BARNET SAFEGUARDING CHILDREN BOARD

Serious Case Review concerning child A

Born: February 2002

Died February 2015

Independent Author: Dr Russell Wate QPM

Contents

1.0 Introduction

1.1 Child A was born in 2002, the first of two children of her mother Adult A with whom she lived.

1.2 Adult B is the father of Child A who had only recently come back into her life in 2014 having been absent from 2004 following his conviction for neglect in relation to Child A. Both parents had issues regarding their mental health with domestic abuse also featuring in their relationship. Child A had a half-sister who shared her mother and was born just less than 5 months before her death. Adult A and the father of her half-sister had separated before the birth.

1.3 Child A in her early childhood had been placed on a child protection plan (in another Local Authority to Barnet) which included living with her maternal grandmother following the physical abuse by her father. There had also been an allegation of sexual abuse on her by a maternal uncle, again at a young age in 2006 whilst in the care of her maternal grandmother.

1.4 On 2nd February 2015, aged 12 years (two days before her 13th birthday) Child A was found unconscious with a ligature (her school tie) around her neck in an area of woodland. She was taken to hospital after paramedics and crew of the air ambulance had attempted resuscitation for some time but sadly life was pronounced extinct shortly after her arrival. It appeared that Child A had tied herself to a tree but subsequently cut the ligature with a pair of scissors resulting in her falling face down onto the ground. The cause of death was recorded as 'consistent with a ligature compression of the neck'.

1.5 During the examination of the bedroom of Child A a notebook was found containing a number of handwritten notes addressed to a number of people, including her parents, which supported the possibility that Child A intended to take her own life.

1.6 An inquest regarding the death of Child A was held at London (North) Coroners Court on 4th August 2015 at which the HM Coroner recorded an Open verdict.

1.7 Prior to her death Child A had exhibited signs of deliberate self-harm and also suicide ideation. These behaviours had been acknowledged by the mother of Child A (Adult A) Who over the period of the review had contact with her daughter's two schools (School 1 and The School 2), Barnet Family Services Children's Social Care and her GP who made a referral to Barnet, Enfield, Haringey Mental Health (NHS) Trust (BEHMT) who arranged for Barnet's Child and Adolescent Mental Health Services (CAMHS) East team to work with Child A.

1.8 Child A was resistant to attending appointments with CAMHS but was spoken to at her home by a CAMHS clinician to whom she shared limited information on one occasion.

1.9 Other factors present in the life of Child A at this time in addition to deliberate self-harming and suicide ideation related to bullying including cyber bullying. There was also the transition to secondary school and subsequent transfer between secondary schools. A significant further factor was the re-appearance of her father in her life who was subject to supervision under s.41 Mental Health Act 1983 by the NE London Mental Health Team.

1.10 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in

relation to serious case reviews, namely:
5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
(2) For the purposes of paragraph (1) (e) a serious case is one where:
(a) abuse or neglect of a child is known or suspected; and
(b) either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The Independent Chair of the Barnet Local Safeguarding Children's Board (BSCB) commissioned this review and asked Russell Wate to undertake the SCR. Chris Miller (Independent BSCB chair) attended a Serious Case Review Panel meeting and the Panel agreed the scope of the review and identified key lines of enquiry, timescales and identified the agencies that would be required to provide a chronology of their involvement and an Individual Management Report (IMR).

1.11 The timescale for the review was agreed to cover the period she started at secondary school (01/09/2013) up to the date when Child A died (02/02/2015). Significant events dating back to 2004 have been considered if relevant.

The review involves Child A.

Born: February 2002. **Died** 2nd February 2015

Relationship to Child A	**Name**	**Date of Birth**
Mother	Adult A	September 1981
Estranged partner of Mother and father of Child A	Adult B	May 1973
Sibling (half-sister)	Child B	September 2014

2.0 Terms of Reference

2.1 The purpose of this review is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are both within and between agencies and how they will be acted upon and why any failings leading to these lessons occurred.

- Improve multi-agency working by ensuring lessons impact positively on practice whilst understanding the root cause of the problems.

2.2 Particular focus will be made towards:

- The decisions made in relation to how concerns regarding Child A's deliberate self-harm and suicide ideation were managed and acted upon
- The part bullying (including cyber bullying) played in the events leading up to the death of Child A and how the concerns raised were managed
- The transition of Child A to secondary school and subsequent transfer between secondary schools
- The family including the father of Child A and his supervision under MAPPA (Multi Agency Public Protection Arrangements)
- Child in Need procedures in relation to Child A
- Joint agency working including information sharing between professionals and agencies
- Advocacy/Support services
- The tracking of the family which moved between several London Boroughs

2.3 The Key Lines of Enquiry for the review will be:

- Were there any communications failures between professionals working with children and/or adult's services and why did these failures occur?
- Were the risks (current and historical) clearly understood and was the risk level to Child A appropriately identified?
- The supervision and recording of information
- Were there any cross boundary or inter-agency communications failures?
- Was the multi-agency response to concerns of Child A's deliberate self-harm (DSH) and suicide ideation robust enough? Were the risks understood and was available information acted upon?
- Are there any specific issues around ethnicity, religion, diversity or equality that may require consideration?

2.4 Contributors to the review

A number of agencies have contributed to this review as follows:

- North East London (NHS) Foundation Trust (NELFT)
- Barnet, Enfield, Haringey mental Health (NHS) Trust (BEHMHT)
- Central London Community Healthcare (CLCH)
- General Practice Barnet (Primary Care Barnet) (GPB)
- London Ambulance Service (NHS Trust) (LAS)
- Metropolitan Police (MPS) Specialist Crime Review Group (SCRG)
- Friern Barnet School (FBS)
- Wren Academy (WA)
- Barnet Family Services Children's Social Care (CSC)
- Royal Free London NHS Foundation Trust (RFL)

2.5 Independent author

Barnet LSCB made a decision to appoint an independent author to carry out the review. The review is supplied by RJW Associates and the lead reviewer is Dr Russell Wate QPM MSc. He

is independent of any agency within the Barnet area. He is a retired senior police detective, who is very experienced in the investigation of homicide and in particular child death and child neglect issues. He has contributed to a number of national reviews, inspections and inquiries, as well as being nationally experienced in all aspects of safeguarding children and public protection. He has carried out a large number of SCR's and is also an independent chair of an LSCB.

2.6 Methodology

The review took the format of the LSCB inviting all appropriate agencies to submit a chronology of significant events and an Individual Management Report. After these were collated and considered the management report authors and key practitioners attended a meeting on 6th July 2015 chaired by Russell Wate. This meeting had a good multi-agency attendance and valuable and honest contributions were made by all agencies. Analysis then took place of the findings and after requests for further information from certain agencies; a report was completed for sharing and presenting to the SCR subcommittee for comment, prior to submission to the Safeguarding Board.

3.0 Summary of the facts

3.1 The following section aims to provide a picture and the voice of the life of Child A, her mother Adult A as seen through their interactions with professionals from various agencies.

3.2 Although not within the specific timeframe for this SCR the following earlier significant events are included as they hopefully provide background information and context which may have/or could have had an effect on subsequent events and decision making processes that are within the specified time frame for the SCR.

Pre- SCR timeline events

3.3 Child A was born in February 2002, at that time her mother Adult A was 20 years old and her father Adult B 28 years old.

