SERIOUS CASE REVIEW

Under Chapter VIII

'Working Together to Safeguard Children'

In respect of the death of

Case Reference - BSCB/2009-10/2

What is a Serious Case Review?

Serious Case Reviews shed light on whether lessons can be learned about the way local professionals and agencies work together in the light of a child death where abuse or neglect are suspected.

Serious Case Reviews are not inquiries into how a child dies or who is to blame. These are matters for coroners and for criminal courts.

Serious Case Reviews focus on improving practices that safeguard and promote the welfare of children.

Please note; That the report has been subject of redaction to protect the identity and privacy of family members and professionals involved in this case.

Report by:

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Presented to Birmingham Safeguarding Children Board

on

15 October 2010

Serious Case Review Executive Summary

INTRODUCTION

The purpose of this serious case review is as outlined in Chapter 8 (8.5) of the Working Together to Safeguard Children 2010 guidance, namely to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

Serious case reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate. In production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality. The Birmingham Safeguarding Children Board (BSCB) has balanced the need to maintain the privacy of the child and family with the need for agencies to learn lessons relating to practice identified by the case and has authorised the publication of sufficient information to enable this to take place.

A decision to undertake a Serious Case Review was made on the 12 April 2010. The BSCB identified those agencies that had had significant engagement with the child and family. The agencies were required to secure and review files and records from the 1 March 2009 until the date of the child's death. Agencies were required to compile an Individual Management Review (IMR) to provide an independent, open and critical analysis of individual and organisational practice. The IMRs should identify lessons learnt by the individual agencies, highlight any good practice and include recommendations to improve practice. The panel also considered the findings from the Health Overview Report and the Independent Police Complaints Commission (IPCC) investigation into West Midlands Police contact with the mother and child prior to the child's death.

The BSCB appointed an Independent Chair, an Overview Author and a Panel of safeguarding experts to conduct the review and brings together the key learning from the case.

The most important issues to address in trying to learn from this case were identified in the Terms of Reference as:

a) Mother's mental health and the impact it had on her caring for her child and whether these issues were recognised and acted on appropriately.
b) Mother and child's isolation from the services that could have supported them.
c) The recognition of the wider safeguarding issues for the child by agencies that were in contact with mother.
d) Consideration of mother's ethnicity and culture and how this could have affected her presentation and others interpretation of the situation including the use of interpreters.

e) The effect of mother's immigration status on her parenting capacity and the child's environment.

f) Agencies responses when mother disengaged from services.

g) Examination of decision making in relation to housing issues, suitability of accommodation, duration and housing moves.

h) Consideration of what referral pathways are open to the police when there is an escalation of calls for help.

i) Whether or not the GP had identified mental health problems and what liaison he/she had with the Health Visitor.

Was information from her asylum application made available to other Agencies.

SYNOPSIS

In February 2010 police officers attended an address in Leicester in response to a report that a mother had arrived at a relative's address without her pre-school age child. There was concern about the mother's mental state and the safety of the child. The mother and child lived in Birmingham and police officers were sent to that address where the body of the child was found. The child had sustained an injuries to the torso and a corrosive liquid had been poured over the body. Due to the severity of the injuries the exact caused of death could not be ascertained. The mother was charged with the murder of the child.

It was determined that the mother was unfit to stand trial due to a severe mental illness. The Court found that the mother was responsible for the

unlawful killing of the child. The mother has been made subject of an indefinite hospital order her release will be dependent upon the order of the Secretary of State.

The family of the child are black African, originate from Somalia and their religion is Muslim. It is believed that the mother and child entered the United Kingdom in March 2009 claiming asylum a week later. The mother alleged that they had entered the country from Somalia and had been living with relatives at an address in Leicester. The mother claimed that she had heart problems and was suffering from shock as a result of events experienced in Somalia. The mother was served notification of illegal entry papers. Since the death of the child and, as a result of the criminal investigation, it has been established that the asylum claim was a fabrication. The mother had lived in Holland since the age of nine years and the child was born in that country.

The day after the asylum claim was made police officers attended a 'domestic incident' reported by a member of the public. This concerned the mother and a male relative and occurred in the street outside the relative's address in Leicester where the mother and child were staying. The mother was distressed and denied any knowledge of the people at the address and did not wish to remain there. Emergency accommodation was arranged for the mother and child prior to being accommodation in Birmingham by the National Asylum Support Service (NASS). The mother specifically requested that she be accommodated away from relatives and alleged that the police had told her it was unsafe to be near them.

In terms of accommodation there was little stability for the child as she went on to live at three different addresses in Birmingham as well as moving back to Leicester for a short time to stay with family. The mother was very protective of the child and she usually kept the child close and in sight. The child was well fed, well dressed and clean, but had little stimulation, had limited speech, had few toys, had no contact with other children and was isolated from wider family.

Soon after arrival in the United Kingdom the family had become concerned about the mother's mental health as she was acting strangely, would talk to herself and to imaginary persons, making strong religious statements. The mother resisted attempts by the family to seek medical attention and isolated herself and the child from family by alleging to professionals that she was being abused and harassed by them.

The child and mother received health assessments when in initial accommodation in Birmingham but there was a failure to record the child on the Child Health system. This resulted in the child not receiving a health visiting service when the mother and child moved into community accommodation.

Soon after moving out of the initial accommodation two calls were received by the police from other residents complaining about the actions of the mother and the next day she went into a police station with her child to allege that she had been attacked and harassed and needed a safe place to go to. She was

taken back to the address and advised that she would have to speak with the housing providers if she wanted a move. She and the child returned to live for a short time with the family in Leicester before returning to Birmingham. Shortly afterwards the mother and child were moved to a third address in view of arguments between the mother and other residents.

The family contacted the UK Border Agency with concerns over the mother's mental health but whilst this was recorded on a database no action was taken as it was assumed that the police were dealing with the matter. This was based on the mother's assertion, during an asylum application interview, that she had reported to the police in Leicester that her family had tried to abuse her.

A housing officer received a late night call from another resident at the mother's address to report that the mother had broken a window. The housing officer observed several empty vodka bottles in the mother's bedroom but no further action was taken.

Three months later the housing officer received a call from a relative concerned over the well being of the mother and child. As a result of these concerns two relatives and the housing officer went to the mother's address. The mother's reaction was to telephone the police and allege that people who had previously abused her in Leicester were at her house and she wanted them removed. The relatives repeated their concerns over the mother's mental health to the police officers but were asked to leave after the mother

produced a letter concerning her asylum application which appeared to support her version of events.

The police officers made a judgement that the mother did not appear to be exhibiting signs of mental health issues but nevertheless made checks with Leicestershire police and with a West Midlands Police child abuse investigator. A prompt referral was made to the specialist police public protection unit and to children's social care. However, the following day it was decided, without discussion with children's social care, that the police would make a single agency visit that day to make a judgment on the referral. The mother and child were seen and the mother reiterated her allegations of being abused by the relatives who she claimed were not in fact her family. The officer saw the child who was sleeping and was described as clean, wearing clean clothing and had clean bedding. The house was sparse but clean. No further action was taken by the police and children's social care recorded the contact as information only in light of the police visit. This was a missed opportunity to probe the allegations made by the mother and to establish from the family the basis of their concerns about the mother's mental health.

