Executive Summary

Serious Case Review in accordance with the guidelines laid out in Working Together to Safeguard Children 2010

Child F
Deceased: 2011 aged 17

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17/01/12

1 Circumstances leading to a Review

1.1.1 In 2011 Child F was killed after he threw himself in front of a lorry on the M25. In 2006 Child A's mother had died after she hung herself. Prior to her death there had been extensive involvement by children's services, police, health and mental health services as a consequence of a combination of domestic violence towards Ms A by her partner Mr C, Ms A's previous suicide threats and concerns about Ms A's and Mr C's substance use.

1.1.2 Following Ms A's death Child F and his brother Child K lived initially with Mr C and Child L, the son of Mr C and Ms A, then with their father Mr R and finally with an aunt Ms E. During this period both Child F and Child K often came to the attention of the police, mainly for instances of anti social behaviour, and both had periods of school exclusion.

2 Review Process

2.1 Terms of reference

2.1.1 In line with 8.5 of *Working Together* the review should:

i. 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;
ii. 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
iii. improve intra- and inter-agency working and better safeguard and promote the welfare of children

2.1.2 The Havering Safeguarding Children Board (HSCB) convened a serious case review panel (SCRP) which agreed terms of reference as set out in 8.39 of Working Together and additionally including:

1. What factors helped or prevented engagement with Child F and his carers and how well were these recognised and understood by those involved at the time, in particular

a. the appropriateness of help and support offered to Child F and his carers following Ms A's death including the reluctance to accept offered services

b. the impact of frequent changes of address and of carer including the significance of changes in service personnel and location consequent upon such changes

c. The significance of Child F's age during the period of the review.

2. Was the assessment and action robust around the decision not to intervene when Child F went to live with his step father? In particular were thresholds for intervention appropriately applied?

3. Was the significance of co-morbidity of domestic violence, mental health and drug and alcohol misuse fully understood and appropriately acted upon?

4. Given the likely impact of Mother's death on the children, how well did agencies singly and together provide services that may have prevented her death, and hence contributed to the possibility of a different outcome for Child F?

5. Did adult services understand and appropriately act upon the concerns and needs of Child F and, did children's services understand and appropriately act upon the concerns and needs of Child F's carers?

6. Was information shared adequately and acted on appropriately

7. Specific considerations: do any issues concerning diversity emerge in the review, for example age, ethnicity, religion, disability, social exclusion? External links: was the family engaged with / known to agencies other than statutory partners?

2.1.3 Individual management reviews and chronologies on which the overview report is based were provided by the following agencies and named authors:

- **Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT):** accident and emergency services
- **North East London NHS Foundation Trust (NELFT)** In and outpatient mental health services to Child F, Child K, Ms A and Ms E
- **Outer North East London Community Service (ONEL CS)**[1] Health visiting and school nursing services
- **ONEL NHS General Practitioner Services:** GP services in respect of several family members.
- **NHS Havering (commissioners)**: Health Overview Report
- **London Ambulance Services NHS Trust (LAS):** Calls outs to several family members
- **Metropolitan Police Service:** Involvement in domestic violence incidents, anti-social and criminal behaviour of some family members, the deaths of Ms A and Child F and other crisis interventions
- **London Borough of Havering Social Care and Learning** – **Children and Young People Services:** Social work services to Child F, K, L and their carers; early years support for Child L
- **London Borough of Havering Social Care and Learning – Learning and Achievement:** Education and support services to Child F and Child K

[1] ONEL CS is now part of the NE London Community Trust (NELCT) but the term ONEL is used as this was the name of the organisation during the period of review

2.1.4 The following agencies had very limited involvement and were therefore asked to provide background information. The reasons are considered in section 6.10

- **East of England Ambulance Service:** Attended the road traffic incident in which Child F died
- **Essex Probation:** Supervision of Mr C
- **Essex Children's Services and SE Essex PCT:** Involvement with Child L after he and his father moved to Essex
- **London Probation Service:** supervision of Mr C

2.1.5 A format for individual management reviews (IMR's) was provided. All authors were independent of the case and had no involvement with the family.

2.2 Parallel Investigations

2.2.1 Consideration was given to the need for a separate adult safeguarding review As a sudden untoward incident (SUI) review had been undertaken following Ms A's death the chairs of both the LSCB and the Adult Safeguarding Board agreed this report provided sufficient analysis to obviate the need for a separate review and that residual questions could be addressed in the NELFT IMR.

2.3 Serious case review panel (SCRP) membership and process

2.3.1 The SCRP comprised the following members:

- Legal Manager (Litigation) London Borough of Havering, Legal Services
- Service Manager, Safeguarding & Service Standards, London Borough of Havering
- Designated nurse consultant safeguarding children NHS ONEL
- Manager, Additional Education Needs Services, London Borough of Havering Learning and Achievement
- Safeguarding Manager for Adults, Children and Young People, East of England Ambulance Service NHS Trust
- Associate Director Children Services, ONEL CS
- Executive Director of Nursing Barking, Havering & Redbridge University Hospitals NHS Trust
- Service Manager Youth Offending Team
- Assistant Chief Officer Barking Dagenham and Havering LDU, London Probation Trust
- Detective Inspector Havering Child Abuse Investigation Team (CAIT)
- Consultant Psychologist, Head of Service, Havering Psychological Services

2.3.2 The panel was supported by the HSCB Business Manager, and the HSCB administrator.

2.3.3 The Panel was chaired by the independent chair of Havering LSCB, Ms Sue

Dunstall. The overview report was written by Bob Cook, an independent consultant. The overview author was in attendance at the panel to hear and respond to information about the progress of the review and to provide commentary on the quality of IMRs. The overview author was not a member of the panel.

