

BIRMINGHAM AREA CHILD PROTECTION COMMITTEE

CHAPTER 8 CASE REVIEW

TONI-ANN BYFIELD

SUMMARY REPORT

Prepared by a panel of the Birmingham ACPC Special Cases Review Group, chaired by David Lambert CBE, Independent Chair, Norfolk ACPC.

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CITY OF BIRMINGHAM AREA CHILD PROTECTION COMMITTEE

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SUMMARY REPORT

Introduction

This is the Summary Report of a Serious Case Review commissioned by the City of Birmingham ACPC following the death of Toni-Ann, a 7 year old young girl. On the 14 September 2003 the Metropolitan Police reported that Toni-Ann had died at her father's home in London, having apparently been shot by an unknown assailant who also murdered Mr Byfield at the same time. At the time of her death Toni-Ann was understood to be living with a 'great aunt' under a kinship care arrangement, under an Interim Care Order to Birmingham City Council.

This Summary report provides a description of the Review process, details of Toni-Ann's case history, and a summary of key conclusions and recommendations for further action by the ACPC and agencies. Findings from the Review have been brought to the notice of the Commission of Social Care Inspection and the Department for Education and Skills.

All references to relationships within the report are based on the evidence given and information provided prior to the death of Toni-Ann. Subsequent DNA testing as part of the post mortem has revealed that Mr Byfield was not the biological father of Toni-Ann.

Review process

This case review has been conducted in accordance with Chapter 8 of Working Together to Safeguard Children (1999). The purpose of such a review according to Working Together (1999: 8.2) is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence,
- To improve inter-agency working and better safeguard children

The following **Terms of Reference** were formulated in September 2003 to guide the preparation of the Review. The Birmingham ACPC commissioned a sub-group of its Special Cases Review Committee (henceforth referred to as the Review Panel) to conduct the review, under independent Chairmanship, and undertake the following tasks,

- Fully examine all areas of concern, including the local authority care arrangements, contact arrangements between parent and child, immigration issues, and the involvement of different agencies in the case
- Focus special attention on the decision making and evaluation of care arrangements related to the decision to allow the child to go to live in London
- Draw conclusions and make recommendations for action by ACPC and/or agencies

Individual Agency Management reviews were received from the City of Birmingham Social Care & Health Directorate, Education Department and Legal Services Directorate, West Midlands Police, the Children and Family Courts Advisory and Support Service [Cafcass], Birmingham NHS Trusts and the Home Office Immigration and Nationality Directorate. Information was also received from the Brent Area Child Protection Committee. An Overview report was prepared by the Case Review Panel.

Brief History of Toni-Ann

Toni-Ann arrived in the United Kingdom on 30 January 2000; she initially came on holiday from Jamaica with Mr Byfield's then partner MA. Toni-Ann had been living with MA from about the age of 6 months. BB was in prison at the time in the United Kingdom serving a nine-year sentence for drug trafficking class A drugs, and her birth mother CR was residing in Jamaica.

It appears that Toni-Ann never returned to Jamaica and remained with Mr Byfield's partner until December 2001 when Mr Byfield, who had been released from prison two months previously, removed Toni-Ann from MA's care. Mr Byfield alleged MA wanted some commitment from him in respect of their long-term relationship and he was not prepared to do this. Mr Byfield placed Toni Ann with his and MA's daughter CB. Both MA and CB resided in Birmingham.

Toni-Ann remained in her half-sisters care until 27 September 2002 when Birmingham Social Services removed her into foster care following Section 47 enquiries into allegations of physical abuse by CB. As a result Toni-Ann was placed in an emergency foster placement. She was subsequently moved to a temporary foster carer on 2 October 2002 and remained in that placement until 9 August 2003

The Local Authority initiated care proceedings in December 2002, and a number of assessments were commissioned. CR was deemed unsuitable to care for Toni-Ann and CB was not considered to be suitable for a long term care placement.

Mr Byfield had a positive assessment in relation to his contact with Toni-Ann and a core assessment was started. However this was halted when Mr Byfield

was unable to achieve priority on the Housing List on the grounds that Toni-Ann was not considered in priority need being subject to immigration controls. Parallel plans were started but did not move forward.

Ms C, identified as Mr Byfield's aunt, was proposed as an alternative carer and Toni-Ann initially went there for a holiday placement on 9 August 2003. Whilst there the plans changed, and it was agreed that Ms C should be assessed as a Kinship carer. Emergency approval for this was given retrospectively on 28 August 2003. The plan was for Toni-Ann to remain in London and have unsupervised contact with her father but no overnight stays.

Toni-Ann was in London at her father's hostel when she was murdered on 14 September 2003

Summary of Conclusions

Although this Case Review was established to examine the degree to which the Local Authority and other agencies had satisfactorily discharged their obligations to care and protect Toni-Ann, the over-riding feeling that the Review evokes is one of great sadness for the untimely death of this young girl. Throughout the review the picture of Toni-Ann that emerges is one of a happy seven year old girl who was beginning to look forward to the prospect of a new life in London with her father. Whatever concerns that there may have been about Mr Byfield's capacity to be a reliable parent, the review has noted that all agree that there were strong and reciprocated bonds between father and daughter. The Review has noted that both met their deaths at the hands of an unknown person.

The conclusions of this review suggest that Toni-Ann's placement in London during the summer holiday of 2003 could have been more thoroughly and thoughtfully planned and more closely monitored. It is recognised that steps were being planned by the professionals concerned to strengthen the arrangements and, but for the tragic event, these may have provided a satisfactory framework for the positive continuance of the placement. However, at the crucial time the safeguarding arrangements were not robust and the Case Review has had to conclude that professionals really had very little knowledge of what was happening to Toni-Ann during the five weeks of her placement in London.