Five weeks later the housing officer was again contacted by another resident at the mother's address. It was reported that the mother was not talking sense, there were concerns about her mental health, there was evidence of her drinking a lot of alcohol, the child was left alone, the mother had left doors and windows open at night. The housing officer made a referral to children's

social care. The resident who raised concerns expressed a willingness to be contacted and had provided contact details. This referral was categorised as high priority recommending an initial assessment but it was to take eight days before the mother and child were seen and the initial assessment carried out. The instructions for the initial assessment were detailed and it was well conducted with appropriate recommendations including consideration of a referral for a mental health assessment of the mother. There was a failure, however, to contact the referrer or the resident to clarify concerns prior to the visit. It was noted that the resident had moved out of the address since making the referral. The mother refused the use of an interpreter and refused consent for lateral checks.

After the visit the mother complained about the social worker claiming that she had been nasty and mean to her. This was dealt with by a team manager who agreed to pass the matter onto the social worker's line manager. The visit was discussed between the social worker and the team manager but the refusal of the use of the interpreter, of consent for lateral checks and the complaint against the social worker did not prompt any heightening of concern.

Half an hour after making the complaint the mother rang the police to report that she was not safe and wanted to be moved as people who had abused her were outside. Within the next hour she made a further four calls to the police repeating that she was scared. Police officers attended the address and observed that the mother was distressed and had been drinking. Contact

was made with the mother's solicitor who outlined that the mother had been assessed for mental health issues and stated there were concerns. However the officers made a judgement that the mother was not a danger to herself or to the child. The officers described the child as 'happy and talkative' throughout, although it was noted that the child could not speak English. A WG392 referral form was completed which was to be sent to the police public protection unit and to children's social care. However within the next two hours the mother was to phone the police a further four times reiterating that she was scared. These calls were all linked together and no further action was taken.

An hour and a half later the mother went into a police station with the child who was described as crying and distressed. The mother was agitated and shouted that she wanted to be placed in a hostel. A police sergeant made enquiries with the officers who attended the address which was in a different police area to the police station. Whilst there was clearly an escalation of the mother's distress, and officers concluded that the mother had mental health issues, the mother's presentation at the police station was dealt with primarily on the basis of a request for accommodation which was refused. There was a failure to assess the wider issues, including the lateness of the hour for a young child to be out and being some distance from the home address. Whilst a further WG392 referral form was completed, no immediate action was taken to contact children's social care or to consider requesting a mental health assessment of the mother. At the time of leaving the police station the child was described as playing happily and looked healthy and well clothed.

However the mother was still agitated and alleged that the police officers were racist and she was being discriminated against.

The following day the body of the child was found at the home address.

LEARNING POINTS

Professionals tended to focus upon appeasing the mother, dealing with practicalities, and accepting her version of events rather than probing the concerns raised by the family and by other residents. Unverified allegations that the mother made about abuse she experienced when living in Leicester were taken as fact and kept the focus on her needs rather than upon the child.

Whilst the mother was very protective of the child, there was insufficient attention given to the impact of her mental health upon her parenting capability. Unqualified opinions were made and accepted which resulted in there being no assessment by mental health professionals and a failure to safeguard the child. Whilst there is some evidence of information exchange there are shortfalls in agencies working together to gain a full and holistic understanding of the vulnerability of the child.

The failure to register the child on the Child Health system and to complete a new to area assessment when the mother and child moved out of initial accommodation resulted in the absence of health visiting contact. This resulted in no assessment of the child's health and development, of the parenting capacity of the mother and of environmental factors.

GOOD PRACTICE

The service provided at initial accommodation for asylum seeking families in terms of advice, guidance, information about support groups and the onsite health assessment provision by the Asylum Seekers Health team.

The mandatory use of interpreters in the appropriate language by the UK Border Agency for key interviews.

Good information gathering by front-line police officers and prompt sharing of information with children's social care. Unfortunately the effectiveness of this action was diluted by a subsequent decision by specialist police officers to make a single agency visit.

The UK Border Agency acted promptly to share the findings from this case in a national review, and audit of reason for refusal letters which were in the process of being quality audited whilst this serious case review was being conducted.

CONCLUSION

After the arrival of the mother and child into the United Kingdom it soon became apparent to family members that the mother had mental health issues. Professionals were made aware of concerns expressed by the family and by other residents in the shared accommodation. Unqualified judgements were made which contributed to missed opportunities to assess the mother's mental health, her parenting capacity and the welfare and safety of the child. Eventually, the day before the death of the child was discovered, an initial assessment by children's social care recommended a referral for a mental health assessment.

It is the view of the Panel and the author that a proper mental health assessment of the mother would have led to better support services, a better understanding of her mental well being and level of potential risk to the child. However, there were no indications that the mother would physically harm the child and hence her death could not have been predicted but could probably have been prevented.

RECOMMENDATIONS

Recommendation 1

Where a child is in the sole care of a parent/carer who displays increasing indicators of mental ill health, professionals to be advised that specialist advice should be sought to ascertain whether a formal mental health assessment is required to ensure the safety and wellbeing of the child.

Recommendation 2

Birmingham Safeguarding Children Board to commission training to enhance professionals' understanding of mental ill health issues, indicators and referral procedures.

Recommendation 3

Children's Social Care to review and amend current procedures regarding parental consent for lateral checks in relation to duty and assessment processes.

Recommendation 4

Children within asylum seeking families should be viewed as potentially having additional needs and any agency (adult or children's service) involved with them should consider using a pre CAF (Common Assessment framework) checklist to determine whether any additional support is needed.

Recommendation 5

UK Border Agency to include a disclaimer in written communications concerning an asylum application to the effect that contained therein are the views of the applicant which have yet to be verified.

Recommendation 6

Birmingham Safeguarding Children Board expects all agencies that have completed an IMR to implement any internal recommendations and to take action where management or practice has fallen below expected standards of professional behaviour.

HEALTH OVERVIEW RECCOMMENDATIONS

1. HOBtPCT undertakes a systems approach to ensure that the process of recording and transferring information on children by the Asylum Seekers Health is both safe and effective.

2. HOBtPCT ensures that the Health Asylum Team adhere to the policies and procedures of the wider organisation particularly with regard to the DNA Policy.

3. NHS BEN Clinical Governance Team develops a standardised New Patient Check and New Patient Questionnaire that incorporates a question on the patient's mental health status.

AGENCY INTERNAL RECOMMENDATIONS

Birmingham City Council - Children's Social Care

1. Children's Social Care should ensure that the action to be taken when an Initial Assessment is categorised as 'high priority' is understood by all Duty and Assessment Social Workers and Team Managers.