2.3.4 The Panel met on four occasions during the course of the review to consider progress with IMRs and the overview report.

2.4 Family involvement

2.4.1 The terms of reference explicitly recognised the importance of wide family involvement and agreed the independent author of the SCR together with a member of the SCR Panel should invite Child F's father, Mr C, Mr R, Child K, Mr and Ms E to contribute to the SCR process. All chose not to participate.

2.5 Executive summary

2.5.1 The executive summary will be published on the LSCB website following receipt of an evaluation from OFSTED. All family members consulted as part of this review will be given an opportunity to discuss the summary and the review findings before publication.

2.6 Action Plans

2.6.1 Individual agencies and the LSCB have produced appropriate action plans based on their recommendations.

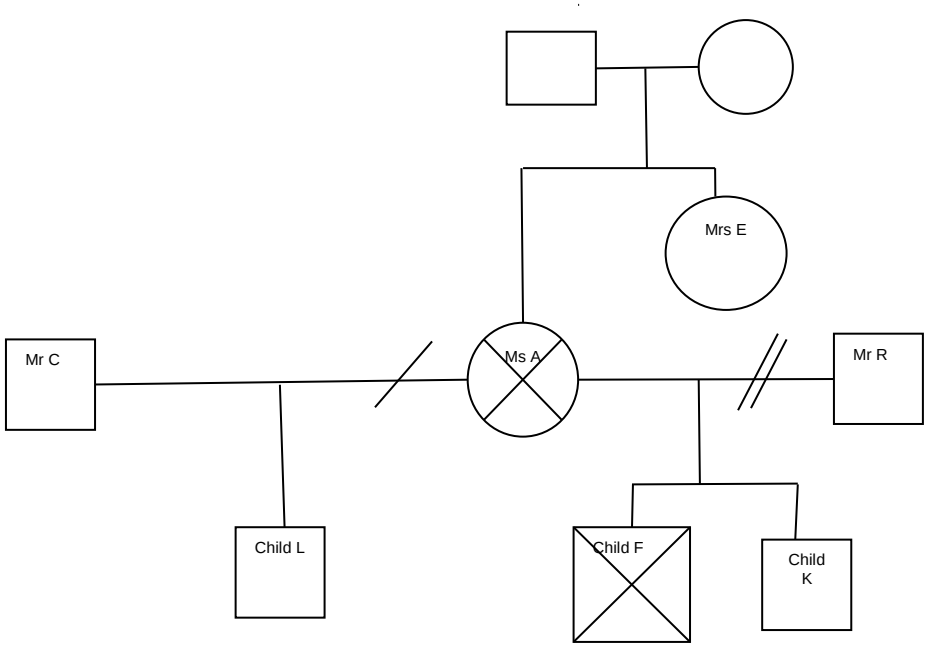
2.7 Publication and media interest

2.7.1 Havering LSCB will manage family, public and media interest through a clear communication strategy. The family members will be informed of the process and findings of the SCR.

2.7.2 In line with statutory guidance the overview report will not be published because of *"…compelling reasons relating to the welfare..."* of Child K, including concerns about possible identification and causing additional and unnecessary distress.[2]

[2] Department for Education (2010). *Publication of Serious Case Review Reports and Munro Review of Child Protection.* Ministerial letter, circulated 10th June 2010 and retrieved 14th November 2011 @ www.education.gov.uk/.../LettertoLSCBsreReviewandSCRs10June20...

3 Genogram: Key carer relationship groupings



4 Summary of events

4.1.1 During the period of six months prior to agency involvement in 2006 there were three incidents of domestic violence between Mr C and Ms A, during all of which the children were in the home. The final incident led to Mr C being charged and subsequently convicted. Both Mr C and Ms A were having treatment for depression, which appeared to be largely consequential on the breakup of the marriage. Ms E had taken an overdose and expressed suicidal views. Child F's school performance was seen to be deteriorating.

4.1.2 A health visitor referral to Havering children and young people's service (CYPS) was made but described as not being a child protection concern. The referral was not followed up by either agency. When the mental health initial assessment team (MHIAT) became involved with Ms A shortly thereafter following a police referral there was no discussion with CYPS by either agency.

4.1.3 Two months later a MHIAT referral to CYPS was made but the case was not allocated for a further month, and despite diligent attempts by social worker SW1, an initial assessment did not commence for a further three weeks due to difficulties in getting Ms A to engage.

4.1.4 During this period there were three further domestic abuse incidents. There was better evidence of liaison between CYPS, MHIAT and the police. On completion of the assessment, SW1 concluded the children were at significant risk from witnessing further domestic violence and recommended a core assessment with a view to convening a child protection conference. However a

final serious domestic violence incident just after the assessment was concluded and where the children were directly involved was not investigated as a specific child protection concern or considered as sufficient grounds for a child protection conferences although Mr C was subsequently charged .

4.1.5 At this point the psychiatric diagnosis for Ms A was most concerned about her use of drugs and alcohol as a stress reaction, though later consensus was that she ceased this behaviour.

4.1.6 SW2, who undertook the core assessment, noted Ms A prevented engagement with the children and concluded Ms A's mental health impacted on her ability to care for them. SW2 also identified concerns about the children witnessing domestic violence. The case transferred to SW3 whose manager TM1 recommended a child in rather than a child protection approach.