3.4 In January 2004 Adult B took Child A to hospital with a serious physical injury which was determined to be a non-accidental injury for which Adult B was convicted of wilful neglect (8.2005). As a result of this incident Child A was subject to a child protection plan (CPP) under the category of physical abuse managed by Hackney CSC and initially went into the care of her maternal grandmother. Around this time Adult A also disclosed to CSC that she had been subject to domestic abuse from Adult B and told her mother, that she had used 'crack' cocaine.

3.5 In 2006 an allegation was made to police that Child A had been sexually assaulted by her 15 year old uncle. There was insufficient evidence to progress the investigation and no further action was taken. However, at this time Child A left the care of her maternal grandmother. Child A's CPP was transferred to Lewisham CSC when Adult A was placed in a refuge in that area.

3.6 Whilst subject to the CPP Child A was in the care of Hackney Children's Services and then Lewisham Children's services.

3.7 In 2008 (23/12/2008) Adult A presented to Barnet CSC as depressed. Adult A asked for Child A to be placed into care. Barnet CSC organised for Child A to be placed within the family with

her maternal aunt. On the 09/01/2009 Adult A mood stabilised and it was decided that the plan should cease and on 03/03/2009 the case was closed as the family were deemed safe.

School transition

3.8 On the 23rd September 2013, Child A joined school 1 and was placed in a form with students she knew from her previous primary school. Adult A had wanted Child A to attend the school 2, but had been unsuccessful in her application; albeit Child A was placed on a waiting list should a vacancy subsequently become available. London Borough of Barnet (LBB) informed School 1 that Child A was officially on their roll in September itself as they had allocated Child A to another school in the Borough which Adult A definitely didn't want her to go to. Child A had attended a mid-term admission meeting with her head of year at school 1 on the 18th September 2013 but had not had the opportunity to participate in the usual pre-transition activities whilst at Primary School. This was due to this late start to her first term.

3.9 On the 23rd January 2014 Adult A had a new partner and had become pregnant. Adult A had become depressed and her midwife made a referral to CSC in relation to the unborn baby and Child A. The assessment deemed that the new baby and Child A were not at risk from the new partner. This assessment was marked NFA on 23.03.14.

3.10 On the 20th March 2014 Child C was involved in a violent fight after school. As a result of the fight Child A was excluded from School. On the 26/27th March 2014 (the exact date is unclear) Child A and mother Adult A attend a Return from Exclusion meeting at School 1 following the fight.

3.11 On the 31st March 2014 Child A and the other girl involved in the fight took part in a Restorative Approach meeting led by the pastoral support manager at School 1. Both signed an agreement form and no other incidents between them were reported at the school to staff.

Father back into Child A's life

3.12 In May 2014 Adult B the father of Child A who was under the care of a Mental Health Team (MHT) and lived in a semi-independent care facility in Waltham Forest Borough and under multi-agency public protection arrangements (MAPPA). Adult B failed to notify police that it had been agreed with the MHT that he could spend 3 days a week at Child A's address and stay overnight. The MHT had discovered that Adult B had been visiting and staying overnight, so they met with him to give him a structure to his visits with a chart, to which Adult B agreed. The MHT also notified CSC and Jigsaw team. Police (Jigsaw team) spoke to Adult B and reminded him that as a Registered Sex Offender (RSO), he had a requirement to register any address that he resides. For this breach he was given a verbal warning. He completed the necessary paperwork & registered Child A's home address as an additional address. Adult B told police that he was not in a relationship with Adult A and was just staying at her address in order to have a relationship with his daughter. He stated he had not been a part of his daughter's life for almost 10 years. A police child concern form was completed and shared with Barnet Children's Social Care.

(Note: In December 2009 Adult B was arrested for sexually assaulting a female not known to him. He was charged, pleaded guilty and was sentenced to a Hospital Order under Section 41 Mental Health Act and a Sex Offenders Notice for life. As a Registered Sex Offender (RSO) he was subject to conditions for life).

A psychiatrist described Adult B as suffering from a mental disorder; diagnosed him as a paranoid schizophrenic and that he required urgent hospital treatment.

Following Adult B's release from hospital, he was subject to Multi Agency Public Protection Arrangements (MAPPA) and assessed as a level 2 subject. Therefore, all agencies were involved in his ongoing risk assessment. Adult B was subsequently assessed as a level 1 subject, therefore no longer subject to multi agency meetings, but managed by the Mental Health Team (MHT), and monitored by the Police Public Protection Desk (PPD).

As a level 1 subject, Adult B would be visited by the PPD, with the onus on him to advise police where he resided and any significant changes to his lifestyle.

Self-Harm

3.13 On the 28th July 2014 Child A attended her GP with mother Adult A who had noticed scarring on the arms and legs of Child A. Child A was examined and scarring on arms noted. It was also noted by the GP that Child A had previously been on a child protection (CP) plan. The GP made a referral to Child and Adolescent Mental Health Services (CAMHS) on the same day.

3.14 On the 29th July 2014 CAMHS referral from GP dated 28.7.14 was received and uploaded onto RIO (their case management system) and received into Barnet CAMHS single point of entry system. There was limited information on the referral which did not mention any previous involvement with a social worker.

3.15 On the 31st July 2014 Child A was recognised by CAMHS as vulnerable, and a priority appointment was recommended.

3.16 On the 7th August 2014 at a CAMHS CAPA (Choice and Partnership Allocation) meeting Child A was allocated as a priority, and an appointment of 21st August 2014 offered. The administration unit were unsuccessful in their attempts to reach mother Adult A by telephone to offer an appointment.

3.17 On the 8th August 2014 a letter was sent to family offering an appointment on 28th August 2014.

3.18 On the 15th August 2014 CAMHS and Social Care Consultation meeting (a normal process that takes place in Barnet) (seen as good practice by the review, and something that the Borough should strive to ensure continues) took place with the allocated social worker (SW) for Child A. After the consultation the CAMH clinician requested that social services keep the case open and also requested an update from SW on any forensic psychiatric assessment of father Adult B.

3.19 On the 22nd August 2014 mother Adult A contacted the CAMHS clinic explaining that she was not able to get Child A to attend her appointment on 28th August 2014. The allocated clinician suggested and offered a home visit to see Child A(this was seen as good practice by the review). The Clinician advises the SW of their contact with mother Adult A and plan to carry out a home visit. The SW advised the clinician that the case would be closed.

3.20 On the 1st September 2014 Child A returned to school in Year 8.

3.21 On the 4th September 2014 a home visit was made by the CAMHS clinician to see Child A. They spoke with Child A and mother Adult A together and also separately. The clinician agreed to offer a further appointment in October 2014. Although the recording of the risk assessment was not completed on RIO (Electronic system) the narrative throughout does show consideration of risk at all stages.

3.22 On the 25th September 2014 Child A attended her GP with Adult A complaining of abdominal pain and the GP referred her to A and E with appendicitis. Child A attended the Barnet Hospital where the decision was made to admit Child A to the Children's ward and theatre on 26th September 2014. Adult A stayed with Child A throughout the day but stated she was unable to stay at the hospital overnight as she had her young baby at home.