One of the over-riding themes that emerges from this Case Review is concerned with the management of delay. Delay in the timely production of social work assessments and reports for court, delay in the regularisation of Toni-Ann's immigration status and delays in the compliance to relevant procedural requirements have all contributed to difficulties with the decision making process and the quality of decisions. This matter needs to be addressed by agencies through improved preparation of staff, strengthened supervisory arrangements and the monitoring of compliance.

The other key theme relates to the need for professionals to maintain a thoroughly watchful and diligent stance in respect of their safeguarding obligations to the children and young people in the charge. This Case Review has concluded that a too positive view was taken of Mr Byfield and his parenting capacities that did not seem to allow for any discordance. In part this was due to the fact that the assessments undertaken were less thorough and questioning, given his previous history, than they should have been. Such a view also seemed to accord with Toni-Ann's wishes and feelings.

The following paragraphs highlight a range of key issues that have been raised during the careful examination of this case. For each of the key conclusions a brief synopsis of the evidence that supports the conclusion is provided. The conclusions are of two types,

- Conclusions about the quality of agency and professional performance
- Conclusions about process and practice issues

1. The Case Review has concluded that an inadequate balance was struck by the professionals in this case between meeting Toni-Ann's expressed needs and feelings, and the protection of her wider interests.

- 1.1 By all accounts Toni-Ann was a seven year old girl who showed few signs by way of behavioural or relationship difficulties that suggested that her fragmented upbringing had disturbed or damaged her in any way. Toni-Ann appears to have coped well with the changes made to respond to her care needs consequent to the child protection investigation in September 2002 and her removal from the care of CB to live with the foster carer who also met her racial and cultural needs.
- 1.2 There does not seem to be any doubt that Toni-Ann was very fond of Mr Byfield and that this was reciprocated on a personal, one-to-one basis. The social workers involved with the case responded to this and supported it by their positive approach to the arrangement of contact between them. However, the Case Review concludes that more might have been done to probe Toni-Ann's feelings, particularly at the point where she learnt that she would stay in London in August 2003 and not return to her foster carer in Birmingham.
- 1.3 The overriding impression from the material presented to this Case Review is that the primary focus of professional work was on the assessment of Mr Byfield's parental capacity and the practicalities of the arrangements for him to undertake his parental role and that inadequate attention was paid to the full and necessary assessment of Toni-Ann's needs.

- 1.4 Both the social worker and the Children's Guardian failed in their duty to ensure, as required under the Children Act 1989, the paramountcy of Toni-Ann's welfare, both through their direct work with the child and through their advice to the court. In respect of both professionals it is difficult to see how, given the very limited number of occasions made available when they were actually in a position to have a direct and private conversation with Toni-Ann, they could make a full and sensitive assessment of her needs and wishes. This is a matter of some concern and raises questions about the quality of work done and supervisory oversight of the case.

2. The Case Review has concluded that the quality of the assessments of Mr. Byfield and Ms C by staff of the Birmingham Social Care & Health Directorate and the Children's Guardian were seriously inadequate and failed to provide a full assessment of risks

2.1 Assessment of Mr. Byfield

- 2.1.1 The quality of the assessment work by the social work staff of Social Care and Health Directorate and the CAF/CASS Children's Guardian is one of the key issues that lies at the heart of this Case Review. It was the impact of that assessment on the decision making process in both the care planning and court arena that would determine whether or not the plans made for Toni-Ann's welfare were well laid or not and, in particular, whether the level of risk to which she might be exposed was actively minimized.

- 2.1.2 In examining the case material related to this matter, the Case Review concludes that there are clear areas of concern about the quality of the core assessment and the degree of thoroughness that was applied to seeking a fully informed assessment of risk. These issues can be summarised as follows:

- The absence of any document purporting to be a core assessment of Mr Byfield and his capacity to provide appropriate levels of care for Toni-Ann and meet the obligations of his parental responsibility has made it difficult to come to a considered view about the depth of critical analysis applied by the social worker to the information that he had been proffered by Mr Byfield, some of which later proved to be partial.
- No enquiries were made to either the Metropolitan police or the London Borough of Brent Social Services Department. Mr Byfield had a conviction for drug dealing and because of this history, careful assessment should have been made to determine the extent of his involvement or not in the local drugs culture.
- The report received from Brent ACP suggests that if they had been asked for information with regard to Mr Byfield and his family a more

cautious view may have been formed which the Birmingham social worker would have been able to factor into the assessment. Brent's information would have been that it was their belief that Mr Byfield was involved in criminal activity.

- Brent Social Services questioned Mr Byfield's commitment to parental responsibilities and the maintenance of a secure family life for his children.
- Brent Social Services reported that they considered that Mr Byfield had had a transient role in the parenting of his children. They also reported that Mr Byfield had four other children who had different mothers and several different female carers. Serious concerns on all of these children had been raised over time. If this information had been sought it could have been explored thoroughly by the social worker and Children's Guardian.

2.1.3 This conclusion also raises issues about the quality of case supervision available to the social worker by the social work team manager. There are issues about the standards of practice in case supervision and the thoroughness of oversight that is maintained in respect to the quality and completeness of assessment documentation.

2.1.4 It remains unclear as to the level of challenge that the social worker applied to the information provided by Mr Byfield and what steps were taken to obtain external verification of his story. With hindsight it is clear that a more penetrating critique of a number of aspects in Mr Byfield's history and lifestyle should have been prepared. However, in the event the social worker appeared to have remained convinced that the plan should be for Mr Byfield to develop his relationship with Toni-Ann through extended and unsupervised contact and that the long term plan was for him to assume her full time care. This conclusion also received some support from Mr Byfield's Probation Officer in London who, in the report to the court, stated that although his present accommodation situation precluded his assuming parenting immediately, he had the capacity to undertake the role. The report was a partial report and made no specific reference to a shooting incident involving Mr Byfield.

