent Domestic Violence Advisers (IDVAs) – components that all contribute to the positive outcomes that have been achieved. (*See Justice with Safety 8 report published March 2008.*)

The programme has developed from the first 25 SDVC systems accredited in 2005/06, to a total of 122 accredited SDVCs, operational from April 2009.

[39] http://www.crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence59.htm

Doncaster has been part of the SDVC programme since April 2007 which is fast tracking domestic violence cases so that they are dealt with in six weeks. The rate of successful prosecution is 79 per cent. The Doncaster police public protection unit now operates a positive arrest procedure for domestic violence and has an arrest rate of 74 per cent. This is judged to compare favourably with other areas.

7.6.3 Hidden Harm – Responding to the needs of problem drug users

The Inquiry by the National Advisory Council on the Misuse of Drugs in 2000 focused on the children in the UK with a parent, parents or other guardian whose drug use has serious negative consequences for themselves and those around them. The council published Hidden Harm that makes recommendations for improving practice.

7.7 Other research and sources of information

7.7.1 Cannabis and the mental health of young people

Major studies including those cited by the Royal College of Psychiatrists (RCP)[40] show that people who use cannabis have a higher than average risk of developing schizophrenia and those who start smoking it before the age of 15, are four times more likely to develop a psychotic disorder by the time they are 26. It seems that, the more cannabis used the greater likelihood of developing symptoms of mental illness.

No one apparently knows for certain why teenagers are particularly vulnerable to the use of cannabis although the RCP believe it may be something to do with brain development. The brain is still developing in the teenage years; up to the age of around 20. Any experience, or substance, that affects this process has the potential to produce long-term psychological effects.

[40] http://www.rcpsych.ac.uk/mentalhealthinfo/problems/alcoholanddrugs/cannabis.aspx

Recent research in Europe, and in the UK, suggests that people who have a family background of mental illness are more likely to develop schizophrenia if they use cannabis as well.

Other studies have established a link between the use of cannabis and self harming and suicidal behaviour.

Appendix 4 Hidden Harm: recommendations relevant to the key learning points in this serious case review

This appendix is included to reinforce the learning and good practice in relation to working with the families of adult drug users relevant to this review. Neither parent was referred to or was known to neither alcohol nor the drug treatment service although the use of both substances appears significant.

Rec 6 The voices of the children of problem drug users should be heard and listened to.

Rec 10 When revising child protection policies and procedures, full account should be taken of the particular challenges posed by parental problem drug use, with the consequent implications for staff training, assessment and case management procedures, and inter-agency liaison.

Rec 26 All early years education services and schools should have critical incident plans and clear arrangements for liaison with their local social services team and area child protection committee when concerns arise about the impact on a child of parental problem drug or alcohol use.

Rec 27 All schools should identify at least one trained designated person able to deal with the problems that might arise with the children of problem drug users.

Rec 28 Gaining a broad understanding of the impact of parental problem drug or alcohol use on children should be an objective of general teacher training and continuous professional development.

Rec 29.1 An integrated approach, based on a common assessment framework, by professionals on the ground including social workers, health visitors and GPs, nursery staff and teachers, child and adolescent mental health services.

Rec 29.3 Appropriate training of children and family service staff in relation to problem drug and alcohol use.

Rec 37 The possible role of parental drug or alcohol misuse should be explored in all cases of suspected child neglect, sexual abuse, non-accidental injury or accidental drug overdose.

Appendix 5: Summary of learning and recommendations from previous serious case reviews relevant to this overview report

The DSCB have published executive summaries on five previous serious case reviews and are available at;

http://www.doncaster.gov.uk/Health_and_Social_Care/caring_for_our_children/Safeguarding_and_Standards/Safeguarding_Children_Board/Serious_Case_Reviews.asp.

They concern the circumstances and lessons to emerge from the separate deaths of five children between October 2004 and May 2008.

There are themes that are repeated in this SCR and acknowledged in the IMRs. In particular the previous SCRs highlight;

- Poor recognition of adult behaviour and lifestyle and its impact on the emotional and physical health of children;
- Giving insufficient attention and significance to what children say;
- Dangers of managing the children of severely anti-social families not as children in need but as offenders
- Inadequate response to domestic violence and substance misuse;
- Poor attention to getting full enough information about family history;
- Insufficient recognition of disengagement by significant adults from services and the implications for assessment and decision making;
- Reliance in some circumstances to self reported information and the implications for being overly positive and optimistic in responding to the adults;
- Inadequate assessment
- Recording and sharing information
- Insufficient co-ordination of intervention and support especially when several services and professionals are involved;
- Differential thresholds of concern between agencies;
- Understanding and complying with procedures.

All the reviews identify points of learning for all the services involved with the children. Of particular significance is the repeated description of problems in relation to the functioning of children's social care services. The difficulties identified in this review reflect longstanding issues.

In addition to the action plans following the reviews, children's services are subject of an improvement plan that describes strategic service wide improvements.

