Bexley Safeguarding Children Board

Serious Case Review

Overview Report

In respect of Child E

Born 7 November 1997
Died 29 June 2012

December 2013

Published August 2014 following the Coroner's Inquest

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OVERVIEW REPORT

1.0 INTRODUCTION

1.1 Bexley LSCB commissioned this Serious Case Review (SCR) following the death of Child E on 29 June 2012, aged 14 years, 7 months. She had been found in the front porch outside the house of her putative father, Mr H at just before 6 am. He called an ambulance and told the operator that his daughter was not breathing and was going blue and was having a cardiac arrest. When the ambulance arrived at the address 9 minutes later Mr H was in the front garden doing CPR as instructed by the ambulance operator, because Child E was not breathing. She was taken to Hospital in Woolwich, accompanied by Mr H in the ambulance where she was declared dead at 6.50am. The paramedic records state that there was "no signs of drug abuse". The initial post mortem showed no organic cause of death and there were no signs of trauma or assault. Toxicology tests have proved inconclusive and the cause of death is unexplained.

There is no evidence to suggest that Child E's death could have been prevented.

1.2 At the time of her death, Child E was a Looked After Child (LAC), and had been accommodated by the London Borough of Bexley under section 20 of the Children Act, 1989. At the time of her death she was in a residential placement in Greenwich registered to provide "care and accommodation for up to five young people with emotional and behavioural difficulties".[1] She had been placed there on 21 April 2012, but at the time of her death had been missing from the home for seven days. During the time she had been placed there she had absconded repeatedly and had been reported missing to the Police on 41 occasions, however the incidents mostly related to unauthorised absences, with Child E leaving late at night returning early the next morning.

1.3 Child E had lived with her maternal grandmother since 10 June 2005. Children's Social Care (CSC) had initiated care proceedings relating to child E and her siblings prior to this. A Residence Order, with a 12 month Supervision Order, had been granted to the maternal grandmother. Child E's case was re-opened to CSC in December 2009 when she returned to live with her mother following the death of her grandmother.

1.4 At that time, Child E's older siblings were also staying at their mother's house. One sibling was subject to a care order and had a residential placement, the other had been subject to a paternal Residence Order. Both siblings stayed intermittently with their mother during the following years.

1.5 Child E was accommodated very briefly in July 2010 at her mother's request, but Child E ran away and returned home. She was accommodated again on 10 February 2012 as her mother was unable to manage caring for Child E. She had two emergency foster placements during this second period of accommodation, but both disrupted, in part due to Child E's challenging behaviours.

1.6 The Serious Case Review Process

The case was referred to the Standing Serious Case Review Panel (SSCRP) on 5 July 2012 and concluded that the criteria for conducting a serious case review

[1] The Residential Placement, Inspection Report for Children's Home, Ofsted, July 2012.

were met, in accordance with paragraph 8.12 of Working Together (2010) and that a recommendation should be made to the LSCB Chair that a serious case review be conducted. The LSCB Chair endorsed the recommendation on 23 July 2012 and the Department for Education was notified on 25 July 2012.

1.7 **Terms of Reference**

Terms of reference for the review were initially drawn up by the SSCRP on 5 July, and modified by the Serious Case Review Panel (SCRP) for this specific case, at its first meeting on 2 August 2012. It was agreed an additional point be added to the terms of reference document on 2 October 2012 when the police raised the possibility that Child E might have been the subject of sexual exploitation (see 1.9 bullet point 8 below).

1.8 In addition to the terms of reference outlined in Working Together 2010, the following questions were agreed by the SCRP to reflect specific issues the panel wished to address in relation to Child E:

- Given the history of care proceedings should Child E have been allowed to return to her mother's care after her grandmother's death? If so, should a child protection plan have been put in place?
- How effective was child in need planning and interventions, including risk management, education provision and helping Child E come to terms with her grandmother's death, from December 2009 to the point of her becoming looked after in February 2012?
- How well were issues of mental health and substance misuse, both for Child E and her mother, understood and acted upon to keep Child E safe?
- What was the quality of all the Looked After arrangements, including management of placement breakdowns, given Child E's various behavioural difficulties?
- How effective was the Missing Person Procedure and its implementation in this case?
- How well was Child E's violent/offending behaviour addressed?
- How well was the complex family network, including the roles of the extended family and significant males, understood and taken account of in all the work with Child E?
- Were the risks of sexual abuse and/or sexual exploitation to Child E while she was missing from home and care effectively considered?