2. To agree a protocol with the Borders Agency to ensure that they notify Birmingham Children's Social Care of the placement of children in their jurisdiction with families who have no recourse to public funds.

3. Children Social Care to ensure that Social Workers consider the potential impact of parental mental ill health or parenting capacity and for the safeguarding of children in all assessments.
4. Where parents refuse the services of an interpreter, this should not prevent an interpreter accompanying the Social Worker during assessment visits and the motives of such refusals should be evaluated as part of the assessments.

5. Robust team management cover must be in place in the Duty and Assessment Service and known to all Duty and Assessment staff.

6. Review current practice and understanding of ascertaining parental consent to lateral checks in screening and duty and assessment processes.

7. Concerns about a child who may be at risk of significant harm, from members of the community should be evaluated as potential referrals

8. The Domestic Violence Screening process should be reviewed to include allegations of domestic abuse from extended family members

Heart of Birmingham Teaching Primary Care Trust – Asylum Seeking Health Team and Birmingham East and North Primary Care Trust – Health Visiting Service and GPs

1. The Asylum Seekers Health Team will immediately implement and ensure compliance with Mainstream Health visiting and School Nursing policy and guidance in relation to its delivery of services for children.

2. The Asylum Seekers' Health Team will implement processes to store and share with relevant professionals and agencies all information from health assessments and contacts with Asylum Seeking families.

3. The Asylum Seekers' Health Team will produce and implement written guidance on the processes to be followed in supporting families' transition to the community and continued engagement with health services through outreach visits.

4. The Asylum Seekers' Health Team will consistently apply the HOBtPCT Interpreting Services Policy:

5. Health Visitors to be reminded of their responsibilities in relation to the New to Area Policy & NHS BEN to undertake an audit of compliance with New to Area and New Registration Policy amongst all Health Visiting Teams

6. NHS BEN Clerical Standards to be amended to clarify actions to be taken by clerical staff when requested records do not arrive within 2 weeks.

7. NHS BEN Clinical Governance Team to establish baseline data & appropriate improvement plan in relation to how many GP practices that directly inquire about mental health history as part of New Patient Checks and New Patient Questionnaires.

UK Borders Agency

1a. A review of the Contract with UPM to establish when and where they breached their contract in not notifying UKBA of incidents in accommodation they managed.

1b. A review of the type of information shared by UKBA with Accommodation Providers in respect of potentially vulnerable individuals.

2. A review of UKBA staff guidance to determine if adequate in the following areas:
   - dealing with allegations that raise safeguarding issues
   - mental health of a parent / possible alcohol or substance abuse
   - making referrals to Children's Services
   - maintaining an audit trail of action taken and recording UKBA's response through file minutes and database maintenance
3. Training provided to staff to be reviewed to see if it adequately covers the following:
   - duty of staff in respect of safeguarding
   - indicators of risk
   - making referrals to Children's Services
   - maintaining a record of actions taken

4. UKBA needs to satisfy itself that the training and guidance provided by UPM Ltd to staff on the issue of safeguarding children is adequate, and that guidance is being followed.

United Property Management

1. Implement a training plan to ensure that all staff in contact with service users receives adequate training on how to recognise signs of abuse and how to respond.

2. Management to reinforce the open door policy.

3. Develop constructive relationships between the company and Children's Social Care.

4. Ensure the company does as much as possible to inform families of support they can obtain from within the local community.

5. Further briefing on the company child protection policy and procedure.

6. Whenever external agencies are contacted

West Midlands Police

1. In order to enhance the training process, a revised audit process to be developed to dip sample frontline staff responses to child safeguarding issues, when dealing with incidents which are not overtly child protection/child safeguarding matters. Additionally the dip sampling to cover child abuse investigator referrals, to assess the effectiveness of child abuse investigator responses to referrals which are not overtly a crime

2. West Midlands Police and LSCB partners to promote new communities' empowerment , awareness and education regarding referral of safeguarding concerns in relation to children

SERIOUS CASE REVIEW PANEL CHAIR AND MEMBERS

Independent Chair Anne Binney

Independent Author Gill Baker

Panel Members

Specialist Named Nurse for Safeguarding Children & Young People Unit, Central Safeguarding (pan Birmingham service)

Operations Manager, North & Eastern Care Management Services,
Social Care, Children & Young People & Families Directorate, Birmingham

Detective Chief Inspector, West Midlands Police

Safeguarding Lead for Children & Young People,
Birmingham & Solihull Mental Health Foundation Trust

Regional Safeguarding Co-ordinator,
UK Border Agency, Midlands & East Region

ENSURING LESSONS ARE LEARNT

The report findings were presented to a full meeting of the Birmingham Safeguarding Children Board on 15th October 2010 and have been ratified by the Chair of the Board. All Safeguarding Board Members welcomed the report findings and agreed to ensure that all recommendations would be fully implemented within the agreed timescale. Birmingham Safeguarding Children Board and the Department for Education Safeguarding Group have closely monitored the implementation of all the key recommendations to ensure that agency are able to demonstrate and evidence that lessons have been learnt from this tragic case. All recommendations have been now been finalised.

AGENCY INTERNAL RECOMMENDATIONS

In addition to the reports six key recommendations, agencies also identified a further 30 areas for improving their own internal safeguarding arrangements. The Birmingham Safeguarding Children Board has closely monitored the implementation of the actions that emerged from the Health Overview Report

and agencies Individual Management Reviews. All of the recommendations have now been fully implemented.

birmingham safeguarding children board

Reviewed and Finalised 27th October 2011

Serious Case Review Action Plan in respect of BSCB 2009-10/2
Date 15th October 2010

Red overdue
Green Pending
Black completed

The recommendations have been accepted by the BSCB and agencies will ensure that identified action is implemented by the agreed target date. The BSCB will receive progress reports from named agencies within 6 months. BSCB monitor the implementation of recommendations and audit compliance.

Recommendation (SMART)	Agreed by Agency Lead	Action Required by Agency	Implementation Lead & Agency	Target date for completion	Summary of Action Taken & Date Received	GOWM & Ofsted Monitoring & Feedback	QA&A Audit, Progress & Finalisation date
Recommendation 1 Where a child is in the sole care of a parent/carer who displays increasing indicators of mental ill health, professionals to be advised that specialist advice should be sought to ascertain whether a formal mental health assessment is required to ensure the safety and wellbeing of the child.	Chief Constable West Midlands Police and Chief Executive, UK Borders Agency	West Midlands Police, UK Border Agency and their commissioned Housing Providers (UPM) to undertake a targeted awareness raising in relation to working with parents who have mental health difficulties . (BSCB policy & procedures section 20) To include 'sign posting' to specialist services - Crisis Home Treatment Teams	Safeguarding Lead for West Midlands Police and Assistant Director West Midlands and East, UK Borders Agency	31 December 2010	**UKBA** Local SCW's delivered training to decision makers on vulnerable cases earlier this year following this case. A signposting guide will also be shared with all staff by the end of this year. It will detail the action required in certain cases. There will also be an audit trail on when cases are referred and who to. This will be managed by the SCW lead. UPM are also providing awareness training to their staff. Currently if there are concerned	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Outcome of awareness raising programme. Reviewed 13/01/2011 awaiting further information from

					about the mental well being of a parent/carer, where the family is in Initial Accommodation (IA) they raise their concerns with the health unit in IA, where family is in dispersed accommodation they would refer the family to the relevant Social Services. **Completed** **West Midlands Police 21st March 2011** West Midlands Police is currently rolling out the CAF process, training for all frontline staff will be put in place to give them an overview of the CAF process, this recommendation will be linked into the training to ensure all officers understand their responsibilities to children should a sole parent have a potential mental health issues, and the requirement to seek specialist assessment. **Completed**		West Midlands Police Progress report from West Midlands Police Reviewed 31/3/2011 **Finalised**
Recommendation 2 Birmingham	Chair	Chair of BSCB	Chair of BSCB	31 December	**25/07/11**	Safeguarding	Progress is reviewed