4.1.7 Following a child in need meeting the focus shifted further away from the children to Ms A's mental health. There was close liaison and joint working between adult mental health worker MH2 and SW3, also to some extent including the health visitor HV3. Police were involved as Mr C resumed contact as soon as his bail conditions were lifted, evidencing an increased risk of further domestic abuse. This did not lead to any revision of the child in need plan and Ms A did not engage with an offered empowerment group for women who had experienced domestic abuse.

4.1.8 Concerns by both SW3 and MH2 that Ms A was a suicide risk were thoroughly followed up by mental health services. Ms A was not admitted to hospital in part due to a cautious new diagnosis by consultant psychiatrist Cpsych2 of a personality disorder, a condition less amenable to change through emergency admission. Ms A appeared better on MH2's last contact and made positive remarks about therapy. The SUI following Ms A's death noted Ms A as a moderate suicide risk and that the circumstances leading to her death could not have been predicted.

4.1.9 There was little evidence of direct work with the children during this period of intervention. Child L was offered a good programme of support by the early years centre. During this period Child F came to the attention of the police for the first time but there is no evidence this led to any reconsideration of a need for more coordinated intervention.

4.1.10 Following Ms A's death Ms A's sisters clearly blamed Mr C for Ms A's death but also recognised his significance for the children and wanted to remain on good terms with him. The children's views were ambiguous. Child F wanted to remain with Mr C but Child K appeared to vacillate between Mr C and Ms E. Child L was Mr C's birth child.

4.1.11 No formal assessment was undertaken by CYPS as to who might best be able to care for the children though support was offered to the family. Mr C took on care of Child F and K as well as Child L. Ms E offered considerable support to Mr C e.g. cooking meals for the children at Mr C's home while he was working.

4.1.12 The only person at this point with parental responsibility was Mr R who was overlooked to the extent that when he rang CYPS in effect making a child protection referral about the safety of the children with Mr C his concerns were

dismissed.

4.1.13 At a child in need meeting concluding CYPS involvement SW4 informed the meeting she had no role as there were no safeguarding concerns evidencing poor understanding of the history and continuing concerns about Mr C's lifestyle. Other agencies had concerns about closure but did not effectively voice these.

4.1.14 Apart from Child L, for whom there was a clear and thorough package of support, there was a lack of resolution about bereavement counselling with different views on when this should start. It is fair to say both Child F and Child K expressed some resistance to counselling.

4.1.15 Mr C was asked by CYPS to obtain a residence order but this was delegated to the early years worker for Child L, EYC1, though neither Child K nor F were within the remit of the early years centre. Mr C did not obtain a residence order or parental responsibility and this was not referred back to CYPS.

4.1.16 While the early years centre evidenced good work with Child L and held reviews the school was not invited to these though both Child F and K were discussed. At one meeting Ms E and Mr C both requested help through a CAF assessment but this was not followed up by the early years centre, missing an opportunity to engage with the family at their own request .

4.1.17 Child K left Mr C's home barely a month after closure of the case by CYPS and went to live with Ms E, later moving in with his father, as did Child F only nine months after case closure.

4.1.18 Child L was no longer in the Havering area having moved with his father to another local authority after an incident of serious violence to Mr C by an acquaintance. During this period it was not always clear with whom Child F and K were living.

4.1.19 Child F's behaviour in school and in the community continued to give cause for concern. The school endeavoured to provide counselling but did not refer back to CYPS. Police stops of Child F were treated as low threshold single incidents and police information was rarely shared with CYPS, even after Child F received a youth reprimand after being found with cannabis.

4.1.20 Child F was eventually subject of a managed move from school to an alternative education provider. This helped him learn a trade and was one of the most successful interventions with Child F. This period also coincided with a reduction in Child F coming to police attention.

4.1.21 A significant opportunity for CYPS to reengage with Child F was missed when a referral was made after Child F came to the attention of health services due to an alcohol related hospital attendance.

4.1.22 Concerns about Child K also increased with him exhibiting similar behavioral patterns in school and the community to his brother. This resulted in Child K changing school, after a period of exclusion, where he subsequently did very well.

5 Conclusions and lessons learned

5.1 Introduction

5.1.1 The circumstances that led to this serious case review are tragic. Both Child F and his mother took their own lives. This SCR has tried to understand whether the death of Child F was predictable and whether it could have been prevented. Some findings relate to matters where there have been changes in practice or policy. These do not require recommendations.

5.1.2 There was much debate within the HSCB at the start of the process whether, despite the manner of Child F's death, the circumstances met the criteria for a serious case review. Factors which swayed the HSCB's decision included national research findings of the often unrecognised vulnerability of older young people (Brandon et al 2010) and the HSCB's own 2011 section 11 audit[3] findings *of lower awareness of the 'hidden harm' to teenagers in some instances and in some agencies.* The HSCB is to be commended for taking the view that undertaking a review could contribute both to the national debate and local circumstances on how to reduce harm to teenagers.

5.1.3 The review has highlighted a number of shortcomings in practice which contain important lessons for professionals though it cannot conclusively be said they would have prevented the circumstances in which Child F died. They included

i. Poor identification and assessment that the children were at risk of significant harm as a consequence of co-morbidity of parental mental health, substance misuse and domestic violence
ii. Failure to assess who might best provide care for the children following the death of their mother the quality of available care and the risks that Mr C might pose to the children as a carer
iii. Failure to consider the possible underlying causes behind Child F and his brother's increasingly challenging and troubled behaviour and to provide a consistent multi agency response.