3.23 On 26th September 2014 Child A had her appendix removed satisfactorily. That evening a student nurse looking after Child A attempted to take the blood pressure of Child A using her left arm but Child A became anxious. The nurse noticed cuts and scratches down the left arm which appeared to her to be deliberate self-harm (DSH) marks. The student nurse raised her concerns with both the night nurses and the nurse in charge. The staff nurse also attempted to see if she could see DSH marks when taking Child A's blood pressure later. The student nurse made an entry in the notes which was countersigned by the staff nurse as required by guidelines for trainees. The notes do not name the individuals the student nurse made her findings known to or if Adult A was present or aware when the marks were noted.

3.24 On the 27th September 2014 the care of Child A was taken over in the day by a nurse who didn't record in the notes any mention of DSH marks. Child A was reviewed by the surgical team which included the completion of a discharge summary by a junior Doctor. This was sent to the GP and included a discharge plan in which there was no mention of the possible DSH marks. Child A discharged from hospital. There is in place regular liaison between the hospital's paediatric department and the CAMHs liaison team, members of the medical teams know about this weekly forum and make use of the opportunity. However, the surgical team currently do not.

3.25 On the 2nd October 2014 Barnet Children's Social Care (BCSC) contacted School 1 and spoke to the deputy designated safeguarding lead regarding the attendance and behaviour of Child A to establish if they had any concerns. School 1 informed SW that no concerns had been raised and that all absences had been authorised. (The fight and exclusion in March 2014 was not mentioned).

3.26 On the 3rd October 2014 CAMHS sent Child A and Adult A letter for follow up appointment on 23rd October 2014.

3.27 On the 13th October 2014 Child A seen by GP with mother Adult A to review appendix scar - noted wound healed and scar tissue clean. No mention made of DSH marks.

3.28 On the 21st October 2014 at school, Child A reported an incident regarding her and two other students who had received inappropriate contact on their phones from an older unknown male. Child A deleted the unknown male from her phone and communicated clearly with staff that she understood the dangers of speaking to people online that she did not know. The police were called and the two other students phones were taken and further investigated by police, but because of Child A's early actions with her phone it was not taken. The school's procedure in these situations would be to notify Child A's mother but there is no record that this took place as these are not kept on file.

3.29 On the 23rd October 2014 Child A and mother Adult A did not attend (DNA) their appointment with CAMHS.

Moves schools

3.30 The 24th October 2014 was Child A's last day at school 1 as she was moving to school 2. The school had not been notified. Child A had mentioned she was moving but the information was not acted upon by the school as it had not been confirmed.

3.31 On the 3rd November 2014 the day Child A started at school 2 Child A made an allegation within this school that she had been bullied at school 1 this was referred to Head of House who worked with Child A's form tutor to help her settle in.

3.32 On the 5th November 2014 school 1 sent Child A's file to school 2 having confirmed she was now on their roll by the Pastoral Support Officer contacting them directly.

3.33 CAMHS sent a final letter dated 8thNovember 2014 (copied to GP- there is however no record of this letter in Child A's GP records) acknowledging DNA and inviting mother (Adult A) to make contact within 2 weeks before closure of the case if no reply. Information regarding youth counselling was provided.

Missing from school and cyber bullying

3.34 On the 5th January 2015 Child A was truanting from school. Adult A was aware and spoke to Child A on her phone. School 2 attendance officer made an internal child protection referral which led to a Social Services referral (who closed the case on 12th January 2015).

3.35 On the 6th January 2015 Child A truanted again. Adult A called Police to report Child A missing on the advice of WA. The school had contacted Adult A to inform her that Child A wasn't in school. Child A had done the same thing the previous day but Adult A hadn't reported her missing as Child A had her mobile phone with her and Adult A was able to contact her. Adult A stated that Child A had recently moved secondary schools because she was being bullied at the previous school. Police conducted a search and found Child A walking in the Barnet area. She stated that she missed her old school friends and the new school was strict. Police reported that Child A appeared street wise, there was no evidence of third party involvement and no concerns reported for her safety and welfare. A police concern form was completed and shared with Barnet Children's Social Care.

3.36 On the 24th January 2015 the Deputy Designated Safeguarding Lead at school 1 phoned the school 2 to inform them that Child A was involved in a group chat (social media) that was threatening and intimidating.

3.37 On the 26th January 2015 the school informed the child protection (CP) officer at school 2 that Adult A had been invited to meet with Head of House. This meeting took place on the 29th January 2015 where Child A behaviour towards school 1 students was discussed along with her settling in at the school 2.

Child A dies

3.38 On the 2nd February 2015 Police received a call from a member of the public stating they had found a young girl face down in Coppetts Wood, Barnet. This girl was Child A. Police attended the scene and attempted resuscitation on Child A. London Ambulance Service (LAS) and the London Air Ambulance attended and transferred Child A to North Middlesex Hospital. Life was pronounced extinct at 11:22hrs.

3.39 A friend of Child A stated she had been with Child A that morning and Child A had stated she wasn't going to go to school but was going to go to Central London. She stated that Child A had told her she had had her mobile phone taken away from her as she had been grounded. The police shared this information with Barnet Children's Social Care.

4.0 Analysis of significant safeguarding events

4.1 This review was helped greatly by the IMR authors, firstly by their reports and chronologies. The review author also thanks the practitioners who attended the workshop, in some cases still contributing to try and provide learning. The review has also really benefited from the work of the SCR panel.

History - the Family Background in relation to Child A

4.2 Adult A, the mother of Child A, as a child had suffered physical and emotional abuse. She had been in care from aged 15 years. As an adult she had disclosed abuse by her step father in her childhood which resulted in him being convicted. Adult A has no criminal convictions but was reported in the past as having used crack cocaine and cannabis and living a chaotic lifestyle. In her relationship with Adults B, the father of Child A, she suffered severe domestic abuse by him (Child A was also in the household). Low mood and depression also featured in her history including asking in 2008 for Child A to be taken into care during one of these periods of depression.

4.3 Adult B, the father of Child A, was seven years older than Adult A. He had a number of criminal convictions which included violent offences and one sexual offence. In 2004 he was convicted of child neglect in relation to Child A who had sustained serious burns which necessitated a two week stay in hospital. The sexual offence was on an adult stranger and as a result in 2010 he received a hospital order (section 41 MHA 1983) and registered as a sex offender for life (RSO). When released from hospital 18 months later he was initially classified as a MAPPA 2 subject that was subsequently reduced to low risk MAPPA 1[1]. In May 2014 it had become known that he had made contact with Adult A and Child A and was staying 3 days a week at their home. This was in breach of his RSO which required him to notify any change of address. He received a verbal warning in relation to this. Both Adult A and Child A had been wanting for some time to get back in contact with each other. It has not been confirmed but Adult B himself says that they had been meeting for a lot longer than this.

[1] The Criminal Justice Act 2003 ("CJA 2003") provides for the establishment of Multi-Agency Public Protection Arrangements ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

4.4 As stated above Child A had been physically assaulted by her father in 2004 when very young (2 years). The injuries included burns which left significant lifelong scarring. At that time she spent 2 weeks in hospital during which time she was rarely visited by her mother Adult A. Child A was placed on a child protection plan (CPP) part of which involved living with her maternal grandmother. In 2006 (aged 4 years) an allegation was made that Child A had been indecently assaulted by a 15 year old which was investigated by the police but resulted in no further action being taken due to the lack of evidence. Child A however stopped residing with her maternal grandmother and was reunited with Adult A who was in a refuge in Lewisham. In 2005 the CPP had ceased and Child A and Adult A were re-housed in Barnet. Adult A was under the impression that a referral would be made to Barnet for support but no referral was received. There is little information in relation to what was done from a safeguarding perspective at this time. The family also moved between Boroughs i.e. Hackney to Lewisham and then Barnet involving three different children's social care departments. In 2008 Adult A presented to Children's Social Care in Barnet as severely depressed and asked for Child A to be placed into care. Whilst Adult A recovered Child A was placed in the care of her maternal aunt under a Child in Need (CiN) plan.