Safeguarding Children Board to commission training to enhance professionals' understanding of mental ill health issues, indicators and referral procedures	Birmingham Safeguarding Children Board	Training Steering Group and Project and Training Development officer to identify current available resources including those provided by the Adult Safeguarding Board and to identify the initial target groups. Rolling Programme of training to be commenced	Training Steering Group	2010 1 March 2011	A new Mental Ill Heath Task and Finish group has been created, headed by George Faulder to revamp George's Mental Ill Heath Course to create a focus on parents who pose a risk to children. They have also been tasked to evaluate existing training currently delivered by Outcomes/single agencies, develop Train the Trainer events using nominated representatives for first line managers to disseminate and use the new evaluation framework to assess changed behaviour and practice. This recommendation formed part of a broader piece of work being progress by the OEG to address parents who pose a risk to children through their mental health illness. The TSG has commissioned multi-agency training to be delivered by NHS and	Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Training Evaluation. Reviewed 25/7//2011 actions now **Completed**

					Social Care from January 2012. The training will be evaluated by the TSG. **Completed**		
Recommendation 3 Children's social care to review current procedures to ensure that social workers understand the options available when a parent/carer refuses consent to lateral checks in relation to duty and assessment procedures.	Strategic Director of Children Young People and Families Directorate	Children's Social Care to review and amend current procedures regarding lateral checks and provide evidence of effective implementation.	Safeguarding Lead for Children's Social Care, Service Director	31 January 2011	**Updated** **3rd March 2011** Qualified expert Social Workers have been introduced into the Duty Screening Service and they ensure appropriate parental consent to lateral checks have been obtained. **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Lateral Checks Procedure. Reviewed 13/01/2011 awaiting update. Children's Social Care response 3/3/2011 reviewed. **Finalised**
Recommendation 4	Strategic	CAF assessment	Children,	31 December	4th January 2011	Safeguarding	Progress is reviewed

Children within asylum seeking families should be viewed as potentially having additional needs and any agency (adult or children's service) involved with them should consider using a pre CAF (Common Assessment framework) checklist to determine whether any additional support is needed	Director of Children Young People and Families Directorate	process tot include reference to potential additional needs of children within asylum seeking families Training inputs and guidance for adult services to incorporate key learning from this recommendation.	Young People and Families Directorate CAF Coordinator	2010	Children within asylum seeking families should be viewed as potentially having additional needs and any agency (adult or children's service) involved with them should consider using a pre CAF (Common Assessment framework) checklist to determine whether any additional support is needed: • On-line CAF raising awareness training is available through www.birmingham.gov.uk/caf - this is accessible by all agencies as a first point of information. • The CAF pre-assessment checklist is available to download from the CAF website • Last year CAF training was delivered in various guises to 1690 delegates, with another 806 delegates this financial year by the central CAF team.	Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Training Plan. Review 13/01/2011 **Finalised.**

					• Specific training is being delivered to Hostel/Temp Accommodation staff, Social Workers & Police (360 delegates) over 6 sessions between 18th Jan-1st March (funded by CAF team, Housing, CSC & Police) • A training plan to encompass Adult Services needs to be addressed but must been reviewed within the capacity of the CAF team post April 2011 • Support with the CAF process is available on request from the central CAF team on a single point contact number - 0121 303 8117 • The determination of whether additional support is needed remains with the agency in contact with the family. CAF assessment process to include reference to		

					potential additional needs of children within asylum seeking families • The Children's Well Being Model (CAF Windscreen) refers to asylum seeking families and some of the additional needs they may exhibit - training on-going to cascade this into the C&YP workforce • These potential additional needs are reflected in the prompts within the CAF form (though specific mention of asylum seekers isn't made) - and this will be amended asap. • Support with the CAF process is available on request from the central CAF team on a single point contact number - 0121 303 8117 **Completed**		
Recommendation 5 UK Border Agency to include a disclaimer in written communications concerning an asylum application to the effect that contained therein are the views of	Chief Executive, UK Borders Agency	UK Border Agency to review and amend policy to ensure a disclaimer is included within	Safeguarding Lead Assistant Director West Midlands and	31 December 2010	UK Borders Agency progress report 29th July 2011 confirmed that they are in the process of making changes to the relevant document with	Safeguarding Leads in agencies have been closely monitoring	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of

the applicant which have yet to be verified.		written communications to address the key learning from this case. Provide evidence of effective implementation of new guidance .	East, UK Borders Agency		the necessary disclaimer. Confirmed received on 27th October 2011 The final draft document was approved and has been implemented by UK Borders Agency. This action is now fully completed. **Completed**	implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) New Policy – Staff guidance Reviewed 27/10//2011 Following response from UKBA. **Finalised**
Recommendation 6 Birmingham Safeguarding Children Board expects all agencies that have completed an IMR to implement any internal recommendations and to take action where management or practice has fallen below expected standards of professional behaviour.	Chief Executive and Chief Officers from all Agencies Completing IMR'	Safeguarding Lead to provide written confirmation that recommendations have been full implemented within identified agreed timescale. Notify the BSCB of the outcome of action taken where management or practice has fallen below expected standards of professional behaviour.	Agency Safeguarding representative on BSB	31 December 2010 31st March 2011	5 Agencies made recommendations within their IMRs. BSCB has written to all agencies seeking report on progress. The agencies below have provided confirmation that the recommendations have been fully implemented: • UK Border Agency • United Property Management • Heart of Birmingham and	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) IMR Action Plan. SCR Sub-Group reviewed

					Birmingham East & North PCT Health Visiting • Children's Social Care • Health Overview Report • West Midlands Police	Group in due course.	15/07/2011 **Finalised**

Reviewed & Finalised 14th July 2011

Implementation of IMR Recommendations in respect of BSCB 2009-10/2
Date commenced 13th July 2010

Red overdue
Green Pending
Black completed

The below recommendations have been ratified by the Strategic Lead for each agency, who will be responsible for ensuring they are fully implemented by the agreed target date. The BSCB will receive quarterly progress reports from named agencies. BSCB will monitor the implementation of recommendations and audit compliance prior to case finalisation.