2.1.5 The assessment of Mr Byfield was further weakened by the absence of checks and balances to the assessment judgments that would normally be provided by the independent assessment work of the Children's Guardian. When the Children's Guardian embarked on her own independent assessment of the case she received a number of indications through Mr Byfield's disposition towards her and his attitudes to Toni-Ann that should have alerted her to take a more questioning stance towards his assessment.

- 2.1.6 The Children's Guardian had information that Toni-Ann had a very wide, extended family and that she had had a number of carers and moves. She had lived apart from her parents and siblings for most of her life, and significantly apart from her putative father other than, one can only presume, for the first few months of her life. This should have raised the need to explore important questions about Mr Byfield's capacity to sustain the father-daughter relationship. As with the social worker's assessment, the Case Review has received little or no evidence to demonstrate that the Children's Guardian took independent steps to address any of these significant questions or to address apparently contradictory information e.g. the different versions of the shooting incident in 2002.
- 2.1.7 The Case Review has concluded that significant questions as to Mr Byfield's capacity to parent consistently and provide suitability remain unanswered.

2.2 Assessment of Ms C (known as Mr Byfield's great aunt)

- 2.2.1 The assessment of Ms C commenced in February 2003. This was initially in respect of her role, as proposed by Mr Byfield to offer support due to his inability to offer staying contact because of his residence at the hostel where the overnight visiting by children was prohibited. On the basis of this first assessment Ms C was accepted.
- 2.2.2 The quality and depth of this assessment remains a matter of concern, but the assessment does not appear to have been challenged, partly due to the fact that it was not tested out for some months as the police and CRB checks on Ms C were not completed until 3 July 2003. The cause for this delay appeared to be related to difficulties in contact and cooperation with Ms C, but this experience on the part of both the social worker and Children's Guardian does not appear to have led to any re-appraisal of her suitability for the role. The Case Review has concluded that this was a missed opportunity and that more could have been done at this point to re-assess the appropriateness of the plan.
- 2.2.3 When in June 2003 the issue of Mr Byfield's planned move to more suitability family accommodation remained unresolved, Ms C was then suggested as an alternative carer for Toni-Ann as part of a parallel longer term care plan. At the end of July she had still not co-operated with visits from the social worker or the Children's Guardian. The social worker did eventually 'catch up' with Ms C and discuss with her the prospective placement for the purposes of the holiday caused by the wish of the foster carer to travel abroad until the end of September 2003.

- 2.2.4 The planned change of purpose for the placement of Toni-Ann with Ms C made it even more important that enquiries were made of the host local authority in London. However, no enquiries or checks were undertaken with the London Borough of Brent, and they were not informed of her placement. This was a serious oversight. Information since received by the Case Review Panel has indicated that Ms C was well known to Brent Social Services Department.

The Case Review has concluded that the inability of the social worker to complete a fuller assessment of Ms C and comply with the pre-requirements prior to the making of a foster placement represents very unsatisfactory and unsound practice.

3. The Case Review has concluded that the Children's Guardian conducted an inadequate independent assessment of the situation and, as a result, fell short of standards set for the performance of her statutory responsibilities

- 3.1 The responsibility of the Children's Guardian is to form an independent view of the best outcome for the child and advise the court of this. It is also incumbent on the Children's Guardian to inform the local authority and the court of any immediate concerns about the safety of the child that might not have been identified in proceedings or if concerns already identified escalate to a point suggesting a possible reappraisal of the care plan, especially if the child might be exposed to the likelihood of significant harm.
- 3.2 Although the focus of the assessment work for the court was on the capacity of Mr Byfield and Ms C to care for Toni-Ann, the role and paramount responsibility of the Children's Guardian was to ensure that the best interests and welfare are secured for the child. The Case Review has concluded that the professional work by the Children's Guardian demonstrated some less than rigorous performance in a number of areas.
- In March 2003 the Children's Guardian first met Toni-Ann at a joint meeting with the child's solicitor. The handling of this meeting clearly limited the Children's Guardian's scope for any changes in her later view of the case and good practice would have counselled a more cautious handling of the information and the conversation with the child.
 - The Children's Guardian did not seek to challenge the social worker's assessment of Mr Byfield or provide her own independent assessment of him.
 - A visit in September 2003 provided an opportunity for further assessment which was not fully explored as one might expect to

explain Toni-Ann's unexplained disappearance, an allegation of sexual abuse and to see Toni-Ann alone.

- Issues related to Toni-Ann's longer term care and support were not explored despite a clear statement by Ms C that she was only willing to have Toni-Ann to stay until 10 September 2003.

3.3 The Case Review has concluded that given the amount of questionable evidence that the Children's Guardian received in the course of her work with Toni-Ann, and encounters with Mr Byfield and Ms C, then she should have adopted a more challenging and independent position in respect of decisions about Toni-Ann's placements and best interests.

4. The Case Review has noted a variable quality in the professional work of the Birmingham Social Care and Health Directorate in the management of this case and action needs to be taken to address this.

4.1 Management of the Contact arrangements

- 4.1.1 Section 34 of Children Act 1989 provides promotion of reasonable contact by parents or other significant family members with children in care. The Act and associated regulations set out an explicit framework for contact arrangements and, if necessary, their termination. The case Review has concluded that the arrangements for Toni-Ann were conducted in accordance with this framework. The court considered the contact arrangements at each of the Direction Hearings. The issue for this Case Review remains one of concern about the quality of assessment and surveillance of the arrangements by the professionals involved.
- 4.1.2 The possibility of contact for Toni-Ann was also explored with CB and with Toni-Ann's birth mother, CR in Jamaica. These enquiries were consistent with Section 34, Children Act 1989. The issue of contact with CB was pursued as she was perceived as having been a significant adult in Toni-Ann's life. A contact meeting was arranged, but this did not prove to be a positive experience for Toni-Ann and no further arrangements were made.
- 4.1.3 In respect of CR the independent Jamaican assessment of her as a potential long-term carer for Toni-Ann had concluded that this would not be viable. She concurred with this conclusion, but there appears to be little evidence that any other form of ongoing contact was actively explored or promoted with her or with Toni-Ann. There should have been evidence of this work in order to assess whether Toni-Ann's best interest were being met by not actively supporting this contact with her birth mother.

