



Agenda Item 12.2

EAST AYRSHIRE CHILD PROTECTION COMMITTEE: 7 DECEMBER 2010

BIRMINGHAM SAFEGUARDING CHILDRENS BOARD SERIOUS CASE REVIEW – CASE NUMBER 14 KHYRA ISHAQ PUBLISHED JULY 2010

1. PURPOSE OF THE REPORT

- 1.1 To inform the East Ayrshire Child Protection Committee (EACPC) of the recent publication of 'Birmingham Safeguarding Children Board, Serious Case Review Case number 14 in respect of 'Khyra Ishaq' and to give consideration to the key recommendations within the report.

2. BACKGROUND

- 2.1 Following the tragic death of Khyra Ishaq on 17 May 2008, Birmingham Local Safeguarding Board (BLSB) commissioned a Serious Case Review which was published in July 2010.
- 2.2 Independent author, John Radford from the NSPCC was commissioned to write a Serious Case Review and his report was published by the Department of Education on 26 October 2010 and contained fifteen recommendations.

3. KEY RECOMMENDATIONS

- 3.1 The Serious Case Review published eighteen key recommendations within the report. All eighteen recommendations from the report are pertinent for all staff in services who are involved in safeguarding and protecting children and young people.
- 3.2 An Appendix of all eighteen recommendations is attached for reference. However, nine key themes were evident from the serious case review which are detailed below.

Communication, recording and information sharing

- Schools sharing information with each other
- Health staff sharing information with each other
- Information being shared with health staff and schools
- Social services communication with referrers
- Communication delayed, mislaid or not undertaken – all agencies

Domestic abuse

- Regular reports of domestic abuse by mum
- Reports by neighbour
- Disclosed to GP and to health visitor
- Reports of domestic abuse emerged after parents separated but this continued to impact on the children

Uncooperative families

- Patterns of missed appointments
- Escalation of missed appointments
- Change in mum's behaviour and attitude
- Relationships with professionals deteriorated
- Use of complaint system to deflect attention
- Knowledge of legislation used to deflect attention
- Parental consent for school health services

Rigid, highly disciplined home routine

- High degree of influence over family routine by mum's partner
- Mum's partner's background influenced his parenting views (though this was not known until criminal proceedings)
- Mum's partner developed beliefs that child was possessed by Djinn spirits and he punished her

Thresholds for significant harm

- Reception services recommending IAF instead of child protection procedures
- Police asked to undertake Safe & Well check instead of child protection procedures
- Referrer dissatisfaction with decision
- Management oversight in managing risk (closing cases)

Mental illhealth

- Identification of concerns relating to partners mental health occurred when he was single man with no links to families or children

- Due to withdrawing contact from external agencies, no one witnessed the deteriorating mental health
- Both parents diagnosed with mental health illnesses after prosecution

Home education

- Assessment of education provision poorly conducted and did not address any safeguarding concerns
- Lack of focus on child – none of the children were even seen
- Agencies made assumptions about the role and responsibilities of the education assessment
- Current home education legislation contains significant flaw in that it does not protect children

Height and weight growth indicators

- Growth indicators not plotted consistently and used to monitor progress
- Growth indicators in school nurse records not added to medical records to gain longer perspective
- Additional information not taken into account when planning reviews of growth

Personality of child

- Khyra recorded and observed to be livelier and more independent than other children

3.3 The Performance & Quality sub group are in the process of considering the recommendations of the Serious Case Review and will report to the next Child Protection Committee in March 2011.

4. RECOMMENDATIONS

4.1 The East Ayrshire Child Protection Committee is asked to:

- i) note the contents of the report.

Susan Taylor
Chair of Child Protection Committee
5 November 2010

Appendix 1

**BIRMINGHAM LOCAL SAFEGUARDING CHILDREN BOARD
SERIOUS CASE REVIEW 'NUMBER 14' – KHYRA ISHAQ
PUBLISHED JULY 2010**

COMPLETE LIST OF RECOMMENDATIONS

1. Birmingham Safeguarding Children Board should commission work to identify how agencies across Birmingham can increase effective professional communication to improve the safeguarding outcomes for children and young people in compliance with policy and procedure.
2. South Birmingham NHS Primary Care Trust should evidence through audit processes that children who are subject to weight and height checks as part of school medicals, have their data fully recorded and plotted on a growth chart in their notes, to provide a complete and readily accessible picture of the child's development.
3. NHS Primary Care Trust's should review processes for obtaining parental consent for child access to the school health service and implement, including a process of follow up action for parental refusal or withdrawal of consent.
4. Where a school has initial concerns the designated senior person should liaise with schools attended by other siblings to ensure an holistic view of the children and family is obtained.
5. Birmingham Children's Social Care must review and demonstrate that staff at all levels understand the appropriate use of the common assessment framework and the application of thresholds for significant harm.
6. Birmingham Children's Social Care and West Midlands Police should review multi agency procedures to ensure that 'Police Safe & Well Checks are not used in place of existing safeguarding policies and procedures.
7. Birmingham Children's Social Care must review and revise their referral and advice screening process to ensure that safe decisions are made based on risk and where the 15 referrer expresses dissatisfaction this is passed to the Line Manager for resolution.

8. Birmingham Children's Social Care should review the assessment process in the Duty & Referral Service to determine robust management oversight at each stage of the process and ensure robust quality assurance measures are in place which are specific to the 'Framework for the Assessment of Children in Need and their Families.'
9. Birmingham Safeguarding Children Board should commission multi agency guidance and training to equip staff in all agencies to work effectively with aggressive and highly resistant parents and carers.
10. Birmingham Children's Social Care should conduct an evaluation survey to quantify Children's Social Care staff's understanding of the role and responsibility of the Education Otherwise Service following the recent awareness campaign.
11. Birmingham Children's Social Care should review and evidence that mechanisms are put in place to ensure that use of the complaints process by parents or significant adults does not adversely affect the actions of staff when pursuing safeguarding matters, or the welfare of children.
12. Birmingham Children's Social Care to review supervisory expectations and standards, ensuring management and decision making processes contain sufficient rigour when managing risk.
13. Education Otherwise should evidence to Birmingham Safeguarding Children Board changes to the recording and assessment process, demonstrating delivery of safe and effective services that contribute to meeting the safeguarding needs of children and young people across Birmingham.
14. The Strategic Director of Children's Services should communicate to the DCSF Secretary of State, the current safeguarding inconsistencies within legislation surrounding children who are educated from home, emphasising that the parents right to home educate does not outweigh the rights of the child.
15. Heart of Birmingham Teaching NHS Primary Care Trust should review and satisfy themselves that all GP's are aware of their professional responsibilities to communicate safeguarding concerns that arise as part of their interaction with children and families, in line with existing safeguarding procedures.

16. 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.
17. Heart of Birmingham Teaching NHS Primary Care Trust and South Birmingham NHS Primary Care Trust, Birmingham Children's Social Care and Education Otherwise agencies should provide evidence to demonstrate an effective response to missed or failed appointments.
18. The Children's Trust in conjunction with the Birmingham Safeguarding Children Board should initiate an education campaign with supporting literature, to build public trust and confidence in ways to effectively safeguard and protect other people's children.