1.9 Ghislaine Miller, Independent Consultant was commissioned as Overview Author and attended SCRP meetings to February 2013 with a remit to question, understand and challenge.

1.10 The Overview Author qualified as a social worker in 1976 and has an MA in Social Work and an Advanced Award in Social Work. She has significant experience in the work of Local Safeguarding Children Boards and Serious Case Reviews and is an accredited Overview Author, accredited in October 2010 by the Tavistock Consultancy, London Safeguarding Children Board and Department for Education. The author is also a trained Lead Reviewer for the Social Care Institute for Excellence (SCIE) Learning Together model of systems based case reviews. The author is completely independent, having never worked in or for the local authority, and with no prior knowledge of or involvement in this case.

1.11 The SCRP Chair was Bob Cook, an Independent Consultant. Mr Cook has over

35 years of child protection experience as practitioner and manager in the statutory and voluntary sectors, and has been involved in over 20 previous Serious Case Reviews as a Chair or Overview Author. Mr Cook has a BA in sociology, University of Exeter (1974), MA in Social work and Certificate of Qualification in Social Work (University of Warwick, 1978), and advanced SCR Accreditation (Tavistock Institute 2010).

1.12 Panel membership consisted of:

Bob Cook, Independent Chair
Detective Inspector, Child Abuse Investigation Team (CAIT), Metropolitan Police
Detective Inspector, Greenwich Borough Police
Representative, Bexley Voluntary Services Council
Designated Doctor, Safeguarding Children, NHS SE London BBSU
Designated Nurse, Safeguarding Children, NHS SE London BBSU
Deputy Director, Social Care, Safeguarding and Special Educational Needs (SEN)
Deputy Chief Executive, Oxleas NHS Foundation Trust
Deputy Director, Youth, Inclusion and Employment, London Borough of Bexley
Deputy Director, Schools and Educational Improvement
LSCB Business Manager
Representative, Safehouses, Independent Fostering Agency (IDFA)

1.13 IMR reports were commissioned from the following organisations:

- Children's Social Care, London Borough of Bexley
- Education, London Borough of Bexley
- Youth Offending Team, London Borough of Bexley
- Safehouses, Independent Fostering Agency
- Ethelbert Children's Specialist Homes Ltd
- Metropolitan Police
- NHS SE London (including GP)
- Oxleas NHS Foundation Trust
- South London Healthcare Trust
- A report of attendance at the incident London Ambulance Service (LAS)

1.14 The SCRP met on 6 occasions from 2 August 2012 – 4 March 2013. The final report was signed off by the BSCB on the 20 January 2013.

1.15 There has been an emphasis on learning lessons from this Serious Case Review, as well as quality assurance. These have been built into the process through:

- A briefing for IMR authors by the SCRP Chair and Overview Author on 21 August 2012 that clarified the terms of reference, and ensured that authors were clear about what was expected of them under Working Together 2010. Timescales were set for submission of reports. Authors were also introduced to the methodology of a Learning Together systems approach and the use of "conversations" with practitioners and managers involved in the case, to try and understand not only what they did, but also to address the "why" question: why they acted in the way they did, and what systemic factors contributed to what they did and the decisions they made.

- A second author's briefing took place on 2 October 2012, providing an

opportunity to address any difficulties. At this point authors had submitted chronologies and were in the process of writing the IMRs.

- IMR authors presented their reports to members of the SCRP on 24 October 2012. This enabled panel members to ask questions regarding discrepancies in information and provided an opportunity for emerging issues to be discussed. This discussion provided an early opportunity to identify lessons for learning, with an emphasis on early implementation of that learning.

- A Learning Event took place on 7 December 2012 for IMR authors, and practitioners and managers interviewed for IMRs. This was facilitated by the Overview Author and LSCB Business Manager. The purpose of this was to share emerging themes and to give practitioners and managers who had been involved with Child E, an opportunity to come together as a group and promote a culture of learning together.

- At SCRP meetings members conducted a quality assurance exercise on each of the IMR reports and highlighted areas that needed amendment or further clarification. Further work (for example clarification, further exploration of particular issues, ensuring that the recommendations flowed from the analysis and were SMART) was requested by the SCRP for some of the reports.