Recommendation (SMART)	Action Required by Agency	Implementation Lead for Agency	Target Date for Completion	Summary of Action Taken & Date Received	BSCB & Ofsted Monitoring & Feedback	SCR Sub-Group. Audit, Progress & Finalisation date of IMR Recommendations
Birmingham Children's Social Care						
1. Children's Social Care should ensure that the action to be taken when an Initial Assessment is categorised as 'high priority' is understood by all Duty and Assessment Social Workers and Team Managers.	Review the current process of prioritisation and allocation of initial assessment.	Service Director for Children Services.	31/3/2011	The introduction of qualified social workers into the duty screening teams will ensure clear instruction and priority. The first workers will be in post 29th November 2010. Series of workshops for duty screening and duty and assessment will be undertaken to set standards and ensure	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.

				compliance to these. **13 Dec. 10** A baseline audit is currently underway in duty screening, sample auditing will take place in January, February and March 2011 to track progress. 3rd March 2011 Stock take audit in Nov/Dec 2010 completed and a memo of instruction to Team Managers had been issued to remind them of the classification of Initial Assessments. **Completed**	Department for Education Safeguarding Group in due course.	**Consider Evidence for Audit** 1) Copy of Review outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010. Reviewed 31/3/2011 **Finalised**
2. To agree a protocol with the Borders Agency to ensure that they notify Birmingham Children's Social Care of the placement of children in their jurisdiction with families who have no recourse to public funds.	1. Review current processes. In conjunction with UK National Border agency 2. Review the sharing of information. 3. Implement new strategies	Service Director for Children Services.	31/3/2011	The remodelling underway of CSC and the children's directorate will ensure clarity in these circumstances. Local protocol to be drafted in line with new CSC structure and in partnership with CAF/CIN team. To discuss with Safeguarding Board the need to raise this as a	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit**

				potential national and local issue in terms of notifications from UK National Border Agency. **Updated** **3rd March 2011** Regular liaison between the directorate and the Border Agency takes place between the Operational Manager with responsibility for the No Recourse to Public Funds service. The Border Agency is able to highlight children and their families who have 'no recourse to public funds' who they are concerned about. An assessment by Children's Social Care will ensue. **Completed**	Safeguarding Group in due course.	1) Copy of review outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010. Reviewed 31/3/2011 **Finalised**
3. Children Social Care to ensure that Social Workers consider the potential impact of parental mental ill health or parenting capacity and for the safeguarding of children in all assessments.	1. Review guidance to social workers. 2. Review current training. 3. Incorporate learning from this	Service Director for Children Services. Heads of Service, Operations Managers, duty	31/3/2011	The remodelling of duty screening will ensure qualified staff respond and make professional Judgments on the basis of having all relevant	Safeguarding Leads in agencies have been closely monitoring implementation	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of

	SCR into their practice.	and assessment and care management.		knowledge including information from key health partners. This action is in conjunction with the improvement action plan. Mental Health Training has been delivered to Duty and Assessment Practitioners in June 2010. Future training requirements are currently being evaluated by learning and development team. **Updated 3rd March 2011** A regular training programme for Social Workers to look at the impact of parental mental ill health on parenting capacity. Birmingham City Council is participating in the Sky pilot. **Completed**	of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Copy of Guidance and Training Evaluation. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010 Reviewed 31/3/2011 **Finalised**
4. Where parents refuse the services of an interpreter, this should not prevent an interpreter accompanying the Social Worker	1. Review current processes. 2. Issue guidance in	Service Director for Children Services.	1/3/2011	Having Qualified Duty Screening Social Workers making clear	Safeguarding Leads in agencies have	Progress is reviewed monthly by the Serious Case Review

during assessment visits and the motives of such refusals should be evaluated as part of the assessments.	light of this SCR.	Heads of Service, duty and assessment, and care management		decisions and recommendations will ensure where deemed appropriate, that interpreters accompany social workers. Consideration of the challenge around use of interpreters will be addressed as part of Practice Standards Arrangements. **Updated 3rd March 2011** **A memo was issued in September 2010 in respect of Social Worker's use of interpreters.** **Completed**	been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Copy of review outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010 Reviewed 31/3/2011 **Finalised**
5. Robust team management cover must be in place in the Duty and Assessment Service and known to all Duty and Assessment staff.	1. Review current process. 2. Amend if necessary and inform staff.	Service Director for Children Services.	1/9/2010	Management cover arrangements are in place for D&A with responsibility held with operational manager's and Heads of Service **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation

					will be provided to the Department for Education Safeguarding Group in due course.	process. **Consider Evidence for Audit** 1) Copy of review outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. ***Completed***
6. Review current practice and understanding of ascertaining parental consent to lateral checks in screening and duty and assessment processes.	1. Review practice through sampling of cases. 2. Amend policy and procedure where appropriate. 3. Disseminate findings.	Head of Service for Duty and Assessment.	31/1/2011	Qualified experienced Social Workers in the duty screening service will be clear in the arrangements for completing lateral checks via workshop/induction arrangements during Dec 2010. **Updated 3rd March 2011** **Qualified expert Social Workers have been introduced into the Duty Screening Service and they**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Copy of review outcome.

				ensure appropriate parental consent to lateral checks have been obtained. **Completed**		Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010. Reviewed 31/3/2011 **Finalised**
7. Concerns about a child who may be at risk of significant harm, from members of the community should be evaluated as potential referrals	1. Review current duty and assessment process 2. Amend if necessary. 3. Inform staff.	Duty and assessment. Operations managers, screening and duty and assessment.	31/12/2010	The introduction of qualified social workers into the duty screening teams will ensure clear instruction and priority. The first workers will be in post 29th November 2010. Updated 13 December 2010 All qualified social workers (12) are now in post. Updated 3rd March 2011 Qualified expert Social Workers have been introduced into the Duty Screening Service and	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Copt of review outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010.

				they ensure appropriate parental consent have been obtained. **Completed**		Reviewed 13/01/2011 **Completed**
8. The Domestic Violence Screening process should be reviewed to include allegations of domestic abuse from extended family members	1. To consider whether 392 documentation can be amended in conjunction with West Midlands Police to include a focus on the child's needs.	Service Director for Children Services. Head of Service for Referral and Advice. Operation Manager for Referral and Advice.	31/12/2011	A review will take place as part of the remodelling of CSC. This is currently underway. Review and evaluation of DV screening has been commissioned via BASCPAN which will inform practice and process of screening DV referrals in the future completion due possibly end of 2011/beginning of 2012 **Updated** **3rd March 2011** West Midlands Police in consultation with AD Safeguarding and the other six local authorities in the West Midlands have reviewed the 390 documentation to include details of the child and any potential risk.	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Outcome of joint review 392. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010. Reviewed 13/01/2011 action progressing this is a longer term action. SCR Sub-