5.1.4 There were also areas in which practice was good:

i. The high level of support Ms A received from mental health agencies, though ultimately unsuccessful in preventing her death. A SUI review undertaken at the time, the key findings of which were reviewed and confirmed by the NELFT IMR undertaken as part of this review, confirmed Ms A's death was not preventable
ii. The levels of support provided by learning and achievement services that ensured both Child F and Child K remained in education and indeed achieved positive outcomes
iii. Support for Child K and his carer, Ms E, after Child F's death.

5.1.5 From the analysis in this review, based upon the panel terms of reference, two broad themes emerge which interact with each other to create the potential for good or bad practice. These are:

[3] S11 of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. The quality of these arrangements is tested in audit by Local Safeguarding Children's Boards

i. Understanding the co-morbidity of domestic violence, mental health and substance misuse
ii. Working with hard to engage families and individuals

5.2 Specific factors impacting on understanding of co morbidity of domestic violence, mental health and substance misuse

5.2.1 Research evidence is that the above three factors in combination create a *"cumulative problems and adversities [that] are not uncommon and present significant risks factors for children." (*Brandon et al 2010).This review has established their significance in this case especially during the intervention while Ms A was alive and, following her death, when Mr C undertook the role of carer.

5.2.2 There was poor theoretical understanding of the inter-linkage of these three factors. While their presence was identified at early stages of intervention they were initially seen as fitting child in need criteria. When police and mental health services became involved and police made referrals to domestic violence agencies neither agency contacted CYPS. When a further referral was made to CYPS, three months after the original concern there was still a delay of a further three weeks before allocation

5.2.3 It is concerning that no agency appeared to be aware of research findings that these were interacting factors that required a prompt s47 response. There were some deficiencies in national and regional policy and procedure which at that point, while identifying all three factors could be simultaneously present and have an impact on children gave no specific reference to their interactivity and how they should be addressed. Lack of clear policy and procedure must have impacted on those working with such families at the time. Detailed procedures addressing the impact of domestic violence on children were also not in existence being first produced by the London Safeguarding Children Board in March 2008.

5.2.4 The potential impact on Child F and Child K of having lived in a situation where these three factors were present for so long was also not understood when their behaviour became more challenging later on. Contemporaneous research evidence shows factors associated with experience of co-morbidity for this age group include poor school performance, emotional disturbance, conduct disorders, fear of exposing family life to outside scrutiny, school exclusion, aggression and risk of suicidal behaviour (Cleaver et al 1999) all of which were present in their behaviour.

5.2.5 Although the school was endeavouring to address the behaviour of Child F and K they did not seek to re-engage the multi-agency network. Havering's 2011 section 11 safeguarding audit has identified this is still an issue noting *"some gaps in teachers' understanding of the forms of maltreatment of teenagers, and the impact that might have.".*

5.2.6 When a health agency later re-referred Child F to CYPS due to concerns he was "falling through the gaps" CYPS merely logged this as a contact. Neither school nor early years centre considered using CAF to re-engage the network. Of particular concern the local early warning system that could have flagged up the need for wider intervention when Child F and Child K started coming to the

notice of the police for anti social behaviour did not appear to reach the anti-social behaviour panel

5.3 Specific factors impacting on engagement with the family

5.3.1 In this case engagement focused on adults' needs and adult experience of domestic violence, mental health and substance misuse.

5.3.2 In respect of Ms A this resulted in a crisis intervention response to specific incidents precipitated by Ms A's mode of engagement of panicky help seeking, often drawing in members of her extended family and involving the emergency services then withdrawing after the crisis.

5.3.3 Mr C exercised significant control over Ms A and demanded the removal from the case of a health visitor who had shown awareness of child protection concern. This went unchallenged despite the health visitor's earlier raising of concerns with her manager even though A's sisters appeared intimidated by Mr C and Mr R seemed unable to stand up to him. CYPS, being focused on adult views and failing to understand the impact of domestic violence on the children, did not look at the competing claims of Ms E, Mr R and Mr C to care for Child F and K. CYPS simply accepted the view of the adults that Mr C's wishes should be paramount.

5.3.4 Because the focus was on the adults, children's agencies had a very limited mandate for engagement. Ms A was initially hostile to the mental health initial assessment team after they made a referral to CYPS. Neither Ms A nor Mr C allowed more than very limited access to the children. If the focus had been on child protection the family could have been required to engage through a child protection plan. In the absence of this the adults needed to see a clear purpose and benefit of engagement by CYPS which was not conveyed to them.

5.3.5 Ms A saw social work support in terms of her own needs, effectively as an adjunct to mental health involvement. Both Ms A and Mr C were willing to engage with the school and early years centre because they did see a perceived benefit in education for Child F and K and in specific help for Child L.

5.3.6 Following Ms A's death, with the exception of support for Child L which was a clear part of early years intervention, the purpose of support was unclear especially in respect of counselling for Child F and Child K with different agencies and time scales being mooted. The agencies' lack of clarity about purpose gave a confusing message to the family that inhibited understanding of the potential benefits.

5.4 General factors impacting on the interaction between co-morbidity factors and hard to engage families

5.4.1 Poor understanding of the significance of co morbidity and on how to engage resistant families was compounded by a number of general factors.