1.16 **Parallel Processes**

Criminal enquiries were opened, these have been concluded and there was no criminal action was taken. An inquest has not yet taken place to determine the cause of Child E's death but is scheduled for April 2014.

1.17 **Involving the Family**

The LSCB Chair wrote to Child E's mother, Mrs F, early on in the process notifying her of the SCR and inviting her to contribute her views. However attempts by the Overview Author and LSCB Business Manager to meet with Mrs F were unsuccessful, including seeking support from social care managers to enable such a meeting. The SCRP was consulted about whether it would be fruitful to pursue this further, and at that time Panel agreed it would not be. Similarly, SCRP did not feel it would be helpful to Child E's siblings for them to be approached at that time.

2.0 FAMILY CONTEXT AND PROFESSIONAL CONTEXT

2.1 Family Context

2.1.1 Child E comes from a large and complex family network, which has experienced a range of significant inter-generational difficulties. Despite these personal difficulties some members of Child E's extended family did try to offer support to Child E and her siblings during their childhoods.
A social care report written in 2001 provides some family history, and details the challenging early lives and relationships of some family members.

2.1.2 Mrs F herself had a difficult childhood and left home at the age of 19. As a young woman she also experienced relationship difficulties throughout the years when her children were small. Child E was her youngest child. Mrs F confirmed in January 2012 that she believed Child E's father was Mr H, also the father of one of Child E's siblings. Prior to this, the man understood to be Child E's father (Mr

G), had not been involved in her care.

2.1.3 With regard to Mr H, it subsequently became known in November 2011 that he was in a relationship with Child E's, Aunt R. Prior to this, Aunt R had been playing a significant role in Child E's care, but this discontinued as a result of her relationship with Mr H.

2.1.4 Between November 2001 and June 2005, CSC was involved with Child E's family. Her siblings became subject to child protection plans, with one subsequently being accommodated under section 20 Children Act 1989, in February 2002.

2.1.5 Child E was also made subject to a child protection plan in January 2003 as it was thought she was beginning to show signs of behavioural problems. She and one sibling remained subject to a plan until June 2005.

2.1.6 In September 2003 care proceedings were initiated in respect of all 3 children. The proceedings were still on-going in January 2005 and her maternal grandmother Mrs F Senior took over the care of Child E as she felt that Mrs F was not coping.

2.1.7 The local authority care plan for Child E was adoption. This plan was contested by the CAFCASS Guardian who favoured Child E living with her maternal grandmother, Mrs F Senior, as Child E had a positive attachment to her and had expressed a wish to continue living with her. The Guardian was of the belief that Mrs F Senior "was able to provide positive parenting"

2.1.8 Child E was seven and a half by the time the proceedings in relation to her were concluded. The Local Authority's plan for adoption for Child E was not accepted by the Court, and on 15 June 2005 a Residence Order was made in favour of Mrs F Senior with a one year Supervision Order to the local Authority.

2.2 PROFESSIONAL CONTEXT

2.2.1 An Ofsted/Care Quality Commission inspection of safeguarding and looked after children services took place in Bexley between 9-20 July 2012. Child E had died 10 days before the start of the inspection.

2.2.2 The overall effectiveness of the looked after children (LAC) services and capacity for improvement were assessed to be 'good'. The overall effectiveness of safeguarding services was assessed to be 'inadequate'.

2.2.3 An independently chaired Safeguarding Improvement Board was established in October 2012, to monitor progress against the requirements of the Department for Education Improvement Notice issued on the 29 October 2012. Its remit is to oversee progress in delivering the Improvement Plan and monitoring the impact of this work.

2.2.4 In analysing practice in relation to this case, if there is resonance with any findings from the Safeguarding and Looked After Children Ofsted July 2012 inspection they will be referenced. Any recommendations will be made in the light of work already underway as part of the Safeguarding Improvement Plan.

2.2.5 The Adoption Service in Bexley has been previously rated as good by Ofsted, and the Fostering Service as outstanding (August 2011).