4.2 Management of Toni-Ann as a Looked After child

- 4.2.1 The Case Review has concluded that Toni-Ann's reception into care had been well handled. Planning for the care of Toni-Ann was well informed and this received the endorsement of the court when it agreed the Interim Care Order at the first court hearing on 5 December 2002. The course of the Care Plan over the next few months was maintained within the regulatory framework for Looked After Children, all LAC reviews taking place at the correct intervals and relevant action being taken at and following each review.
- 4.2.2 Attention has been drawn to some quality issues in the work of the Local authority social workers during this phase. The first allocated social worker who managed the initial reception into care and the Interim Care planning complied with the regulatory requirements of weekly visits. This should have provided adequate opportunities to get to know and work with Toni-Ann, especially if she were seen on her own, as is good practice. However, no detailed recordings of these visits were made.
- 4.2.3 From December 2002 the second allocated social worker initially maintained a similar level of contact. Again, no existing record of these visits is available and it would appear that weekly visiting ceased in June 2003. This clearly affected the capacity of the social workers to fully understand and represent the wishes and feelings of Toni-Ann.

5. The Case Review has concluded that there was inadequate planning and preparation for the summer placement. As a result the placement was commenced on an inappropriate basis that did not accord with the law or with regulation.

- 5.1 The consideration of a longer term placement of Toni-Ann with Ms C was precipitated by the need to provide a solution to another problem, namely the fact that Toni-Ann's immigration status meant that she could not holiday abroad with the foster carer. In the event what started out as a summer holiday placement for Toni-Ann was transmuted into a kinship placement in what, with hindsight, has been shown to be an unsatisfactory way.
- 5.2 From advice in the IND agency review it is not clear that IND would not have sought to remove Toni-Ann from the country, firstly on grounds that as a Looked After Child she was safe and did not present any welfare issues and secondly to return her as an unaccompanied minor would have required extensive enquiries overseas. However, had the engagement of IND been achieved at this stage, and speculating that they would have agreed that in the circumstances it was in her welfare interests to remain in Britain, the consequential difficulties in 2003 with

respect to Mr Byfield securing housing may have been eased and Toni-Ann may have enjoyed a summer holiday abroad with her foster carer.

- 5.3 The Fostering procedures provide support for the social worker's decision to proceed down the kinship care route in order to resolve situations such as Toni-Ann's arrangements, as a Looked After child, their care plan was aimed at a return to live with their parents in the foreseeable future. Social workers are advised to consider weighing up the advantages of a kinship care placement against the disruption of a further move.
- 5.4 It has been suggested that, due to the pressure from Mr Byfield's solicitors and the Family Proceedings Court's concern with delay, the decision to go down the emergency Kinship placement route was a pragmatic one. There is support for this view. The placement of Toni-Ann with Ms C on an emergency kinship basis was finally approved post-placement by the social services manager on 28 August 2003, in accordance with the regulatory framework for emergency placements. As a consequence kinship placement procedures were not adhered to, with relevant paperwork being signed post-placement. No contact was made with the London Borough of Brent and there was no written contract with Ms C.
- 5.5 Although at that point some completed elements of the assessment required for kinship care were available, a more thorough probing of Ms C's personal situation and motivation to take on the longer-term commitment was not fully assessed in accordance with procedures.
- 5.6 It remains unclear what was the legal basis on which the placement commenced on the 9 August 2003. The Directions Hearing on 22 July had not agreed staying contact for that period and work on the kinship placement proposal did not begin until the 15 August 2003. Although by then Ms C had been asked if she wanted to be considered as a long-term carer, this had not been very actively pursued by that stage.
- 5.7 The Case Review has concluded that the placement of Toni-Ann by Social Care and Health Directorate with Ms C on 9 August 2003 did not fully accord with requirements of Regulation 38 of the Fostering Services Act 2002 and was therefore unlawful.

6. The Case Review has concluded that the management and surveillance of the kinship placement in London was not adequate to protect Toni-Ann.

- 6.1 The Case Review has examined the circumstances of the management of the emergency kinship placement in some detail and has concluded that more could have been done to ensure that Toni-Ann was well cared for and safe during that period. This conclusion is supported by the

appraisal of a number of critical factors of the manner in which the placement was managed and monitored.

- The Fostering Services Regulations require the social worker to visit on at least a weekly basis. This was not achieved in this case. One of the primary purposes of this level of oversight is to ensure that the welfare, wishes and feelings of the child about the placement are properly reflected in the decision-making. During her stay in London, Toni-Ann was seen once by the local authority social worker and, apart from one other telephone contact, it is difficult to conclude that this allowed adequate opportunity to assess the child's wishes and feelings in respect to her proposed new life.
- At no point was contact made with the London Borough of Brent Social Services Department as required by procedures and regulation.
- By the 3 September 2003 both the social worker and the Children's Guardian had discovered that Mr Byfield had reportedly taken Toni-Ann to another friend's house between 9 August and 15 August 2003, giving rise to concern on the part of Ms C and in clear breach of any agreement or understanding that her place of residence in London should only have been at Ms C's. This incident gives cause for serious concern.
- It was also known that Ms C had encountered difficulties in the degree of cooperation afforded her by Mr Byfield and clearly the placement was not going as smoothly as thought.
- Although a disclosure of historical sexual abuse was made to Ms C to both the social worker and the Children's Guardian no detailed file record of these conversations exists so it has not been possible to judge the degree of seriousness of the disclosure and consequently to weigh that element of risk that might be enhanced by any tardy response.
- Despite the disclosure no Section 47 enquiries or strategy meeting took place. Toni-Ann was not visited and the allegation remained uninvestigated and unresolved. This lack of an appropriate response to a direct disclosure by a child is in contravention of Birmingham ACPC's procedures and represented unsafe practice.