5.4.2 Firstly the quality of social work assessment, planning, supervision and handover in this case was poor. The initial assessment by social worker SW1 did locate the case within the child protection spectrum but failed to appreciate the seriousness of a further incident requiring an immediate child protection

conference in line with existing procedures. Later interventions, while still recognising the presence of these factors, shifted the focus back to child in need. This appeared to be a decision made by the CYPS team manager TM1 who recommended a child in need meeting when the case transferred to their team.

5.4.3 There is no explanation for this change on case or supervision records and those most directly involved could not be located so could not be interviewed. It is however an example of the rule of optimism where and over focus on adults' needs practitioners may be reluctant to make negative professional judgments about a parent's behaviour to their child (Brandon et al 2010 p 55).

5.4.4 No CYPS manager attended either of the key child in need meetings that were held so there was poor managerial accountability for decision making and the minutes revealed poor structure and unclear recommendations. At the point CYPS closed the case after the children went to live with Mr C there was dissonance between what the minutes recorded participants saying and what those participants' own case notes showed. However there was no challenge to this.

5.4.5 Three different social workers during the six month period of intervention while Ms A was alive were a consequence of a structure with separate teams for duty, assessment and family support. This required a clear handover to ensure continuity. There was no evidence of clear handover between workers, managers and teams. Thus the not uncommon and legitimate structure itself created the unintended consequence of discontinuity in this case contributing to the result of an unevidenced and inappropriate change of focus from child protection to child in need.

5.4.6 There was evidence of the final allocated social worker SW4 not understanding the legal position when Mr R, the father of Child F and K and the only person actually to have parental responsibility, contacted CYPS expressing concern about Mr C's ability to care for the children. Mr R's legitimate claims to be involved were not only ignored but agencies discouraged from dealing with him. The social worker and team manager at the time were both from overseas and there are unresolved questions about their understanding of UK child care legislation as neither could be interviewed. The local authority now has a thorough induction programme for overseas workers.

5.4.7 Roles were sometimes unclear and undifferentiated .While there was some good evidence of joint working between social worker SW3, mental health practitioner MH2 and health visitor HV3 this focused on supporting Ms A. While this was appropriate for MH2 as an adult mental health practitioner, SW3 lost focus on her proper remit in respect of the children. Later HV3, though having and reporting concerns to her manager about Mr C did not escalate these when her manager failed to respond

5.4.8 MH2 did identify concerns about the children but at no point did SW3 and MH2 step back and consider their respective roles and how they should interact e.g. to consider how the changes of diagnosis in respect of Ms A might impact on the care of the children. Nor, despite her offer to visit, was MH2's mental health experience utilised by CYPS following Ms A's death in considering how to engage with the very distressed family members.

5.4.9 Later the early years worker EYC1 who provided a good and level of support for Child L was tasked by SW4 with taking the lead role to ensure Mr C obtained a residence order in respect of Child F and K. This was inappropriate for an early years worker. Mr C did not do so and EYC1 did not re-refer to CYPS. SW4 told other agencies including school and early years centre her role was only in respect of safeguarding.

5.4.10 This was a poor understanding of the CYPS role and of threshold criteria. It effectively discouraged a re-referral to CYPS under child in need criteria, quite apart from failing to recognise existing safeguarding issues and continuing concerns about Mr C. Most concerningly, despite misgivings among participants, no agency challenged this interpretation.

5.4.11 Understanding of thresholds has been identified in a recent safeguarding inspection as a continuing concern and the s11 audit, the latter noting *"evidence of the 'understanding of', and 'buy in' to thresholds at a strategic level…[but]…much more ambivalence at operational management and practice levels."*

5.4.12 There was a focus on presenting behaviours and responding to incidents rather than understanding underlying causes. This particularly manifested in the approach to Ms A but also in later police and school responses to Child F and Child K's later challenging behaviour.

5.4.13 There were some deficiencies in information sharing. There was no contact with the GP for Mr C, Ms A and the children. Contact could have established Mr C's relevant medical history and looked at how the GP could support Ms A. There are particular concerns about the GP over prescribing medication to Mr C and poor record keeping where hospital information evidenced as being sent to the GP about Ms A's psychiatric treatment and references to domestic violence were not on file.

5.4.14 There were occasions when police information did not reach CYPS, resolved through a new system prior to this review, and when A&E did not pass on concerns. The social work emergency duty team did not evidence follow up requests for welfare checks. When Mr C and Child L moved to another authority information sharing seemed perfunctory.

5.4.15 Finally no presentencing reports were requested by the court for either of Mr C's two domestic abuse convictions against Ms A. Such reports could have led to intervention though the criminal justice system that could have reduced the likelihood of further violence and indeed contributed to addressing the interactive factors.

5.5 Towards better understanding of co-morbidity factors and how families may be engaged

5.5.1 This review has identified a number of possible models that could have facilitated better understanding about what was happening in the family and how to engage with them. These include the elements of authoritative practice identified in the final Munro review (Munro 2011); the interrelationship between child, family and community and how agency intervention set out in the government sponsored biennial reviews of serious case reviews (Brandon et al

2008, 2009 and 2010) and ensuring a binding mandate for intervention with non engaging families.

5.5.2 Central to good practice is understanding the cumulative impact of domestic violence, mental health and substance misuse on children and to look at the underlying reasons for these rather than simply responding to specific incidents. As previously argued this requires knowledge of theory and research.

5.5.3 To evaluate this would have required a continuing and focused process of assessment that took full account of the family history. As Munro put it a *"critical analysis of evidence about what is happening in a child's life including recognition of child abuse and neglect"* (Munro 2010). This needed the backing of a process of reflective supervision where options could be considered and challenged and direct discussion with colleagues, both informally and sometimes a strategy meeting, e.g. when considering the impact of concerns and how to reengage after Ms A's death.