4.5 These significant events although outside the specified time frame for the SCR clearly contain the presence of important risk factors e.g. domestic abuse, drug taking, mental illness, physical abuse, neglect, criminal convictions, violence, sexual abuse, placed into care and separation that impacted in some way on all members of the family. It also set the context from which the events of the death of Child A evolved. It is therefore important information that should have been communicated between the multi-agency partners who had contact with Child A and her family. It appears that not everyone involved with Child A was aware of all the information or its relevance when considering whether to share the information. This will be mentioned more specifically later in this section. The review author is not able to say if at all, any of this family background impacted on Child A, it is clearly of significance in knowing what life had been like for her growing up.

4.6 Linked with the relevant history of Adult B in May 2014 Waltham Forest Public Protection Desk (PPD) were advised by the Mental Health Team (MHT) supervising Adult B information that Adult B was staying at the home address of Child A and Adult A three days a week and every other Sunday. As this was not one of Adult B's registered addresses he was in breach of the Sex Offenders Order imposed on him. The PPD visited Adult B and verbally warned him for failing to register an additional address. Adult B pointed out that the Sex Offenders Order required him to notify his addresses but did not prevent him from visiting his daughter. The PPD shared the information regarding Adult B visiting his daughter with Barnet Children's Social Care (BCSC). As Adult B was considered a level 1 low risk registered sex offender (RSO) both the PPD and MHT felt that they had satisfied their statutory requirements by completing this course of action and informing BCSC.

4.7 As said above it is possible that the family history listed above had a long-lasting negative impact on Child A and on Adult A, it certainly included recognised risk factors. Adult A was raising concerns but having difficulty communicating with Child A which was compounded by the presence of Adult A's new partner and father of the unborn baby who Adult A was expecting, in September 2014. Before the birth Adult A and the baby's father had split up. Adult B was back in Child A's life, and whilst it appears he was present to re-establish his relationship with his daughter and there is no suggestion of any hostility shown to Adult A by Adult B.

4.8 In relation specifically to Adult B coming back into the life of Child A it appears that Adult B wanted to establish a parental relationship with Child A and likewise Child A wanted to be like her peers and have a father figure in her life. Adult B was stable and engaging with his MHT and whilst he was told there were issues with Child A regarding DSH and to slow down his contact with her, he as her father felt she needed more of his time and not less. Whilst a number of what could be considered negative factors were present, it is perhaps several factors being present rather than a single factor in isolation that created a negative effect. In isolation Child A's father being back in her life could have been having a positive effect at times (This was certainly felt by both parents when spoken to by the review author). The risk factors together with the circumstances i.e. Adult A new partner, Adult A pregnant, new addition to the family, Adult A and Adult B mental health and Child A perception of this (and how they might be affecting her mental state), issues with friends at school may have together had a negative impact on the psychological well-being of Child A having to cope with them all simultaneously with limited support.

Transitions and Secondary School

4.9 Adult A had wanted Child A to go the School 2 a church school but was allocated a place at School 1 in September 2013. However, Child A remained on the LA managed waiting list for WA.

4.10 School 1 were not notified that Child A was coming to their school until weeks after term had commenced and Child A didn't start attending until 23rd September 2013. Unlike the other students, several from her Primary School, she missed out on the transitional arrangements they had experienced. For example in June a visit by school 1 staff to their Primary School, information gathering in consultation with Primary school teachers and meeting with parents where expectations were shared, in July a taster day at school 1 to learn geography of school and tutor groups, in September on their first day just year 7 in school, produced a 'me' capsule and second day lessons on 'me and my community' all designed to help the students settle in well and quickly. However, Child A did attend the Mount team building day on the 23rd September and there was a settling in evening to which Child A and her Mother Adult A would have been invited. It is not known however if they did in fact attend.

4.11 Information on Child A was obtained from her Primary School through admissions and their pastoral support - although similar information it would have contained less detail than if school 1 staff had a meeting with the class teacher at the Primary School. Child A was not alone in this position; the intake for a year is 162 students of whom the school would expect to have seen in transition arrangements around 150 plus of those. School 1 also made a deliberate decision to put Child A in a form containing a lot of students she knew from primary school which seemed to have a positive effect with Child A settling in and appearing confident. In her first term there were no issues with Child A.

First referral to CSC

4.12 Between January and March 2014 Adult A was pregnant and the midwife made a referral to the hospital social work team in relation to Adult A, the unborn child and Child A. The reason for the referral was due to some of mum's history including domestic abuse. This was also because LA Adult A's new partner who had other children, was known to Social Services and

expecting another baby with a third female. A child family assessment was undertaken by a student SW supervised by a senior SW. There was little mention of Child A as the focus was on mum Adult A, her pregnancy, her partner and the unborn baby. The referral from the midwife was good and the student SW did a good job obtaining source documents from Hackney LA containing information that was not previously known by LBB about Adult A's past history. Child A was seen on 18th February 2014 by student SW and noted that she presented as 'confident, happy at home and school and not having problems'. This is in contrast to the school report which suggested Child A was anxious about the arrival of the new baby e.g. sharing her room and if the baby is a boy have to move and lose contact with her friends. Child A spoke of wanting to resume her relationship with her father Adult B so she could be 'like her peers' and commented that her mother Adult A was supporting her in this.

4.13 It was not unusual for a student SW to work in this way supervised by a senior SW but it appears the SW manager relied on the senior SW to supervise the student SW and refer to the SW manager if required. The SW manager could have more closely supervised the assessment process to ensure a more detailed assessment was completed in relation to Adult A. Although the review author fully accepts that the senior SW was/is very experienced, and is an advanced practitioner, which would have mitigated this needing to happen. The assessment focused on establishing whether the father of the new baby posed a risk of domestic abuse and concluded he did not. It was not an in depth assessment of Child A and appeared more of an add on rather than an integral part of the assessment. On the 23rd March 2014 the assessment was completed, and the file marked NFA 8th April2014.

4.14 On the 20th March 2014 Chid A was involved in an altercation outside school which has been referred to as Child A being bullied, but circumstances suggest Child A and the other girl were equally responsible. Circumstances of this incident were that a new girl was moved into Child A's class. An existing friend of Child A thought that Child A had chosen to be with the new girl rather than her which created friction between them. Child A apparently got two year 9 girls after school to approach her original friend and have a 'chat' with her about her attitude. Child A who was also present then got into a fight with her original friend. Teachers who brought the girls back into school were shocked at the level of violence by both girls. Child A had a gash on her face. Adult A attended school on 21st March 2014 for a meeting with the school for Child A to write a statement. Adult A was angry with the other girl but the teacher explained Child A was equally responsible and targets were set which Adult A signed. Child A and the other girl were both excluded from school for two days (24 to 26th March 2014) for physical assault and as they were in school uniform bringing the school into disrepute. The police safer school's officer was informed of the incident but no further action was taken. There were no further exclusions following this incident.