6.2 Given the general concern about the inadequacy of the assessment work in this case, the uncertainty about Ms C's motivation and Mr Byfield's reliability, and the fragility of the placement framework including the social worker's capacity to support the placement, it was important that there should have been urgent consideration of what other safeguards would have also been required to strengthen the placement.

- 6.3 It would have also been important to identify what additional steps needed to be taken to monitor the placement more closely, including visiting, not least to prevent Mr Byfield again 'disappearing' with Toni-Ann. There should also have been a review of the risks incurred by a continuation of the placement and a consideration of whether termination or at least suspension of the kinship placement would have been in Toni-Ann's best interests at this point. If risks were identified then necessary action to plan against these should have been agreed and recorded.
- 6.4 The Case Review has noted that at the Professionals meeting the decision was to persevere with the placement rather than undertake a fundamental evaluation of the risks. On the 4 and 5 September 2003 a more pro-active plan to move the case forward agreed some strengthening proposals as outlined above, including an agreement between professionals that a clearer and firmer working agreement with Mr Byfield and Ms C was needed and that social worker 2 would visit during the week beginning 8 September 2003 to 'take control of the situation'.
- 6.5 In the event, the social worker did not visit although during that week he did assist Mr Byfield with information for the registration of Toni-Ann at a school in Brent. Regrettably the sad death of Toni-Ann on 14 September brought an untimely end to the pursuit of any further action to strengthen and monitor the placement.

CONCLUSIONS ABOUT PROCESS AND PRACTICE ISSUES

Many aspects of this case and the management of professional workers are not new, but that they have been noted suggests that positive action still needs to be taken to ensure that standards of professional work are satisfactorily achieved. The key issues of concern highlighted by this case are as follows

7. Child Protection Policy and Procedures

7.1 Clarification of Birmingham ACPC procedures with respect to 'dual Conference' arrangements for children on the CPR who are, or become Looked After children

- 7.1.1 The reception of Toni-Ann into the care of the City of Birmingham Social Care and Health department was precipitated by the child protection referral activated by the teaching staff at School 1 on 27 September 2002. The allegation of physical abuse of Toni-Ann by her half sister, CB, was appropriately investigated under Section 47 of the Children Act 1989.

- 7.1.2 The manner in which this child protection referral was dealt with by the agencies provided an example of good practice. Intervention by the school, health professionals, police and social services was timely and effective. There appeared to be good and appropriate communication and close collaboration between agencies. The safeguarding of Toni-Ann was secured by her placement in a foster home and the interests of her wider welfare considered.
- 7.1.3 Whilst the safeguarding of Toni-Ann was assured by her placement with the foster carers, she should still have remained subject to Child Protection procedures. This case suggests that it would be helpful to have clearer procedural and practice guidance for situations where children straddle the child protection and Looked After Children systems.

7.2 Clarification of thresholds and procedures for notifications by schools to parents and carers of sexually inappropriate behaviour, with particular attention to arrangements for Looked After children

- 7.2.1 On the 31 January 2003 School 2 sent a letter to the foster carer that outlined their concern that Toni-Ann had displayed sexualised behaviour with another pupil. The school had not referred this information within a child protection framework, or with an explicit request for action, but had sent it for "information" for a parent or carer. This was a matter that was taken seriously by the foster carer and social workers, but does raise an issue about what are the appropriate means for reporting concerns of this nature between schools and corporate carers.
- 7.2.2 This incident draws attention to two aspects of practice that may warrant further consideration. Firstly, it has to be recognised that this is an area of practice where matters of careful judgment come into play. Establishing reliable thresholds for child protection referrals, especially regarding sexualised behaviour displayed by children in this age group, is extremely difficult. Secondly, what are the appropriate means of communicating this kind of behaviour in cases where the child concerned is a Looked After child, and how best to handle it.
- 7.2.3 The Case Review recommends that this matter is examined by the relevant agencies and schools.

8 The Case Review has examined the handling of Care Proceedings by the local authority and CAFCASS and has identified a number of issues that impacted on the effective handling of the case.

8.1 The Children's Guardian joining the case only after the third court hearing

- 8.1.1 Due to a serious backlog of work it was not possible for Cafcass to allocate a Children's Guardian at the first Court Hearing on 5 December 2002. The overriding impression is that from this belated starting position the Children's Guardian never really fully engaged with the case and, as a result, did not satisfactorily fulfill her statutory role and duties.

8.2 Problems associated with management of a case in a distant location

- 8.2.1 Although the Case Review has noted that, contrary to requirements and regulation, no contact was made in this case with relevant London Borough Social Services Department, there is a strong impression that management of the case was made more difficult by the distance of the placement from Birmingham and the logistics of contact and visiting.

8.3 The delay in the case due to late completion of papers and assessments

- 8.3.1 Delay was introduced into the handling of this case through the Court process, primarily due to the late presentation of assessment reports and other papers as detailed in the analysis. The other main factor in delay related to the consequential hold-ups in the smooth progress of the care proceedings was the inability to clear the blockage caused by the need to regularise Toni-Ann's immigration status before the Brent Housing Department would begin to consider Mr Byfield's re-housing in family accommodation.

- 8.3.2 The Family Proceedings Court was properly concerned about these delays.