5.5.4 While the concept of reflective practice is mentioned in Havering's current supervision procedures, the definition and process of how this will be applied in the supervisory context is not explicitly developed. This should be an important future area of learning and development given the highlighting of this process in the Munro review and elsewhere. A similar point has been noted in the most recent OFSTED/Care Quality Association safeguarding inspection of the HSCB area.

5.5.5 Following assessment, workers needed to be clear with family members both before and after Ms A's death about what needed to change and how to diminish "oppressive factors" (domestic violence, substance misuse, overdoses).

5.5.6 To achieve this required a focus on the children's needs and a clear mandate to engage. This needed to be authoritative, with a requirement to engage through a child protection plan but also compassionate involving purposeful relationship building with children, carers and families.

5.5.7 Even if Ms A's death could not have been prevented, authoritative engagement through a child protection plan, initiated prior to her death, would have facilitated workers in looking at what each member of the family network could offer and what the risks were after her death. This would determine who was best able to look after Child F and Child K and what support they might need.

5.5.8 The agencies needed to be clear about their own and each other's roles and purpose, especially those of children's and adult services. This needed a reflective step back, prior to meeting with the family, to discuss what the remit of each agency should be and how they would interact e.g. how and when to provide therapeutic support or how to assess risk to the children.

5.5.9 The family's strengths could have been better drawn out. These included

i. The support the aunts offered each other and the children
ii. The importance of Mr C to Child F and Child K
iii. The need to have the opportunity for Child F and Child K to re-engage with their father after their mother's death

iv. Respectful understanding of the grief and pressure family members were under and how this might impact on what they could offer.

5.5.10 These were all important to the boys especially as at the time the adults were giving mixed messages, discouraging Mr R and placating Mr C. Child F and Child K reflected these views but, as there was no direct discussion with them, it could not be established if this represented their true feelings and opinions. It is unlikely this was so as both boys later voted with their feet leaving Mr C and going to live with Mr R and later with Ms E. To have engaged with the boys at the time would have required skills in communicating with them to overcome their initial reluctance, and the reluctance of the adults around them.

5.5.11 This would not have meant dismissing Mr C who was an important figure in the boys' life. It would however have meant challenging him about his violence and requiring him to address this. This might have meant he would not have felt able to take on the children or be seen as appropriate to do so. It would have been better for this to have happened in a supported way which might have enabled Mr C, Child F, Child K and Child L to retain some contact . The impact of losing Mr C for Child F is not known but may have been considerable given the previous closeness.

5.6 Other learning: Multi agency working with hard to engage young people

5.6.1 Much of the above has more applicability for the interventions led by CYPS when Ms A was alive and immediately after her death. Later interventions involved Child F and Child K more directly. There was good practice within the learning and achievement service and good outcomes for both Child F and K.

5.6.2 External inspection evidences very good provision and attainment in ensuring young people are in education, employment or training. There is additionally a programme of continuing improvement set out in the authority's young people's participation strategy.

5.6.3 However in this case there was, as previously argued, an over focus on incident response and managing Child F and K's undoubtedly troubled behaviour rather than looking at underlying causatory factors. Three factors have been highlighted in the review and fit with priority areas for the LSCB. All could have been opportunities to re-engage the multi-agency network.

5.6.4 Firstly was the failure to consider use of CAF. It is concerning that two other Havering SCRs, have also highlighted poor use of CAF as has the 2011 OFSTED/Care Quality Association inspection of safeguarding and looked after children. The 2011 Havering section 11 audit has identified continuing problems with CAF implementation and teachers' lack of confidence in using the process which resonate with the findings in this review.

5.6.5 Secondly, there was poor use of the local early warning system enforced by the police and used as an alternative to prosecution. This could have highlighted risk to Child F and his brother if fed back into the anti-social behaviour panel (now incorporated into the community safety partnership).

5.6.6 Thirdly there was a poor response on some specific occasions to concerns about Child F and Child K's use of alcohol and cannabis that could have led to

engagement with the drug and alcohol action team (DAAT). A professionals' toolkit to aid such referrals was later introduced by the DAAT.

5.6.7 There is an added concern given the post mortem finding that Child F had been using substances prior to his death. The DAAT should review the learning from this case in respect of Child F and Child K's alcohol and substance misuse and incorporate findings into its action plan.

5.6.8 There were delays in the Child Death Overview Panel (CDOP) being informed by the Coroner's office of Child F's death. This delayed the rapid response meeting and risked adding to the family's distress. Though it cannot be evidenced this was a factor in the circumstances of this case information sharing in such circumstances has been identified as an ongoing national issue and a recommendation about disseminating learning has been made.

5.6.9 While there was no indicator that would have been apparent to any agency that Child F was about to take his own life, he was clearly in a vulnerable category requiring a range of support services and understanding by himself, his peers and family, as well as referring agencies, of how to access these.

5.6.10 Given this is the third review in the past six years in which a young person in the HSCB area took their own life it is important the HSCB considers a model of suicide intervention. This would also address concerns raised in the s11 audit about developing "*a new multi-agency focus on safeguarding adolescents"* and addressing *"hidden harm' to teenagers."*

5.6.11 Finally it is acknowledged that, as a consequence of recent external inspection, HSCB audit findings and the current children and families transformation programme some findings of this review especially around CAF, threshold identification and reflective practice are already high on the agenda of the LSCB and its partner agencies. The recommendations in this review therefore seek to contribute to and strengthen this existing work.