				Completed		Group to Review progress 15/07/2011 Reviewed 31/3/2011 **Finalised**
Heart of Birmingham Teaching PCT (HOB tPCT) Asylum Seekers Health Team and NHS Birmingham East & North PCT (BEN – Health visiting service and GP)						
1. The Asylum Seekers Health Team will immediately implement and ensure compliance with Mainstream Health visiting and School Nursing policy and guidance in relation to its delivery of services for children.	The following policies and guidance should be implemented immediately by the Asylum seekers' health Team: • Health Visiting and School Health Record Keeping Guidelines (in relation to generating reference cards, opening active intervention records, transfer and handover) • HOBtPCT Clinical Record Keeping Guidelines (in relation to transfer of records through the (Child Health	Asylum Seekers Health Team Service Manager – responsible for ensuring implementation. HOBtPCT Safeguarding Children Team Manager – responsible for completion of record keeping audit.	Immediate implementation of agreed policy and guidance Completion of audit to evidence compliance by 30/09/2010	**<u>HOBtPCT</u>** Completed Associate Director of Provider Services has confirmed on 26/05/10 that the following policies / guidance have now been implemented by the Asylum Seekers' health Team: • Health Visiting and School Health Record Keeping Guidelines • HOBtPCT Clinical Record Keeping Guidelines • HOBtPCT Patient Administration System Guidelines for Health Visitors / School Nurses	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Copy of Guidance. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**

	Department) • HOBtPCT Patient Administration System Guidelines for Health Visitors / School Nurses (in relation to recording of all patient related contacts) Compliance will be reviewed through a record keeping audit to be completed by the Safeguarding Children Team by 30/09/2010			An audit of open and transferred records for families in IA has been completed. Audit results were reported to SCYPG on 12/10/10. SCYPG has confirmed this recommendation is complete. **Completed**		
2. The Asylum Seekers' Health Team will implement processes to store and share with relevant professionals and agencies all information from health assessments and contacts with Asylum Seeking families.	The Asylum Seekers' Health Team will: 1 Store full copies of the Red and Blue books for families with children under 17 years of age 2 Inform the identified contact in responsible PCTs of all families with children under 17 years of age being dispersed into their area 3 Forward all	Asylum Seekers Health Team Service Manager – responsible for ensuring implementation HOBtPCT Safeguarding Children Team Manager – responsible for completion of record keeping audit.	1 To be implemented by 30/06/2010 2 To be implemented by 15/06/10	1. Completed Action implemented by photocopying records and filing in secure cabinet at health unit 06.07.10 2. Complete action implementation by sending fax to receiving PCT on dispersal of family from health unit 06.07.10	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit**

	information copied from Blue and Red Books to GPs and Health visitors responsible for dispersed families, or, where this is not known, to the named PCT contact in the dispersal area. 4 Compliance will be reviewed through a record keeping audit to be completed by the Safeguarding Children Team by 30/09/2010		3 To be implemented by 15/07/10 Completion of audit to evidence compliance by 30/09/2010	3. Complete action implemented by posting copies of records to the receiving PCT named person on dispersal of the family. 06.07.10 An audit (see attachment 'case 20 asht audit report') of open and transferred records for families in IA has been completed. Audit results were reported to SCYPG on 12/10/10. SCYPG has confirmed this recommendation is complete. **Completed**	Safeguarding Group in due course.	1) Audit outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**
3. The Asylum Seekers' Health Team will produce and implement written guidance on the processes to be followed in supporting families' transition to the community and continued engagement with health services through outreach visits.	Guidance to address: • planning / appointing outreach visits with families • considerations and appropriate actions in the event of failed contacts.	Asylum Seekers Health Team Service Manager – responsible for producing guidance and ensuring compliance Safeguarding Children Team Manager – responsible for	Guidance to be written and implemented by 30/06/10	Flow Chart produced confirms adherence to PCT no access policy 05/10/10 Audit evidencing compliance completed An audit (see attachment 'case 20 ASHT audit report') of open and transferred records for families in	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.

	Compliance will be reviewed through a record keeping audit to be completed by the Safeguarding Children Team by 30/09/2010	completion of record keeping audit	Completion of audit to evidence compliance by 30/09/2010	IA has been completed. Audit results were reported to SCYPG on 12/10/10. SCYPG has confirmed this recommendation is complete. **Completed**	Department for Education Safeguarding Group in due course.	**Consider Evidence for Audit** 1) Audit outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**
4. The Asylum Seekers' Health Team will consistently apply the HOBtPCT Interpreting Services Policy: The Asylum Seekers' Health Team will consistently apply the HOBtPCT Interpreting Services Policy:	- All ASHT staff should be sent a copy of the interpreting services policy by the Service Manager who will discuss this with the team to ensure a shared understanding of its requirements. - Decisions to use or not use interpreters and any patient contacts with interpreters whether by phone or face to face should be recorded in the patients records - Compliance will be reviewed through a record keeping audit to be completed by the Safeguarding	Asylum Seekers Health Team Service Manager – responsible for ensuring awareness of and compliance with Interpreting Services Policy Safeguarding Children Team Manager – responsible for completion of record keeping audit	Policy disseminated to and discussed with ASHT by 15/06/2010 Completion of audit to evidence compliance by 30/09/2010	Complete 06.07.10 action implemented by e mailing copy of interpreter policy to each individual team member and discussing it at next available team meeting. 06.07.10 All interpreter contact (face to face or telephone) is recorded in each patient record (red or blue book). Unless the patients or carers ability to speak English is judged to be good. 05/10/10 Audit evidencing compliance completed **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) New Policy. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010.

	Children Team by 30/09/2010					**Finalised**
5. Health Visitors to be reminded of their responsibilities in relation to the New to Area Policy &NHS BEN to undertake an audit of compliance with New to Area/ New Registration Policy amongst all Health Visiting Teams	Safeguarding Brief to remind staff of this responsibility and to make it clear that Health Visitors need to capture this initial contact on the Patient Administration System. This issue to be highlighted at SCR training for health Visitors in July 2010 Health Visitors to be audited on their compliance with the new to area policy. 'Survey Monkey' Tool to be used to devise a self report survey for all health visitors in relation to compliance with New to Area Guidance. Health Visiting Managers to use the Corporate Team Tool to provide them with assurance that the policy is being complied with. A small sample audit of new to area children to be	PCT Safeguarding Team & Operational Manager for Health Visiting	1/11/2010	SCR Training delivered to HV's and Clerical Staff in July 2010 – stressing the need to comply with NTA guidance. Survey Monkey Took devised to audit HV's on compliance with New to Area Processes. To be sent to all HV's during August 2010. Report from Survey Monkey to be produced in Sept 2010. Corporate team Tool includes Compliance with New to Area Processes Audit tool devised to sample compliance August 2010 – audit to be rolled out from September 2010. Trial of tool in one health visiting team started 9th August 2010.	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Training evaluation 2)Training attendance 3)Survey Monkey Report on NTA Processes 4)GP report available from July 5)Health Visiting Report available from September 2010. 6)Corporate Team Tool 7)Sample audit report available from 20/8/2010 Draft of Clerical standards available in August 2010.

	completed to determine whether the initial contact has been made within 5 working days of notification			Clerical Standards to be reviewed to ensure initial capture of first New to Area contact. **Completed**		Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Audit outcome to be reviewed prior to finalisation **Finalised**
6. NHS BEN Clerical Standards to be amended to clarify actions to be taken by clerical staff when requested records do not arrive within 2 weeks.	NHS BEN Clerical standards to be updated to include the need to re-request records that do not arrive within 2 weeks of the original request being sent. All clerical staff involved in requesting Health Visiting Records to receive written notification of this change. This change to be discussed at Clerical Team Meetings	Clerical Manager for NHS BEN & Safeguarding Children Nurse	1/11/2010	Changes complete August 2010-10-06 All changes to be discussed at clerical meetings by Clerical Manager **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Copy of revised Clerical Standards Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Clerical Standards available.