8.4 Inconsistency in legal representation of Local Authority's case in court

- 8.4.1 The case was allocated to a Birmingham Legal Services lawyer who acted as case officer and who provided clear and consistent legal advice and maintained a constant grip on the administration of the case. However, it has been noted that in all, a total of six lawyers represented the case for the local authority in court, and another two lawyers had a hand in some part of the case's administration due to staff cover arrangements.
- 8.4.2 This raises the question as to the degree that this inconsistency affected the quality of service provided. This situation has to be contrasted with the constant attendance at each hearing of the child's Solicitor, Mr Byfield's counsel and the Children's Guardian. This is recognised as an unsatisfactory state of affairs and not helpful to the interests of the child. It is reported that action has now been taken to ensure that this is minimised.

8.5 Clarification of a collaborative working protocol between Legal Services and social services professionals detailing respective roles and inter-relationships in respect of care proceedings

8.5.1 The Case Review has noted a general issue about the nature of the working relationships between lawyers and social workers in such situations represented by this case. It is important for there to be close working relationships, but these can become strained if one party or other fails to meet agreed tasks or objectives set by the requirements of the court. If the court's timetable is not met then there are clear legal and financial consequences.

8.5.2 The Case Review was pleased to note that, since the inauguration in November 2003 of the Protocol for Judicial Case Management in Public Law Children Act Cases [Lord Chancellor's Department, June 2003], the Social Care and Health Directorate and Legal Services had entered into a joint working protocol that is designed to assist professionals in both departments to work collaboratively so as to achieve the model timetable for Care Proceedings set out in the LCD Protocol. It is understood that all social work practitioners have had the opportunity for training in respect of the protocol.

9. The Case Review has drawn attention to a number of issues of professional practice and standards of work, including the quality of professional casework recording, maintenance of case files and frameworks for professional supervision

9.1 Standards of Supervision and Support

9.1.1 This case review has drawn attention to the need for quality supervision and support arrangements to be available to front line workers in agencies. At the heart of the critique of this case lies concern that the core assessment work undertaken on members of the family was incomplete and the work of the professionals concerned not sufficiently challenging. The function of supervising managers is to ensure that procedural and practice standards are effectively achieved and that front line workers are supported in their difficult work. The Case review panel were concerned about the support and mentoring element of the supervisory task and whether this was satisfactorily fulfilled.

9.2 Quality and thoroughness of case recording

9.2.1 Some of the work of analysis of this case by the Case Review Panel and the agency reviewers was hampered by incomplete or absent

recording of assessment reports, notes of conversations, and of visits. Much communication appears to have been conducted on an essentially verbal basis that, as this case has shown, can prove a fragile basis when matters get difficult or breakdown. Good practice also assumes that a record will be made of all relevant verbal exchanges and this was lacking.

10. The Case Review has demonstrated the need to develop closer working relationships between local social care and health services and the national Immigration Service

- 10.1 One of the more important of the key issues central to the resolution of this case has been the matter of Toni-Ann's immigration status and the impact that this had on the effective management of her case by the local authority. The Case Review has established that Toni-Ann, following her initial six-months of holiday in 2000 became an illegal overstayer with no rights to remain indefinitely in the UK. As noted in the foregoing history and analysis, the inability on the part of her father to successfully apply to the Immigration and Nationality Directorate (IND) for the change of status seriously impeded moves to achieve the desired outcomes for the care plan as Mr Byfield was unable to obtain appropriate housing from Brent whilst this matter remained outstanding. It also effectively contributed to the reactive planning of alternative summer holiday arrangements once it was appreciated that Toni-Ann would be unable to accompany her foster carer abroad.
- 10.2 The Case review has examined the actions of the agencies and lawyers in respect of these issues, and in particular the nature of any joint working or communication between the social care agencies responsible for Toni-Ann, the legal advisers to Mr Byfield and the Immigration service. There are two over-riding conclusions from this analysis. On the one hand there is a pressing need for a more proactive approach to the achievement of more effective practice and mutual understanding between local authority services and the Immigration service if the future welfare of children in a similar position to Toni-Ann is to be assured. On the other hand there is a need to ensure close and collaborative working between the care authority and a clients' solicitors so that any cause for delay in progressing a case is minimised.
- 10.3 The Case Review Panel welcomed the Government's proposals that Immigration Officers are trained in techniques designed specifically for interviewing children and looks forward to the full implementation of that policy.

TONI-ANN - Recommendations

Recommendation 1

Birmingham ACPC, to be satisfied that agencies have up to date guidance regarding assessment of children in need.

Compliance with such guidance must be audited in order to ensure professional standards of assessment, which safeguard the child are consistently met. Practice must take into account the interests of family members and significant others but the interests and safety of the child must remain paramount.

Recommendation 2

Birmingham Social Care and Health Directorate and Cafcass should reinforce guidance regarding social work management, provide regular, appropriate, supportive supervision of frontline practitioners ensuring understanding of and working within legal and regulatory frameworks and audit compliance.

Recommendation 3

Senior managers must be able to demonstrate a thorough understanding of the principles of assessment, analytical skills, and the ability to identify static and dynamic risk factors, (particularly exposure to violence and/or drugs) safe risk management and defensible decision-making.

Birmingham ACPC to be satisfied that Social Care and Health and Cafcass have implemented recommendations.

Recommendation 4

Action to ensure full compliance with its Assessment and pre-placement procedures in respect of fostering placements.

Recommendation 5

The policy, procedures and practices in respect to Kinship Care. Arrangements to be reviewed and steps to be taken to ensure that all staff and managers are cognisant of best practice in this area. Special attention should be given to reinforcing guidance on the making of emergency kinship placements.

Recommendation 6

Birmingham Social Care and Health Directorate to take steps to improve the management of contact arrangements for children with their birth relatives and significant adults. To improve clarity of recording of the agreement surveillance of contact meetings for managers to audit arrangements.