4.15 On the 23rd March 2014 SW manager signed off the assessment completed by the student SW and supervised by the senior SW but without having any professional discussions about the course of the case as they trusted the judgement of the senior SW. (as already stated above the senior SW was/is very experienced, and is an advanced practitioner, which may have mitigated this needing to happen). This signing off was at the time of the fight and what had been described as 'bullying' issues. If the SW manager had discussed the assessment and noted the minimal assessment of Child A she may have asked for Child A to be seen again for a more thorough assessment to be completed which would have discovered the 'bullying' incident and an opportunity to look at other underlying issues affecting Child A.

4.16 On 31st March 2014 Child A and the other girl involved in the altercation participated in a Restorative Approach meeting facilitated by the school. In the meeting they discussed how they felt, why it happened and identified ways to move forward both signing an agreement. Both students conducted themselves well in the meeting and were fine when they returned to form. The school considered that this was the correct approach.

4.17 CSC records state that checks were made with the school regarding Child A at around this time (23/1/14-23/3/14) which include that a) Child A had friendship issues and other girls have reported in school she had said on Blackberry Messaging (BBM) she "wants to kill herself and if she was gone no one would notice") b)Child A is normally quiet but has been in conflict with other young people who do not attend school - school state they are addressing this, and c) mother (Adult A) reports Child A has been assaulted by another girl from her school outside of school. It is not clear when this information was provided but appears to be connected with the assessment undertaken by the student SW working on the Hospital Social Work Team. At the Practitioner Workshop the staff from school 1 did not seem to be aware of this information their school had provided to the SW. However, it appears that CSC were aware of the additional concerns regarding Child A which reinforced, in the view of the review author, the need to carry out a more detailed assessment of Child A in March 2014.

Second referral to CSC

4.18 There is again some confusion between the records of agencies eg Police/Health/CSC as to when the information that Adult B had started visiting Child A was shared.

4.19 HELFT became first aware on the 23rd April 2014 when Adult B had gone missing 3 times from his supported accommodation. When spoken to regarding this by his Forensic Outreach Worker (FOW) who explained that they would have to share the information with CSC Adult B agreed that he would not stay at his daughter Child A's address until necessary checks had been made.

4.20 On the 22nd May 2014 NELFT records show 'contact has been made with social services' which is a month after the need to inform CSC had first been identified. The delay as recorded around 28th April 2014 stated that Adult B social worker (social supervisor) that they needed more information from Adult B's FOW regarding Child A's contact details prior to being able to share the information with CSC. There is a suggestion that there may have been a verbal sharing of information around this time but not recorded, so the overview author is not able to say it took place.

4.21 On the 28th April 2014 the FOW alerted the police supervising Adult B. The police IMR states that in May 2014 that Waltham Forest PPD was advised by the MHT that Adult B was staying at Child A's address. However the police child protection information record suggests the police record was made on 5th June 2014, noted again on the 19th June 2014 and also on this date mailed to LBB CSC.

4.22 CSC IMR from their records suggest that they received referral from the police on 23rd June 2014 but that there was no section 47 strategy discussion undertaken which was contrary to policy and procedure as required by 'Working Together 2015'. This referral was dealt with by the Duty Assessment Team (DAT). The first referral was dealt with by the hospital SW team. A Child and Family assessment was completed in July 2014 and Child A subject to a Child in

Need (CiN) plan under section 17 (No risk assessment appears to have been recorded). In the authors opinion had a multi-agency Section 47 strategy meeting been convened including for example Police, NELFT, Education, with CSC a much more complete picture would have become clear to all the agencies with responsibility for safeguarding Child A. The CSC IMR states this second assessment was not of a good enough standard. This raises issues of supervision and management oversight to ensure quality of assessment.

4.23 Between the 23rd June 2014 and 30 September 2014 the SW dealing with the referral described Child A as a "confident, bubbly" young person who is excited about the new baby and about contact with her father which commenced May 2014. The SW also states that Adult A is agreeing to supervise this contact and seems aware of the risks. She has reduced contact from 3 times a week to 1 saying this was too intense for Child A.

4.24 School 1 were contacted by the SW on 3rd July 2014 for information on Child A but were not told what the enquiry related to or provided with any information. This was contrary to the ethos behind information sharing to safeguard children. The school had more involvement with Child A than any other agency, they had information which assisted other agencies fulfil their roles but equally were entitled to information to fulfil their role and responsibilities. Information regarding Child A home environment, Adult B back on the scene, mental health issues concerning parents, Adult A expecting a baby with an absent father were all factors which would have helped them support Child A.

Deliberate Self Harm

4.25 During this period clear concerns were raised in relation to Child A. At school 1Child A asked to change form due to friend issues so a meeting with Adult A and Child A was arranged to discuss this and other issues on 21st July 2014 with the school. Adult A informed the school that Child A has been self-harming and has scars on her arms and legs. School 1 advised Adult A to take Child A to her GP for an urgent CAHMS referral. The school decided as it was only two days before the end of term that Adult A making referral would be much quicker. The school didn't believe there was sufficient time (before the end of term) for them to complete a CAF referral which they considered to be a cumbersome process as would require a CAF referral and consultation before CAHMS would take it. This was also apparently why the school didn't consult with their secondary project worker from CAMHS or contact CAMHS duty worker to explain the urgent matter.

4.26 On 28th July 2014 Child A attended GP with mother Adult A who had noticed scarring on arms and legs of Child A. Child A was examined and scarring on arms noted. It was also noted by the GP that Child A had previously been on a child protection (CP) plan. The GP made a referral to Child and Adolescent Mental Health Services (CAMHS) on the same day. On a positive note the GP identified the safeguarding concerns and made the referral immediately.

4.27 On the 29th July 2014 CAMHS received the GP referral and assessed by CAMHS ACCESS on 31st July 2014 who decided a priority appointment was required. On 7th August 2014 it was allocated to CAMHS East and an 'allocated clinician' at their allocation meeting. Initially an appointment for 21st August 2014 was offered and attempts made (not recorded) to contact mother by telephone then changed to 28th August 2014 and a letter sent to Adult A regarding the appointment. It was a 'priority' but in context Child A was not extremely high risk. There is a national issue regarding CAMHS capacity, however, it is down to local

definition of what 'priority' is. In Barnet this is defined as soon as possible within next few weeks, which aims to have an appointment within 13 weeks.

4.28 On the 15th August 2014 the allocated CSC SW for Child A independent of the GP referral attended a CAMHS CSC consultation to talk through concerns she had about Adult A succeeding in helping Child A. There was no formal written record of the meeting but both parties made their own notes and agreed a plan. In this case it was for CAMHS to see Child A and the SW to keep the CiN plan for Child A open but to update CAMHS with any developments. The concept of these consultation meetings, which also include difficult to engage cases, is good practice but written records need to be maintained particularly including details of any agreed plan. Options for recording could include a joint note of the consultation, contemporaneous notes entered directly onto a computer including the plan, or individual notes but jointly agree a written paragraph that could be emailed to the specific SW involved. (This is now in place.)