620. This review highlights in relation to **professional knowledge and skills**;

- Children's need and right to adequate parental care, effective supervision and appropriate guidance and the role of lead professionals in securing this;
- The pervasiveness of emotional and physical neglect and the extent to which services were unable to recognise, describe, analyse and address it and how this undermined their opportunity to develop effective interventions;
- The compromising impact of problematic alcohol or drug misuse on parenting capacity and emotional availability and the implications for assessment and care planning; this factor was insufficiently recognised by any service; appendix 4 reproduces eight of the recommendations from Hidden Harm of direct relevance to this review; the significance of drug and alcohol use by children for their emotional and psychological well being must not be underestimated or ignored;
- The importance of professionals understanding the legal and procedural context relevant to their roles and responsibilities;
- The importance of professional teams and core groups individually and collectively having a sufficiency and clarity of information to reach sound judgements that result in appropriate and effective action being taken; this has implications for ensuring clear arrangements are in place for a lead professional with the appropriate knowledge, experience and statutory authority commensurate with the circumstances of the child;
- The importance of assessing the capacity and competence of parents (and the adults they choose to share their responsibility with) to prioritise and meet their children's needs; this takes account of the degree to which the complexity of a child's needs may present additional risk or unmet need; the value of a well informed social and family history taking and recognising the significance of finding our about parent's personal history and lifestyle; being prepared to be respectfully intrusive;

- Good working knowledge and clarity about the methods, purpose and criteria for making referrals to specific services that include children's social care and other higher tier services;
- The need to anticipate and recognise how vulnerable and multi need families will attempt to control professionals through a range of strategies; and understand the implications for training staff and providing good reflective supervision; the extent to which chaotic and neglectful families have an impact on both children and practitioners; feelings of helplessness and having nothing more to give;
- Recording and organising information appropriately; recording information that is relevant and significant for the purpose of shared intelligence and understanding events within historical and family or social context; most of the services reported some degree of difficulty in the quality and access to relevant recording and none had a sufficiently effective chronology of events that would have provided historical context and identified patterns and escalations of need within the family as illustrated in the missed opportunities;
- Distinguishing between describing problems or events and providing sufficient analysis of information to help develop an understanding about the nature of the needs and problems and a theoretically competent framework for planning intervention;
- Knowledge about and understanding the implications of domestic violence for children's emotional health and well-being and having training and strategies to undertake competent assessments and develop appropriate intervention; this requires a very clear focus on the perpetrators of violence using the full range of statutory powers and sanctions as necessary;
- Knowledge and understanding the implications of children's emotional and physical neglect for their mental well being and having access to appropriate specialist advice and intervention to assist in achieving balanced judgements;
- Understanding the importance of compliance with legal requirements and national standards; understanding the purpose of and planning the conduct of key activity such as making a referral, when to use a CAF, convene strategy meetings and undertake appropriate assessments to collect and analyse information about risk and need; if departing from those standards to have a clear and recorded reason for this and ensuring senior managers and accountable bodies such as lead councillors and the safeguarding board are aware;
- Senior managers and accountable bodies placing the safeguarding and welfare of children at the centre of agency policy, planning and decision-making; the attempts to escalate action failed in this case;

- Ensuring that when either communities or individuals feel threatened by the behaviour of other's there is explicit consideration about the impact on children; this needs to extend wider than simply being the concern of individual practitioners or councillors;
- The challenge of trying to remedy poor parenting and neglect with older children and in particular when they become looked after and require higher level interventions and support; the placement of J1 and J2 was not guided by sufficient assessment of them or of the capacity of the foster carers to meet their needs; this is not to imply that the carers were responsible for events in April;
- Recognising the significance and relevance of self harming behaviour;
- The important role of all primary health care services in recognising indicators of possible parenting and childhood difficulties including health professionals working with adults where there are indicators that parenting may be compromised as a result of factors that include mental health and substance misuse;
- Knowledge and theoretical perspective about the relevance of significant harm in relation to young people engaged in anti-social or criminal behaviour;
- Engaging with non – cooperative families and young people; the reasons for non engagement can be a result of many different factors that require planned enquiry and informed analysis;
- Need for clarity about reaching sound well informed judgements that precede clear decision making;

621. This review highlights in relation to **professional action**;

- The importance of organisational arrangements at corporate and the service specific level that support practitioners working with complex, challenging and neglectful families; the importance of coordinating services effectively especially when several services are simultaneously involved with a family;
- this means having access to challenging and reflective supervision; workloads that reflect the complexity of work and the responsibilities of practitioners; performance standards and audit arrangements that collate and analyse information about the quality of practice and outcomes for children as well as meeting other standards including timescales;
- Practitioners having the capacity to undertake assessments that can interrogate, collate and analyse information about inter-relating risks and need and support judgements;

- The importance of having agreed multi agency strategies and plans for engaging with hostile, anti-social, chaotic and non – cooperative families;
- Structuring the planning and conduct of enquiries;
- Integrating community safety arrangements with safeguarding children procedures and protocols;
- Senior managers and accountable bodies ensuring they have sufficiently good arrangements to challenge and enquire about practice and have an effective means for making informed judgements about the quality and consistency of practice; the fact that referrals are not responded to or that assessments are not completed should have been picked up the in the internal management review;
- The importance of school staff in early identification and securing appropriate support for children presenting with emotional and behavioural difficulties; the importance of ensuring intervention is based on good assessment and clear plans;