Recommendation 7

Review the effective management of distant placements and provide guidance.

Recommendation 8

Review current procedural guidance concerning Looked After Children and their relationships with the child protection system.

Recommendation 9

Action is taken by SC&H and CAFCASS to ensure that communication between professionals on cases is prompt and accurate, especially in situations subject to unplanned change.

Recommendation 10

Action is taken to reduce delay through compliance of the Judicial Protocol.

Recommendation 11

Closer partnership working between Immigration and Nationality Directorate and Local authority Social Services Departments and future Local Children Safeguarding Boards at local level needs to be developed to ensure better dissemination of information on children seeking to enter the United Kingdom.

Recommendation 12

The Immigration and Nationality Directorate must demonstrate commitment to improving the spread of best practice by immigration officers in safeguarding vulnerable children who seek to enter the United Kingdom in keeping with 'Keeping Children Safe, September 2003', [paras 98 & 99]. Arrangements need to be developed whereby Immigration inform Social Services immediately if an immigration officer considers, or has reason to believe, a child to be at risk of harm. In addition to applying the above criteria to children seeking entry the IND should apply the same duty of care for children who come to their attention after entering the UK.

BIRMINGHAM AREA CHILD PROTECTION COMMITTEE

CHAPTER 8 CASE REVIEW ACTION PLAN IN RESPECT OF TAB

RECOMMENDATION	ACTION	RESPONSIBLE	TIMESCALE
<p>Recommendation 1.</p> <p>Birmingham ACPC, to be satisfied that agencies have up to date guidance regarding assessment of children in need.</p> <p>Compliance with such guidance must be audited in order to ensure professional standards of assessment, which safeguard the child are consistently met. Practice must take into account the interests of family members and significant others but the interests and safety of the child must remain paramount.</p>	<p>1a. ACPC Quality Assurance sub-Committee to undertake monitoring of the quality of agency audits of compliance with procedures to ensure consistency and coherence with CP procedures.</p> <p>1b. All agencies to establish an audit process for compliance with procedures and ensure professional standards of assessment.</p> <p>1c. The dissemination of this Action Plan to front line practitioners and managers must emphasise the necessity of compliance with inter-agency assessment protocols.</p> <p>1d. ACPC should audit the quality of single agency training programmes to deliver enhanced training on evidenced based assessments and report writing.</p>	<p>ACPC QA + A Sub-Committee All agencies.</p> <p>Social Care and Health</p> <p>All agencies</p> <p>All agencies</p> <p>ACPC Training Sub-Committee</p>	<p>1. July 2004 2. Oct 2004</p> <p>File Audit programme launched March 2004</p> <p>Sept 2004</p> <p>May 2004</p> <p>Oct 2004</p>
<p>Recommendation 2.</p> <p>Birmingham Social Care and Health Directorate and CAFCASS should reinforce guidance regarding social work management, provide regular, appropriate,</p>	<p>2a. Birmingham Social Care & Health to establish regular audit of compliance with Supervision Standards.</p>	<p>Birmingham SC&H</p>	<p>New supervision procedure launched April 2004.</p>

<p>supportive supervision of frontline practitioners ensuring understanding of and working within legal and regulatory frameworks and audit compliance.</p>	<p>2b. CAFCASS to establish regular audit of compliance with supervision standards.</p> <p>2c. Birmingham Social Care & Health Quality Assurance & Review Service to report Management Information and QA Audit results to ACPC bi-annually with particular regard to the FACIN timescales and quality of assessments</p>	<p>CAFCASS</p> <p>Birmingham SC&H</p>	<p>Compliance audit due Oct 2004.</p> <p>Sept 2004</p> <p>Audit programme in place, report to ACPC Sept 2004</p>
<p>Recommendation 3.</p> <p>Managers must be able to demonstrate a thorough understanding of the principles of assessment, analytical skills, and the ability to identify static and dynamic risk factors, (particularly exposure to violence and/or drugs) safe risk management and defensible decision-making.</p> <p>Birmingham ACPC to be satisfied that Social Care and Health and CAFCASS have implemented recommendations.</p>	<p>3a. Practice to be reviewed via staff development interviews and supervision.</p> <p>3b. Approved Officer training to be provided for all Team Managers who have not yet received it.</p> <p>3c. Birmingham Social Care & Health to review and re-launch FACIN interagency protocol for assessment.</p> <p>3d. CAFCASS to develop practice guidelines.</p> <p>3e. Existing CAFCASS Guardians should be reminded of CAFCASS Service Principles and Standards Framework.</p>	<p>Birmingham SC&H</p> <p>CAFCASS</p> <p>Birmingham SC&H</p> <p>Birmingham SC&H</p> <p>CAFCASS</p> <p>CAFCASS</p>	<p>New staff supervision procedures April 2004</p> <p>Launch Sept 2004</p> <p>July 2004</p> <p>July 2004</p> <p>In progress to be completed Sept 2004</p> <p>Completed April 2004</p>