						Finalised
7. NHS BEN Clinical Governance Team to establish baseline data & appropriate improvement plan in relation to how many GP practices that directly inquire about mental health history as part of New Patient Checks and New Patient Questionnaires.	Baseline data to be collected from BEN GP Practices. Improvement Plan based on data to be developed and audited 6 months to get baseline data – November 2010 Quality Improvement Plan and audit – end of May 2011.	Acting Assistant Director of Health Care Governance	**30/11/10** **31/5/2011**	• Baseline data to be collected from BEN GP Practices. • Improvement Plan based on data to be developed and audited • Audit questionnaire in progress to identify the number of GPs who ask about the patients Mental Health status at the new patient check. Audit closes 24.12.10 • In addition guidance on the recommended question about Mental Health to be added to the existing template. • This issue has also been picked up in Level 2 GP training. **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Improvement Plan. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required for next meeting **Completed**
Health Overview Report						
1. HOBtPCT undertakes a systems approach to ensure that the process of recording and transferring information on children by the Asylum Seekers Health is both safe and	A fail-safe system that does not fail because of human error	HOBtPCT Strategic Safeguarding	30/4/2011	Managers confirmed implementation of the mainstream policies including recording and	Safeguarding Leads in agencies have been closely	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure

effective.		Lead		transferring records. October 2010 SCYPG confirmed this recommendation complete on the based of audit report (see attachment case 20 ASHT BSCB audit report). **Completed**	monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) New recording and Transfer System. 2) Audit Outcome Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010 **Finalised**
2. HOBtPCT ensures that the Health Asylum Team adhere to the policies and procedures of the wider organisation particularly with regard to the DNA Policy.	Uniform DNA Policy throughout organisation	HOBtPCT Strategic Safeguarding Lead	31/12/2010	Managers confirmed implementation of the mainstream policies including DNA policy. The audit provided further evidence that the service had	Safeguarding Leads in agencies have been closely monitoring implementation of key actions.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the

				implemented these in day to day practice. October 2010 SCYPG confirmed this recommendation complete on the based of the audit report (see attachment case 20 ASHT BSCB audit report). **Completed**	Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) DNA Policy. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010. **Finalised**
3, NHS BEN Clinical Governance Team develops a standardised New Patient Check and New Patient Questionnaire that incorporates a question on the patient's mental health status.	Standardised New Patient Questionnaire	BEN PCT Strategic Safeguarding Lead	31/12/2010.	Audit questionnaire in progress to identify the number of GPs who ask about the patients Mental Health status at the new patient check. In addition guidance on the recommended question about Mental Health to be added to the existing template. Audit questionnaire completed to identify the number of GPs who currently ask about the	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Audit outcome.

				patient's Mental Health status at the new patient check. In addition guidance on the recommended question about Mental Health will be added to the template currently being developed by the Clinical Governance Team. At next QOF visits in Apr/May a check will be conducted to review all GP Practice NPQs to ensure that they contain the relevant questions. Where appropriate, a standard template will be provided. Evidence: Copy of letter and accompanying New Patient Questionnaire. Copy of report profuced January 2011 from Clinical Governance Team **Completed**	Group in due course.	Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010. Reviewed 23/02/2011 **Finalised**
UK Border Agency						
1a. A review of the Contract with UPM to establish when and where they breached	Meet with UPM to agree where contract	Contract Manager	30.6.10	Meeting with UPM has already taken place.	Safeguarding Leads in	Progress is reviewed monthly by the

their contract in not notifying UKBA of incidents in accommodation they managed.	breached in relation to specific events. Penalty clauses to be invoked			UPM reminded of their contractual obligations, and the breaches to the contract. Financial penalties to be applied by way of deterrent. **Completed**	agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Contract. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**
1.b A review of the type of information shared by UKBA with Accommodation Providers in respect of potentially vulnerable individuals.	To review what information can and should be disclosed to housing providers, and to put in place guidance to staff on when and how to share such information	Asylum Senior Manager	30.6.10	Information relating to an individual/family's needs which impact on the type of accommodation required, transport needs and reception at the property, is indicated in the accommodation proposal UKBA send to the Accommodation provider, such as wheel chair access or fridge	Safeguarding Leads in agencies have been closely monitoring im Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence**

				for medication. Information relating to mental or physical health is at the discretion of UKBA as to whether it s relevant for the Accommodation provider to be aware, and this depends on the individual case weighing up the human rights of the individual for privacy and data protection. **Completed**	evidence of implementation will be provided to the Department for Education Safeguarding Group in due course. Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course	**for Audit** 1) Information Sharing outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Completed**
2. A review of UKBA staff guidance to determine if adequate in the following areas: • dealing with allegations that raise	Asylum Senior Manager to review the guidance staff have available,	Asylum Senior Manager	31.7.10	A review has taken place and the findings discussed with relevant members of staff. The	Safeguarding Leads in agencies have been closely	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure

safeguarding issues • mental health of a parent / possible alcohol or substance abuse • making referrals to Children's Services • maintaining an audit trail of action taken and recording UKBA's response through file minutes and database maintenance	identify the gaps and agree with the Office of the Children's Champion and Asylum Policy the most effective means to address any deficiencies.			regional safeguarding coordinator has also highlighted issues arising from this SCR with the national Office of the Children's Champion (OCC) in order to inform wider learning. Our SCWs have delivered training locally to COs on the subject. We have also produced a directory providing details of organisations providing service on mental health issues. That COs can make referral to (Aug 2010) **Completed**	monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Staff Guidance. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**
3. Training provided to staff to be reviewed to see if it adequately covers the following: • duty of staff in respect of safeguarding • indicators of risk • making referrals to Children's Services • maintaining a record of actions taken	Asylum Senior Manager to review the training provided to staff, identify the gaps and work with the Office of the Children's Champion to update the training package and arrange delivery to relevant staff	Asylum Senior Manager	31.7.10	Training has been reviewed locally and amended accordingly. Local training officers have also addressed the need to highlight the possible impact that adult mental health issues might have on a parent's capacity to care for their child. This has also been flagged up for national	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.