This review also highlights in relation to **resources**;

- The importance of ensuring that major reorganisation or reconfiguring of services is subject to an adequate assessment of risk and impact on key statutory services for vulnerable children; ensuring they are sufficiently resourced and are accountable to managers with sufficient knowledge and capacity to challenge and oversee arrangements for children;
- The importance of effective and informed scrutiny arrangements and oversight by councillors, an effective Children's Trust and a properly functioning Local Safeguarding Children Board;
- The importance of having access to effective behaviour management services in education; the limitations and dangers of using exclusion as a method to control behaviour and the risk to children when they are not in school or EOTAS; and ensuring all children receive their full entitlement to education;
- Ensuring that education for children other than at school is of sufficient quality, content and duration to meet statutory requirements and the needs of the child;
- The importance of ensuring all agencies who come in to contact with families and children train their staff to be alert to recognising when children may need protection and how to report it and follow it up;

- Agencies ensuring staff have appropriate training and sufficiency of knowledge about relevant procedures, how to use the law effectively and understand what constitutes good and effective practice; understanding and using the statutory powers available to promote children's emotional, psychological and physical well being;
- Ensuring staff have clear working protocols and receive training about the purpose as well as how to comply with legal requirements and national standards;
- The importance of public agencies understanding the concept and fulfilment of corporate responsibility and ensuring clear leadership is given strategically and on individual cases;
- The importance of being able to get access to good quality specialist services including support with serious and challenging behaviour in education; that good working arrangements between practitioners can be promoted or impeded by organisational arrangements; the panel were told of poor working arrangements between some services;
- The importance of specialist services such as educational psychologists to provide support in meeting more complex pupil needs;
- The capacity and ability of supervising managers to oversee practice and service arrangements and make well informed evaluations and decisions and create opportunity for reflection particularly in relation to complex long term cases such as this;

7.8 National research and evidence from serious case reviews

622. Evidence from national research and evaluation of serious case reviews identify themes that are reflected in this review. In addition to those already highlighted they include;

- The absence of a thorough and shared social history on which to base coherent and developmentally informed analysis; a major difficulty in this case lay in gathering the vital uncollated information about the family and the individuals which was distributed among a large number of local agencies;
- Insufficient attention by key or lead professionals to developing a sufficiently rigorous theoretical understanding and framework within which to analyse information and make informed judgements about what is significant information; the only time this is really offered in the case is the delayed and largely ignored independent assessment;

- An awareness of and capacity to use inference when information is insufficiently clear to make a clear and objective judgement;
- Hesitancy in challenging the opinion of other professionals (that can stem from a lack of confidence, knowledge, experience or status). The difficulty of sustained challenge and differences of opinion or judgement are rarely pursued to a satisfactory conclusion; this is a feature of this case; in spite of concerns raised by individual practitioners it fails to secure any improved response from DAS
- Neglect; many families where children are severely neglected are well known to agencies over many years as in this case. Family histories can be complex, confusing and overwhelming for practitioners as was the case in this family. A common way of dealing with feeling overwhelmed and helpless is for practitioners to adopt 'a start again syndrome' which features strongly especially in the practice and decision making of DAS;
- Families can be ambivalent or hostile to help as was the case here. Adults will use strategies to control and impede professionals and particularly those who are seen to be influential and or powerful.
- Staff can be fearful and intimidated. None of the IMRs identify this as a concern in this case although there is evidence that witnesses and neighbours felt intimidation. Mother avoided some professionals and rejected others especially from social care when they do respond who in turn avoided or rebuffed referrals about the family through a succession of workers, closing the case, losing or re-interpreting key information, reassessing and referring on. All of this behaviour features in this case. Problems are exacerbated by an absence of shared understanding of thresholds for neglect, that includes the children's emotional care, leading to confusion and delay in key decisions; this is evident in this and previous cases and is clearly a significant problem for local services;
- Physical assaults on children occur in families where domestic violence is present and there is 'volatility', tending to erupt into violence. The misuse of drugs/alcohol increases the risk further *but does not predict serious injury*; this should make all professionals especially vigilant about enquiring into what is happening in families and securing the views of children to form judgements about how they are effected; this did not happen with sufficient clarity and focus and an absence of information led some professionals to arrive at very optimistic assessment in DAS as well as YISS in relation to the ONSET process;
- The police tend to be the agency with most involvement where there is domestic and community violence; police officers need to develop skills that enables them to identify indicators of risk and have the capacity for judging when a referral is required to another service rather than simply processing data and information forms; danger for children occurs where there is a lack of awareness on the part of health and police staff to link domestic violence and the risk of harm to children;

father's violent outbursts at the hospital were minimised in spite of previous information that should have been available within each service;

- The importance of effective supervision that helps practitioners to think, explain and understand rather than simply focus on compliance or process. It needs to help them cope with the complex emotional demands of work with children and families with entrenched needs;