4.29 This promise of communication to CAMHS by the SW did not materialise in this case but the SW did note subsequently that Adult A reported that Child A refused CAMH support and felt she could talk to friends, teachers or her. SW recorded that Child A may need emotional support in the future given the historic risk factors and suggested Adult A contacts her GP should this be required. In addition SW recorded that Child A's room was very messy and that father of the new baby is recorded as telling the Social Worker that Adult A is depressed again and not opening the curtains/tidying the house. SW did not assess Adult A as depressed. SW included that school report Child A was doing well, but this is in contradictory to the fact that on 31st July 2014 Adult A had reported that Child A had self-harmed by cutting her arms two weeks previously and mother had agreed a CAMHS referral.

4.30 In the absence of a section 47 enquiries or a robust multi-agency CiN process there seems to have been great reliance placed on Adult A to manage the situation on her own by the school and CSC. However, Adult A clearly had issues in her life which were having a negative impact on her ability to do this e.g. pregnant, absent partner, depression. This option relied on Adult A to make things happen on a voluntary basis whilst if a Section 47 process had been in place with CSC it would have had 'more teeth'.

4.31 Because of the reluctance of Child A to attend CAMHS the allocated clinician offered to make a home visit which was accepted and took place on 4th September 2014, the day before Child A returned to school. This worked well with the clinician able to engage both Child A and Adult A separately and individually during the visit. Child A appeared to be in a better mood and no current worries were identified. Child A was also confiding with the girl next door. They agreed to monitor the situation and endeavour to have another meeting in October 2014. This type of visit is not usually offered but the clinician identified that this would help them to engage with Child A and should be seen as good practice, and something that the CCG should seriously consider commissioning. A recommendation made later on in this as learning from this review.

4.32 Child A returned to school in year 8 in September 2014 but had a number of absences due to abdominal pain which culminated in her being admitted to hospital to have her appendix removed. Whilst in hospital a student nurse noted deliberate self-harm (DSH) marks on Child A which she recorded and also notified to a qualified staff nurse. Whilst Child A was a patient on the ward she was under the care of the surgical team, who were responsible, for completion of a discharge summary. This was sent to the GP, it included a discharge plan for post-operative care it did not mention of the possible DSH marks. Child A was discharged

from hospital. The student nurse did well to identify and report her concerns but the review author is of the opinion that paediatric services in the hospital should have been informed and had some oversight of all children and young people when being treated by another speciality. The overview author has been informed that this process is now in place.

4.33 On 30th September 2014 the SW closed the case (this is only four days after the DSH on CHILD A was seen) after telephone conversation with CAMHS, even though there is no record on the CSC records of the outcome of the CAHMS consultation. Child A is not seen again by SW and no risk assessment is completed, the feedback to the review from CAMHS was that the case should be kept open. The CiN plan had focused on Child A summer activities and contact with family members, but made no mention of concerns regarding Child A's emotional health needs, how the situation would be monitored or followed up. Supervision was noted by CSC IMR as task orientated. The review author has reviewed the current CiN procedures for Barnet and is of the opinion that these were not adhered to in this case (even though it probably should have had a section 47 strategy discussion at the point that it was known that Adult B was back visiting Child A). A main concern is the lack of CiN meetings either initial or review, and no tangible CiN plan. Reassurance and an update and re-launch of these procedures is a recommendation made later on in this report as learning from this review.

4.34 On 2nd October 2014 deputy safeguarding lead was contacted again by SW gathering information who again did not disclose why they were asking for this information. Reason for enquiry was linked with Adult B being asked by his NELFT to slow down contact with Child A on the advice of the SW. School 1 should have been told this reason as information it would have been useful for them to know in safeguarding Child A.

4.35 On 21st October 2014 Child A and two other students had inappropriate contact from an unknown male on their phones. Child A deleted the unknown male from her phone and communicated with staff that she understood the dangers of speaking to people online she did not know. The matter was dealt with by the school in relation to Child A and by the police in relation to the other two students. No record that Adult A was contacted regarding this as those calls not kept on file. Child A acted responsibly in relation to this incident which links in with some comments made by staff from school 1 that Child A was an "eloquent, bright and intelligent girl", " strong minded and did not struggle to put her view across", and " a big character, very vocal".

Transfer to School 2

4.36 Child A's last day at school 1 was 24th October 2014 although Child A had told her class mates and teachers they did not respond to the information as it had only come from the child and not been confirmed. School 1 stated that they had not been informed by either the Local Authority or Adult A. They followed this up after half term break but awaited confirmation from school 2 that Child A had arrived.

4.37 Child A had told school 1 that she was leaving because it was what her parents wanted but that she didn't want to leave. Adult A told the review that Child A had been on the LA waiting list and moved because a vacancy had become available. Adult A had apparently told school 2 that peer group relations were having a negative effect on Child A. On her first day at school 2, the 3rd November 2014 Child A told a member of staff that she had been bullied at school 1. This allegation was referred to the head of house who worked with Child A and her form tutor to help her settle in.

4.38 The process explained to the review author was that the LA makes the school aware of a student transferring to them and then that school is responsible for informing the previous school. The child remains on their current school roll until the new school confirms in writing that the child is now on their school roll. This is to ensure that it is known where the child is at all times and does not get lost between schools if they don't subsequently arrive at the new school but leave the old one. It was suggested that there should be specific time lines and checks established to be undertaken in relation to this transfer process between schools by the LA.

4.39 On 23rd October 2014 Child A had not attended her appointment with CAHMS and this should have been dealt with as a DNA (did not attend) instead it appears to be have been dealt with as a concerning DNA, instead it appears to have been dealt with as a non-concerning DNA. A letter was sent to the family dated 8th November 2014 acknowledging that they had not attended and inviting Adult A to make contact within the next 2 weeks or the case would be closed but they could use the GP or school to re-open the case. This placed a lot of responsibility and liability on Adult A especially when CAHMS were already lacking information on the other risk factors present (e.g. DSH marks noticed at hospital by nurses on 26.9.14) because of poor information sharing between the agencies. Child A should still have been seen, but because of the paucity of information available to them there were 'not enough alarm bells' ringing. The quandary CAMHS faced was that Adult A did not present as uncaring and Child A was clear she did not want to go to CAMHS - what should they do instead? In the authors view this could have been a trigger for a referral to CSC under Section 47 had all the information about earlier concerns been put together. There is now in Barnet a form that school nurses fill-in that includes the pupil's wellbeing that may have highlighted Child A.

Truanting from school 2

4.40 On two consecutive days, the 5th and 6th January 2015, Child A truanted from school. On both occasions WA made a child protection referral to CSC. WA also contacted Adult A on both occasions. Adult A said that on the first occasion after an argument she had subsequently located Child A in a McDonald's by contacting Child A on her mobile phone. When Child A failed to turn up at school on the second occasion Adult A was unable to contact Child A on her mobile phone as Adult A had confiscated it so WA suggested she contact the police. Adult A contacted the police and explained to them that Child A had recently moved schools because she was being bullied. The police located Child A walking in Wood Green and were told by Child A that she missed her old school friends and that the new school was strict. The police considered Child A streetwise, found no suggestion of third party involvement or any concerns regarding her safety or welfare. Police completed a child concern form which was shared with CSC in the Multi-Agency Safeguarding Hub (MASH) on 7th January 2015.