6 Recommendations

1) The HSCB should strengthen its multi-agency learning and development programme to improve understanding of and practice in working with families where domestic violence, mental health and substance misuse are present (16.3.2). This should include:
   i. Developing an authoritative mandate for engagement with individuals and families and their wider networks (16.6)
   ii. Ensuring the centrality of the child's needs and voice (16.6.7-12)
   iii. Understanding personal roles and those of other agencies (16.5.8)
   iv. Working together and sharing information in a reflective process (16.5.13-15)
   v. Improving co working between children's services and adult drug teams as identified in the 2011 HSCB section 11 audit (16.6.9).

2) The HSCB should ensure that the learning from this SCR contributes to the development of a better multi-agency focus to identify and support young people at serious risk of hidden harm. (16.7.9) This should include:
   vi. A multi agency model of suicide intervention (16.7.8-10)

vii. Developing a multi-agency understanding of young people's counselling needs and ensuring availability of this (16.3.5-7).
viii. Improving the awareness of children and young people about mental ill health in themselves, their parents and carers and their peers (16.7.8)

3) The HSCB should utilise the learning from this review in taking forward strategies identified in their 2011 section 11 audit, OFSTED Safeguarding inspection and the current children and families transformation programme regarding continuing problems with CAF implementation and some agencies lack of confidence in using the process in order to improve early assessment of need (16.7.4).

4) The HSCB should utilise the learning from this review in taking forward strategies identified in their 2011 section 11 audit and the current children and families transformation programme to improve agency understanding at operational level of thresholds for child protection and children in need (16.5.10-11). This should include ensuring staff in all member agencies are aware of and confident in escalating concerns about practice set out in section 18.5 professional conflict resolution of the pan London child protection procedures (16.4.3 and 16.5.6).

6.1 Recommendations for individual agencies

5) All agencies must implement the recommendations made in their Individual Management Reviews and provide an update on their implementation to the LSCB as required.

6) All agencies must take action to ensure that learning from this review is fed back to staff members who were involved and is effectively disseminated throughout all levels of their organisation.

7) CYPS should develop a model of authoritative practice in assessment and intervention with families based on the framework set out in section 6.41 of the final report of the Munro Review of Child Protection (16.6.6). This should specifically include the following points identified in this review:
ix. A clear mandate for engagement that requires and empowers families and individuals to change (16.6.7-12)
x. The importance of authoritative but compassionate engagement with families to ensure focus remains on the child (16.6.6-9)
xi. Evidencing, discussing and reflecting on any change in focus from child protection to child in need (16.5)
xii. A clear structure and appropriate chairing for child in need meetings to maintain focus on assessment findings and future work (16.5.3)
xiii. The importance of understanding family history (16.6.4)
xiv. Effective management of transition between case workers and teams to ensure no loss of focus or delay in action to protect children (16.5.4)
xv. Seeing assessment as a continuing process (16.6.4)
xvi. Reflective and challenging supervision (16.6.4-5)

8) In the light of findings from this review the community safety partnership should review the operation of the red and yellow card system to ensure that the

partnership is able to identify young people at significant risk and to engage appropriate agencies (16.7.5)

9) The local authority should ensure the social work emergency duty team evidence follow up of requests for welfare checks or recording why they have not been undertaken (16.5.14).

10) The DAAT should review the learning from this case in respect of Child F and Child K's alcohol and substance misuse and incorporate findings into its action plan. (16.7.6-7)

6.2 Recommendations with national implications

11) The LSCB chair should write to the Ministry of Justice to share learning from this review in respect of the responsibility of courts for considering children's well-being when hearing domestic abuse cases

12) The LSCB chair should discuss with the CDOP chair how to feed learning from this review about the impact of delay in Coroners' notifications into the current national debate.

7 Appendices

7.1 Recommendations from IMRs

MPS

1) Havering BOCU - Policy/Procedures: It is recommended that Havering Borough Operation Command Unit should review their current policy and procedures, to support the new Standard Operating Procedures regarding the allocation and investigation of Serious Personal Injury collisions.

2) Havering BOCU - Policy/Procedures: It is recommended that Havering Borough Operation Command Unit review their current policy and procedures on the investigations of sudden deaths, such as suspected suicides.

CYPS

1) The children and young people's audit programme will monitor the quality of assessments undertaken in children in need cases in the duty and safeguarding teams so that the issues of concern identified in this IMR are robustly addressed.

2) Management action will be taken to remedy any identified shortfalls and learning from these audits will be disseminated and measured to ensure that they impact on practice outcomes

3) Introduce an audit of supervision that will take account of the frequency and quality of reflective supervision and how this links to improved outcomes for children and young people.

4) The issues of the co-morbidity of domestic violence, substance misuse and mental health and their impact on the outcomes for children should be included in the CYPS training programme. The impact of this learning should be evaluated to measure its impact on practice and outcomes.

5) Establish dedicated and consistent resources to work with vulnerable teenagers who may be at risk of harm

Learning and Achievement

Record Keeping

1) Schools to ensure that their Nominated Child Protection Coordinator (NCPC) maintains clear written records of all contacts with agencies about a child or children and that this information is shared with key staff in school on a need to know basis.

2) Schools to ensure that these records are available for review or transfer when an individual moves from post or is absent from school for a significant period of time due to ill health.