				consideration by the OCC. Review of the training given to COs took place and our finding fed to Children's Champion's office and to the Central Training Team. The training have taken our findings on board and are amending the training materials. Our SCWs have delivered training locally on the subject. (Aug 2010) **Completed**	Department for Education Safeguarding Group in due course.	**Consider Evidence for Audit** 1) Review of Training. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**
4. UKBA needs to satisfy itself that the training and guidance provided by UPM Ltd to staff on the issue of safeguarding children is adequate, and that guidance is being followed.	Asylum Senior Manager to liaise with Contract Managers to establish the training provided and that up to date Policy and Procedures are in place.	Asylum Senior Manager	31.7.10	The child protection policies and procedures have been discussed with UPM and updated in September 2010. UPM have been directly involved in the SCR with Birmingham CC and have provided information on these issues and details of staff training on child protection. UPM have named people within their organisation who are responsible for child protection at the regional IA and head office UPM have	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Audit outcome. Agency action reviewed by Serious

				implemented a training plan to ensure that all staff in contact with service users received adequate training on how to recognise signs of abuse and how to respond, and have supplied details of all staff who have undertaken training in child protection. In addition UPM have purchased a training package from the NSPCC on child protection and this is currently being rolled out to all staff. Each UPM regional manager has been provided with a list of all contacts details for their local authority designated child protection officer to make contact and develop a comstructive relationship. We are satisfied that the training and guidance provided by UMP LTd to staff at UMP is adequate and is being followed. **Completed**		Case Review Sub Group on 19.11.2010. Progress report required by 17.12.2010. **Finalised**
United Property Management						

1. Implement a training plan to ensure that all staff in contact with service users receives adequate training on how to recognise signs of abuse and how to respond.	Source suitable training package and deliver training to all staff in contact with service users.	Designated Child Protection Officer in the North West	1/11/2010	NSPCC Safeguarding Children: everybody's business training package purchased and currently with management in preparation for delivery to all field staff. Delivery target from 1st November 2010 onwards. **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Training Package. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**
2. Management to reinforce the open door policy.	Mangers to speak to their staff to reinforce at weekly team meetings.	Line Managers	9/8/2010	Line Managers now include discussions regarding child protection during weekly team meetings and also as a fixed item on the monthly management meeting agenda. **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation

					will be provided to the Department for Education Safeguarding Group in due course.	process. **Consider Evidence for Audit** 1) Outcome Team meeting. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**
3. Develop constructive relationships between the company and Children's Social Care.	Regional managers to make contact with their local authority designated child protection officer.	Regional Managers	1/11/2010	Each regional manager has been provided with a list of all contact details for their local authority designated officers. **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course. Safeguarding	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Safeguarding Network. Agency action

					Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course. Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course. Safeguarding	reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**

					Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course. Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	
4. Ensure the company does as much as	Collate details of	Regional	31/8/2010	Details of local	Safeguarding	Progress is reviewed

possible to inform families of support they can obtain from within the local community.	local community groups and play centres and include in the "welcome pack" provided to service users.	Managers		community support groups, church groups, parent groups etc have been collated. These need to be incorporated into the "welcome pack" provided to service users. **Completed**	Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Audit outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**
5. Further briefing on the company child protection policy and procedure.	Managers to conduct regular refresher briefings on the policy and procedure for reporting concerns or allegations.	Line Managers	Ongoing	Line Managers informed that it is a requirement to periodically review the policy and procedure with their staff. **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation

					will be provided to the Department for Education Safeguarding Group in due course.	process. **Consider Evidence for Audit** 1) Briefing Document. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. **Finalised**
6. Whenever external agencies are contacted	Referral to be submitted.	Regional Manager	Ongoing	All staff have been informed & are to be reminded on a regular basis that they must follow this procedure. **Completed**	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Briefing Note. Agency action reviewed by Serious Case Review Sub Group on

						19.11.2010. **Finalised**
West Midlands Police						
1. In order to enhance the training process, a revised audit process to be developed to dip sample frontline staff responses to child safeguarding issues, when dealing with incidents which are not overtly child protection/child safeguarding matters. Additionally the dip sampling to cover child abuse investigator referrals, to assess the effectiveness of child abuse investigator responses to referrals which are not overtly a crime	Existing audit process for Public Protection front line staff to be reviewed. Process to be manageable and streamlined, and to include initial actions on receipt of referral and subsequent follow up processing and management.	Detective Chief Superintendent Public Protection Unit.	28/2/2011	Audit process allocated to HQ PP team for review and development - May '10 **UPDATE 08.10.10** The audit review process is ongoing, we are currently exploring how to capture frontline staff responses to safeguarding issues and the effectiveness of the mandatory training programme regarding section 10 and 11 responsibilities along with safeguarding concerns. West Midlands Police 'organisation and service delivery' have been approached to consider assisting in this audit. An audit has just been completed in relation to call-handling procedures and	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Regular meetings are held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. **Consider Evidence for Audit** 1) Audit outcome. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required for 17.12.2010 Reviewed 13/01/2011 progress update required. Reviewed 31/3/2011

				frontline staff responses to child safeguarding issues, when dealing with incidents, which are not overtly child protection/child safeguarding matters. The audit covered 1st November 2010 (2,639 oasis logs reviewed) and 20th November 2010 (2,814 oasis logs reviewed) A report is currently being compiled outlining the audit findings. Once the initial audit findings are reported upon, a subsequent audit will be completed reviewing the outcomes of the safeguarding concerns highlighted on the two dates, through the respective PPUs. The second audit will assess the effectiveness of child abuse investigator responses to the identified referrals. **Updated 22nd March 2011** The audit process		**Finalised**

				outlined above is an ongoing internal audit process, currently (as of 8th March 2011) public protection child abuse incidents are being audited to ensure appropriate investigation/safeguarding takes place. The value of 'audit' is recognised by West Midlands Police, therefore there will be a variety of audit processes conducted in order to assess different aspects of child abuse investigation and safeguarding. Due to the ongoing nature of this action suggest it is concluded as; **completed**		
2. West Midlands Police and LSCB partners to promote new communities' empowerment , awareness and education regarding referral of safeguarding concerns in relation to children	To raise at LSCB to generate agreement to develop a shared awareness and education plan	Detective Superintendent Public Protection	1/12/2010	This action has been referred to BSCB Operational Effectiveness Group to action. The OEG have established a Task & Finish Group to develop and deliver a targeted 'public awareness campaign'	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Regular meetings are	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part

				Police OEG member to lead on this action. **Completed**	held with GOWM Children's Advisor and BSCB to review progress and agree evidence of compliance; Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course	of the finalisation process. **Consider Evidence for Audit** 1) Education Plan. Agency action reviewed by Serious Case Review Sub Group on 19.11.2010. Progress report required for 7.1.2011 meeting. **Referred to OEG for finalisation**