4.41 The MASH enquiry was closed on 12th January 2015 having been unable to contact the mother and so had only spoken to the school. MASH noted that attendance over only a short time on the roll was 80% (3 absences) but that the school had met Adult A regarding this and would refer any safeguarding concerns to MASH. MASH relied on the police safe and well check rather than undertaking a return home interview or instructing an independent agency e.g. Barnardos, to complete one. They then passed responsibility to the school for monitoring the situation although the school had limited information regarding

the background of Child A and the other risk factors that were present.

Cyber-bullying episode

4.42 On the 21st January 2015 School 1 was made aware of some offensive group chat (social media). It was threatening and offensive involving Child A and students at school 1. The chat included Child A threatening to get her dad (who she commented was mad), threats of stabbing and abusive language including from an unknown cousin of one of the students who had posted comments about Child A being bisexual and an EMO (in this context someone who self-harms).

4.43 School 1 notified school 2 on 26.1.15 regarding the abusive chat involving Child A. Child A was spoken to on 26th January 2015 at school 2 who reported that Child A became very upset and told them that she had been bullied at previous school which caused her to self-harm (although she no longer did it) but she wanted to return to school 1to be with her friends. On 29th January 2015 the head of house held a meeting with Adult A and Child A to discuss the situation including that Child A wanted to return to her previous school. Adult A made it clear that this was not an option. Child A was offered a range of suggested activities to help her settle in to school 2 but these were all declined. The meeting ended with a decision to review the situation again in a few weeks' time.

4.44 School 2 commented at the practitioner's event that this was the first time they had become aware of self-harming in relation to Child A. However, CSC records reported that *'Checks completed with Child A's school in March 2014 indicate she has friendship issues and other girls have reported in school she has said on Blackberry messaging (BBM) she "wants to kill herself and if she was gone no-one would notice."'* School 1 also advised Adult A to go the GP re DSH on 21st July 2014 prior to the school holidays (see para 4.25). Having become aware of this incident and, whether or not the schools knew previously about the DSH this is another opportunity where a referral could have been made to CSC.

Child A dies

4.45 On Monday 2nd February 2015 Child A was found face down with a ligature, her school tie, around her neck along with a pair of scissors which it appeared had been used to cut the tie. Child A despite extensive work by London Ambulance Service (LAS) including Helicopter Emergency Medical Service (HEMS) died.

4.46 Other information following her death from notes made by Child A and comments made by students from the schools suggested that Child A had relationship issues with both her parents and with some of her friends. Some of the students revealed that they had been aware of Child A self-harming and Child A not agreeing with Adult A's views on church or related choice of school. Whilst it is common for children to have a different view to their parents on the choice of school, Child A's perception of the implications of Child A's choice was not an isolated factor but one of many. The fellow students of Child A when spoken to by the police following Child A death, seemed to know more about the issues affecting Child A than many of the agencies or her family. More needs to be done to create an environment where children not only feel able to share concerns or information with people who can help but also understand the importance of sharing these concerns or information as well.

4.47 No issues relating to ethnicity, religion, diversity or equalities has been identified by the organisations involved within this review. However, comment was made by school 1 that mum was religious and this was the reason she wanted Child A to go to school 2 (A church school). There was also a mention by one of the friends when spoken to after Child A death about her being interested in witchcraft. A note made by Child A also alluded to this. Although the review author is of the opinion that professionals had no issues with ethnicity or religion the comment of school 1 is noted here.

5.0 Family perspective.

5.1 Both Child A's mother and father have been spoken to by the review author. The process of what a serious case review is was explained. The prime goal of learning lessons was highlighted to them.

Mum comments to review

5.2 Described Child A as someone who was fine until she went to secondary school. The mum felt that whilst at School 1 she was subject to bullying. This bullying was never adequately dealt with in Mums opinion.

5.3 Mum had always wanted Child A to go the 'School 2 but wasn't given a place. She was allocated another school, which mum definitely didn't want her to go to. Then later in September was allocated the School 1 which she did attend. Child A was also placed on the waiting list for the School 2.

5.4 When she first found about Child A self-harming mum approached the school for help. they advised GP and then to CAMHS. This mum did, and had a CAMHS appointment. Child A was insistent that she was not going to go. CAMHS then offered a home appointment and mum thought this was a really good way to engage.

5.5 Mum felt that professionals from all agencies were a little bit dismissive of self-harm and almost described it as normal behaviour and not to worry. There should be better guidance and processes not just for professionals but also parents.

5.6 When the 'group chat' incident came about in January 15. Mum felt that she had no idea about internet safety and what to do. Mum also thought that there should be learning delivered for parents about how to keep children safe.

5.7 Mum felt school 2 was really good but school 1 let Child A down. They offered counselling but this never transpired.

5.8 Mum felt that dad coming back into Child A's life was not an issue; they had both wanted this for some considerable time before it happened.

Dad comments to review

5.9 He said Child A had wanted for some time to have him back in her life. He agreed to this and started to see her at the beginning of 2014. Increasing his contact and time spent with her after May 2014. He was told to slow this down in about the September 2014 by a SW due to

the self-harm. He felt that this was the wrong thing to do as she needed more of his support rather than less.

5.10 He freely said he had some mental health issues, but was managing well. He felt this made him very knowledgeable about what should have been done for his daughter.

5.11 He felt there should have been a team around her, to cater for the self-harm episodes. He thought the home visit was good, there should have been medication and other therapies rather than purely counselling in the future. He would like a recommendation to be about there being a community child mental health team.

5.12 The school (school 1) really didn't deal with the bullying very well. They should have stopped it.

5.13 Professionals should have more training and guidance on how to deal with bullying and self-harm.

5.14 There should also be set up anti-bullying hotline a bit like child line.

Comments professionals made about Child A to the review

5.15 Professionals at the review meeting made the following comments about Child A. They described her as a "bright bubbly girl", "an eloquent, bright and intelligent girl", "a big character and could be very vocal", "very creative with regards to arts, drama and music", and someone who was "strong minded and not struggle to put her view across".

6.0 Conclusion

6.1 The above commentary and analysis shows what happened in the build up to the significant event involving Child A on 2nd February 2015, and at times why it is thought actions were taken or not taken. The review author also concludes that the death of child A couldn't have been predicted by any of the professionals or agencies involved. There are however lessons that can be learnt from Child A's life.

6.2 The review process has revealed the below key themes that have arisen from this review.

- Relevance of past history including identifiable risk factors
- Communication - Information sharing between agencies - timing - quality - recording
- Training and guidance in relation to self-harm and suicide ideation
- Need to ensure CiN procedures are adhered to
- CAMHS provision

6.3 It is essential that everyone who is involved in making decisions that impact on a child or their family are aware of the relevant history and context as this will impact on the

effectiveness of any decision making processes in relation to safeguarding. In this case there were a number of recognised risk factors present which a number of agencies were unaware of or had limited information on even though the information was available.

6.4 Communication - WT 2015 Key Principles paragraph 16 states

No single professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

In this case some agencies failed to identify concerns e.g. in relation to past history and number of risk factors, and did not share information e.g. one way communication between SW and school, or take prompt and effective action e.g. initiating a S.47 enquiry after the first or second referral.

The GP made a prompt referral to CAMHS but provided insufficient information about her safeguarding history. The Student Nurse who noted the DSH marks reported and recorded her concerns but others in that agency failed to pass those concerns on and they were not included in the discharge plan. It must be noted however, that the GP was already aware of the DSH, as they had referred Child A to CAMHS.