Information Sharing

3) To ensure that the Additional Needs and Provision Partnership (ANPP) is supplied with all relevant information about the child they are reviewing, including contacts with other agencies.

4) Alternative education providers to be made aware of all relevant information about a child/young person prior to the commencement of their placement.

Referrals

5) To make schools aware that if a child has previously been subject to a Children's Plan or a CIN process and behavioural problems are linked to family concerns then the school should inform Children's Services.

6) The use of the CAF by schools to be reviewed to identify why they may be reluctant to use the process and the issues identified to be addressed to ensure that the CAF is used to support multi agency working.

BHRUT

1) All staff to be made aware of key DV support services and referral pathways through training and provision of resource packs. This will enable staff to provide basic support and referral to appropriate services, and to be alert to the welfare of children in the family.

2) Generic DV posters and leaflets to be displayed in A&E areas to signpost victims to DV support so that they can make contact with DV services when it is safe for them to do so.

3) Discussion about the commissioning of a DV service in A&E, as an expansion of the existing BHRUT DV Maternity Service, to develop DV policy, procedure and protocol. This would enable a change in culture through training and leadership so that staff are alert to addressing not just the presenting issue / injury but also to considering the background issues, such as frequent attendances and concerning incidents in patient's previous attendance, and are confident in enquiring and referring for support.

4) Symphony database to be reviewed to include the reason for previous attendance at A&E, alongside the dates of attendances. Simple one word reasons, such as 'overdose', 'self harm', 'intoxication', on display on the front page of the system, would provide a readily available alert to staff, of any recent concerning attendances.

5) The use of a psycho social and safeguarding assessment tool for young people should be introduced for use in A&E. Amendment to the FRAMED checklist (Royal Free Safeguarding Team, 2010) will ensure that a holistic view of the child / young person's life is documented, which includes details on family, relationships, alcohol, mental health, education and employment, and the use of drugs.

6) Key staff who work with families, particularly front line staff such as those in A&E, should have child protection supervision on a formal and regular basis. This will enable them to reflect and improve on their practice, in a supportive environment, with the aim of achieving better outcomes for children.

NELFT

1) Clear guidance is given to NELFT that RIO is the system for recording service user information.
2) The use of RIO is audited. Through the process determine an action plan to ensure compliance.

3) Clear guidance is given to teams within NELFT to communicate with each other to promote the welfare of children

4) To develop greater understanding and communication between adult services and CAMHS

5) To enhance understanding, responsibility and action to promote children's welfare through early intervention.

6) To develop better communication between Children services and adult inpatient services.

ONEL CS

1) NELFT must ensure that staff are aware of the need to always act in the best interests of the child, assess the needs of the child in the context of their family history and understand the need for access to a protective adult

2) NELFT should remind practitioners of the importance of seeing and listening to children when there are concerns about their welfare

3) NELFT must ensure that staff are aware of the supervision policy and adhere to it in daily practice

4) NELFT must ensure that practice is sensitive to racial, cultural, linguistic and religious identity and any issues of disability of the child and family

5) NELFT should review its DNA policy for missed appointments to ensure that it is robust and offers guidance to school nursing staff when drop in sessions are not attended

6) NELFT should ensure that all staff are aware of their roles and responsibilities when escalating concerns when there is a professional disagreement

7) NELFT should commission a training package on the toxic trio – domestic abuse, drug and alcohol misuse & parental mental illness

NHS Havering GPs

1) NHS Havering should urgently meet with Practice 1 to discuss the concerns identified in this report. NHS Havering should develop an action plan to assess clinical quality in the practice with a view to a general improvement in standards. The issues to be addressed include the generic concerns about clinical standards. In addition to this, an assessment should be undertaken in relation to GP1's knowledge of safeguarding practice and her general understanding of the mental health issues commonly seen by GPs.

2) NHS Havering should ensure that it has an effective programme for safeguarding training for its GPs. It should assess the training to ensure that it can be reasonably certain that the level of competence achieved at the end of the training is satisfactory. GP practices to undertake the RCGPs child protection training Levels 1, 2 & 3

3) NHS Havering should arrange for GP1 to undertake a clinical audit around the prescribing of hypnotic drugs. Once the audit is completed, an appropriate clinical review should be offered to any patient considered to have inappropriate prescribing of hypnotics.

4) NHS Havering should ensure that GP1 addresses the issues of inappropriate prescribing for individual patient(s) identified in this report are addressed by inviting the patient(s) in for an assessment and referral to the appropriate specialist service.

5) NHS Havering should meet with Practice 2 and 3 to discuss the overview report and plan a learning event to address the issues identified in it

LAS

1) The Trust should provide feedback to the staff involved.

2) The Trust should highlight the circumstances in the Trust's internal magazine; personally issued to all Trust staff, so to draw attention to the need to make a referral in these circumstances.

Health Overview

1) Risk assessment pro-forma to be developed and rolled out to GP practices

2) Within all health organisations there is a need to strengthen the quality of supervision in line with national guidance (Working Together 2010 and Intercollegiate guidance 2010) and better staff support as ways of promoting professional judgement or supporting reflective practice

3) Medical Director and Designated nurse (NHS ONEL) should meet with Practice 1 to discuss the concerns identified in this report and develop an action plan to assess clinical quality in the practice with a view to a general improvement in standards.

4) All staff to be made aware of key domestic violence support services and referral processes.
5) All health agencies to review their escalation policies for safeguarding of children and vulnerable adults and contact details of designated and named safeguarding staff to be circulated.