	<p>3f. CAFcASS to review their arrangements for the induction and preparation of all newly appointed Children's Guardians.</p> <p>Report to ACPC</p>	<p>CAFcASS</p> <p>ACPC Q&A Sub Committee</p>	<p>National Induction training developed and in use subject to continuous review</p> <p>Sept 2004</p>
<p>Recommendation 4.</p> <p>Action to ensure full compliance with its Assessment and pre-placement procedures in respect of fostering placements.</p>	<p>4a. Birmingham Social Care & Health to re-issue guidance to front line managers with regard to the requirements of the Fostering Standards in respect of the approval of foster carers, kinship carers, placements and Panel procedures; with particular regard to 'emergency' placements.</p> <p>4b. Compliance with procedures identified above must be audited by the Fostering Service and the Quality Assurance and Review Service.</p> <p>Monitoring to be undertaken and reported to the Quarterly Performance Board.</p>	<p>Birmingham SC&H</p> <p>Social Care & Health</p>	<p>June 2004 following Independent Review</p> <p>June and October 2004</p>
<p>Recommendation 5.</p> <p>The policy, procedures and practices in respect to Kinship Care. Arrangements to be reviewed and steps to be taken to ensure that all staff and managers are cognisant of best practice in this area. Special attention should be given to reinforcing guidance on the making of emergency kinship placements.</p>	<p>5a. Birmingham Social Care & Health must undertake an immediate audit of all Kinship Care arrangements and devise and implement an action plan to address non-compliance with procedures.</p>	<p>Birmingham Social Care & Health</p>	<p>Audit completed December 2003 with decision-making raised to Operational Manager level. Independent review to commence May 2004.</p> <p>Conference on Kinship Care January 2004 to be repeated in June 2004</p>

<p>Recommendation 6.</p> <p>Birmingham Social Care and Health Directorate to take steps to improve the management of contact arrangements for children with their birth relatives and significant adults. To improve clarity of recording of the agreement, surveillance of contact meetings. Managers to audit arrangements.</p>	<p>5b. Children's Guardians should scrutinise placement of children under Kinship Care arrangements</p> <p>5c. Birmingham Social Care & Health Fostering Panel Team to undertake a review of the capacity of the Fostering Panels to approve carers and placement arrangements within prescribed timescales.</p> <p>5d. ACPC to take action to raise awareness about kinship care following reports from Social Care & Health</p>	<p>CAFCASS</p> <p>Birmingham Social Care & Health</p> <p>ACPC</p>	<p>Further guidance issued January 2004</p> <p>May 2004</p> <p>Implemented April 2004</p> <p>Independent review to commence May 2004.</p> <p>Panel monitoring arrangements in place reporting to AD Strategy and Area Directors.</p> <p>July 2004 to receive report from SC&H.</p> <p>Autumn Awareness Campaign</p>
	<p>Review of Child Care Procedures in respect of contact arrangement with particular regard to: -</p> <ul style="list-style-type: none"> ▪ Management ▪ Distant Placements ▪ Supervision ▪ Professional Observation ▪ Adherence to agreements ▪ Recording ▪ Criteria for suspension of arrangements ▪ Reporting within Family Court Proceedings 	<p>Birmingham Social Care & Health</p>	<p>Review commissioned to be completed September 2004</p>

<p>Recommendation 7.</p> <p>Review the effective management of distant placements and provide guidance</p>	<p>7a. Dissemination of guidance to Team Managers for compliance to regulation.</p> <p>7b. Audit of management and compliance of social work support to distant placements and of notifications to the host local authority</p>	<p>Birmingham Social Care & Health</p> <p>Birmingham SC&H</p>	<p>Work commissioned New guidance due May 2004</p> <p>Individual Case audit programme implemented March 2004. Reported to performance board Sept 2004. Themed audit July 2004.</p>
<p>Recommendation 8.</p> <p>Review current procedural guidance concerning Looked After Children and their relationships with the child protection system.</p>	<p>8a. ACPC Policy and Procedures Sub-Committee to Review existing procedure in respect of criteria for proceeding to Initial Child Protection Conference in respect of Looked After Children Guidance.</p> <p>8b. To disseminate and ensure training for practitioners</p>	<p>ACPC Policy and Procedures</p> <p>ACPC Training Sub Committee</p>	<p>September 2004</p> <p>December 2004</p>
<p>Recommendation 9.</p> <p>Action is taken by SC&H and CAFCASS to ensure that communication between professionals on cases is prompt and accurate, especially in situations subject to unplanned change.</p>	<p>Protocol to be established</p>	<p>Birmingham SC&H CAFCASS</p>	<p>Sept 2004</p>
<p>Recommendation 10.</p> <p>Action is taken to reduce delay through compliance of the Judicial Protocol.</p>	<p>10a. SC&H to comply with Judicial Protocol / reporting to Monthly Area Performance Meetings. Arrange further training for new members of staff.</p>	<p>Birmingham Social Care & Health All Agencies</p>	<p>Protocol launch Nov 2003. Staff training programme ongoing.</p>

	10b. Prompt allocation within two days of Children's Guardian to a case.	CAFCASS	Currently being achieved and subject to monthly monitoring
<p>Recommendation 11.</p> <p>Closer partnership working between Immigration and Nationality Directorate and local authority Social Services Departments and future Local Children Safeguarding Boards at local level needs to be developed to ensure better dissemination of information on children seeking to enter the United Kingdom.</p>	<p>11a. Local protocols to be established for the referral of concerns in relation to the children seeking to enter this jurisdiction or following the identification of children as 'overstayers'</p> <p>11b. Joint training for designated IND, Social Care and Health and Health Trust staff to be commissioned by the ACPC (Local Safeguarding Children's Board).</p>	<p>ACPC</p> <p>ACPC</p>	<p>October 2004</p> <p>October 2004</p>
<p>Recommendation 12.</p> <p>The Immigration and Nationality Directorate must demonstrate commitment to improving the spread of best practice by immigration officers in safeguarding vulnerable children who seek to enter the United Kingdom in keeping with 'Keeping Children Safe, September 2003', [paras 98 & 99]. Arrangements need to be developed whereby Immigration inform Social Services immediately if an immigration officer considers, or has reason to believe, a child to be at risk of harm. In addition to applying the above criteria to children seeking entry the IND should apply the same duty of care for children who come to their attention after entering the UK.</p>	<p>ACPC Chair to formally write to Immigration and Nationality Directorate at a local level to invite to discuss the findings from the review and agree a way forward to implement the recommendations.</p>	<p>ACPC Chair</p>	<p>May 2004</p>