6.5 Awareness, implementation and resourcing of safeguarding processes. WT 2015 Key Principles paragraph 17 states:

'In order that organisations and practitioners collaborate effectively, it is vital that every individual working with children and families is aware of the role that they have to play and the role of other professionals. In addition, effective safeguarding requires clear local arrangements for collaboration between professionals and agencies.'

And paragraph 20 states

'Effective safeguarding systems are child centred. Failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children.'

A number of potential opportunities were missed, particularly when the two safeguarding referrals were made (firstly from the midwife and then the police). Both occasions should have prompted a Section 47 strategy meeting. Likewise there was a missed opportunity when DSH was noted by the nurse. This should have been escalated to the paediatric team and CAMHS who would then consider if a referral to social care was required. This is now in place within the hospital, and Child A would have been discussed at the now held weekly meeting and liaison taken place with the school nurse.

Lord Laming in The protection of children in England: A progress report (3/2009) stated that

'Policies, procedures and structures are important 'but more so the robust and consistent implementation of these policies and procedures which keeps children and young people safe'.

6.6 Training and awareness of key issues in relation to safeguarding procedures for dealing with DSH and possible suicide ideation is important in some degree to all the agencies involved in this review, but schools in particular. Self-harm and suicide are major public health problems in adolescents, with rates of self-harm being high in the teenage years and suicide being the third most common cause of death in male adolescents worldwide (after road traffic

accidents and violence). Hanging is the most commonly used form of suicide in the UK and has a high case mortality (more than 70%).

Risk factors for completed suicide in adolescent's share many similarities with those for self-harm and include restricted educational achievement, family history of suicidal behaviour, parental separation and divorce and substance misuse. It is a myth that those who discuss suicide will not follow it through and up to three quarters of those who take their lives have communicated the intent beforehand (Schneidman 1973; Hawton & James, 2005).

6.7 Although the review author is of the opinion and has highlighted in the report that there were missed opportunities for the use of Section 47 enquiries, the use of CiN procedures was not well used. The Barnet CiN procedures appear on review by the author of this report to be fit for purpose, but need to be robustly used by CSC and its partners, which didn't happen in this case.

6.8 The review author has debated whether the impact of her father returning to Child A life was the tipping point and the significance of this coinciding with the fighting with other girls, self-harming, cannot be denied. There are also a number of unanswered questions in relation to what the relationship actually was like between the father and Child A. It is felt that this should have been explored during child A's life, but also examined in full post her death by the police and CSC (which it wasn't). The review author however, feels that it was the accumulation of all of the risk factors highlighted in this report that actually was the tipping point. The lack of an in depth assessment has not helped to form a robust conclusion. What is clear though is a lack of knowledge of MAPPA and how to deal with MAPPA that professionals from all organisations that work in the children sector within Barnet could do with being upskilled in their knowledge.

6.9 The review has looked at the bullying incidents including the cyber one. Although now known exactly what professionals knew of this in relation to Child A, it is not really known what extent it went to. The parents told the review that the bullying was a key part of Child A DSH and how she was feeling. Her friends told the police after her death about this as well. Although schools have individual bullying policies it is felt by the review author worth joining this up across the Borough and more information given to parents and carers.

6.10 Engagement with support services by child and carers is essential. A balance needs to be effectively maintained between encouraging users to engage and freely participate in the process, taking responsibility for the situation alongside supporting vulnerable people who are not able to do that without substantial support and assistance. In this case CAMHS working with limited information, in the short term provided extra assistance with a home visit but then long term relied on Adult A to manage the situation effectively on her own to 'leave the door open so Adult A would engage in the future - and not feel compelled'. Child A was not willing to attend CAMHS for help; Adult A appeared to be struggling and needed some assistance which a CAMHS outreach provision in the community may have provided.

6.11 Mixed messages - A member of the review commented that young people are sometimes their own worst enemy by portraying they are fine when they are not. Professionals have the difficult task of trying to read beyond what the young person is saying to ascertain what they are actually trying to tell you - perhaps in actions rather than words. In this case early history of neglect and other risk factors should have acted as an alarm bell. The way Child A behaved in this case nearly 'made you forget her'. If communication had been better between agencies the mixed messages Child A was giving of being fine in school compared with the experience of her peers who heard and saw other worrying signs, coupled with her history may have become more evident. Similarly Adult A the school said was good at telling

you Child A would not be coming to school but not good at saying why she would not be attending school.

6.12 This Serious Case Review concerning Child A has made a number of recommendations as detailed below and the implementation of these will assist the partnership to deal more effectively with children and vulnerable young people in the Barnet area.

7.0 Recommendations

It is hoped that the following recommendations that have been developed from this review will help the BSCB to improve the effectiveness of the partnership in safeguarding and promoting the welfare of children in the Barnet area.

7.1 **Recommendation 1**

a) BSCB need to seek reassurance from Barnet CSC that CIN cases are being dealt with in accordance with the child in need procedures and that all professionals are fully aware of the procedures and participate accordingly.

b) Barnet CSC to ensure that where the threshold is met, multi-agency strategy meetings are convened in accordance with working together including representation from social care, health, police and education.

7.2 **Recommendation 2**

a) The BSCB should review existing guidance on bullying including cyber bullying. In particular have focus to an all Barnet Schools bullying policy (albeit the review appreciates that it is each schools individual responsibility to tackle bullying). They should also ensure information is circulated or at least made available to all parents and carers.

(Red Balloon Learner Centres (2015) in association with the Anti-Bullying Alliance have produced a publication 'Information for parents and carers on bullying' which includes certain expectations from schools, some of which are statutory.)

b) The newly implemented school nurse health questionnaire should be reviewed to include an additional prompt under 'bullying' so that the issue of cyberbullying is not overlooked.

7.3 **Recommendation 3**

The BSCB should though their links with strategic boards in the Borough advocate to the CCG or other relevant commissioning body for CAMHS to include the offer of the option for home visits, and If possible, to go further, and develop outreach workers integrated into generic CAMHS in the Borough of Barnet.

7.4 **Recommendation 4**

a) The BSCB should ensure itself that across its membership that proper information sharing in a safeguarding context is required of all partners. Government advice for practitioners providing safeguarding services to children, young people, parents and carers' was published in March 2015 and could be a used as a means of developing effective practice https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice)

b) The BSCB should ensure the Health overview recommendations are implemented.

7.5 **Recommendation 5**

a) The BSCB should seek assurance that guidance has been issued to schools and other relevant professionals on the impact of deliberate self-harm and how to deal with it.

b) The BSCB should work with Public Health, the CCG, Local Authority, Schools, Health and other partner agencies to ensure that an adolescent suicide prevention strategy, pathway and related good practice guidance for professionals is developed.

7.6 **Recommendation 6**

a) The BSCB should develop MAPPA guidance and awareness sessions for all professionals working with children and young people in Barnet, whose parents or carers maybe subject to MAPPA conditions. This needs to ensure that when MAPPA subjects are having contact with their own or other children, action is taken to assess the impact the MAPPA subject is having on them. This should include seeing the child on their own to establish their views.

b) In cases of unexpected child deaths where that child has been in regular contact with a MAPPA Offender, the police/offender manager should consider on every occasion interviewing any MAPPA offender, who has had recent contact with the child prior to its death. This will help to understand the nature of their relationship.

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