3.0 HISTORY OF PROFESSIONAL INVOLVEMENT (December 2009 - June 2012)

3.1 December 2009 – July 2010 - Child E Returns to Mother's care

3.1.1 Child E returned to the care of her mother in December 2009 after her maternal grandmother became ill and subsequently died. At this time one of Child E's siblings was living in the family home and had been assessed as a Child in Need by CSC and was receiving support from Social Worker 1. Social Worker 1 also became Child E's social worker. A new referral was not opened in respect of Child E, or an initial or core assessment undertaken.

3.1.2 Following Child E's return home, Social Worker 1 contacted Child E's mother and asked her to re-assure Child E that she would be cared for within the family and would not be taken into care. This was in response to Child E's stated concerns to Social Worker 1 about being removed from her family whilst she grieved for her grandmother. Social Worker 1 subsequently advised Child E's mother to apply for benefits for Child E and she herself contacted School 1 to apply for free school meals for Child E. On 18 December 2009 Social Worker 1 did a joint visit to the family home with the social worker of another sibling who was also at home for Christmas.

3.1.3 A Child in Need meeting took place on 12 January 2010, at Child E's school. A representative from a local voluntary mentoring and befriending service attended the meeting, having been asked to offer support to Child E given her recent bereavement.

3.1.4 On 18 January and 24 February 2010 School 1 reported that Child E had been seen sniffing/misusing aerosols, and that Child E had written about her grief over her grandmother's death, and worrying about members of her family. On 9 March 2010 a second Child in Need meeting took place.

3.1.5 During late March 2010 School 1 became concerned about incidents of defiance by Child E and reported some difficulties in contacting Mrs F to collect her from school.

3.1.6 A third Child in Need meeting took place on 27 April 2010. Mrs F attended the meeting and also reported some behavioural difficulties at home. Child E's views, conveyed to the meeting by her mentor, were that it was "not working out" with both her and one of her siblings living at home. School 1 reported that Child E was being defiant at school and had been excluded for two days the previous term. It was agreed the referral for a befriender was to be "fast tracked".

3.1.7 During May 2010 there was significant activity by agencies involved with Child E. On the 4th May the School held a meeting "of all involved" with Child E, and on 12 May made a referral to CAMHS as they were increasingly worried about Child E's erratic behaviour.

3.1.8 On the 20 May Social Worker 1 also made a referral to CAHMS but the referral was not accepted because Child E did not meet the eligibility criteria. School 1 also made a further referral to CAMHS on the following day but this referral was also turned down as there was "no evidence of mental health difficulty". CAHMS suggested instead that a CSC plan be put in place.

3.1.9 A further Child in Need meeting was subsequently held on 25th May when the

school raised concerns about the number of people living in the family home and Mrs F's ability to manage them. Following this meeting, the school made a referral to the Youth Engagement Service for support for Child E.

3.1.10 During June 2010 the School continued to have concerns about Child E and convened a Professionals Meeting. The CAMHS Operational Manager attended the meeting, but Social Worker 1 would not attend the meeting, as Mrs F had not been invited.

3.1.11 On 11 June the school referred Child E to the Education Welfare Officer (EWO) and made a referral to the Think Family service on the 16 June. On 21 June the School also made a referral to the Early Intervention Team (EIT) as the Deputy Head expressed "extreme concerns" for Child E.

3.1.12 On 24 June 2010 CSC Emergency Duty Team (EDT) was contacted by a caller expressing concerns about Child E's safety and wellbeing, however the caller was not coherent and was unclear in the information given. It was also reported that another adult had been staying in the home about whom concerns had been expressed previously leading to Child E being made subject to a child protection plan. Child E was seen by Social Worker 1 on the following day however and was asked if she wanted to come into foster care, but she refused. Social Worker 1 had supervision later that day and reported that both Child E and her mother had "said no" to Child E coming into care.

3.2 July 2010 – December 2010: Mother Struggles with Child E's Care

3.2.1 On 7 July 2010 a meeting took place between Mrs F and Social Worker 1 at the social work office. Mrs F said she was finding the care of her children very difficult and so agreed to Child E being accommodated. Mrs F said she felt guilty about this. Social Worker 1 made a referral to the Child Placement Service for a placement for Child E.

3.2.2 The following day a Child in Need meeting took place and discussed arrangements for Child E to be accommodated. It was also agreed that a referral would be made to the Family Centre for parenting help for Mrs F.

3.2.3 On 9 July 2010 a placement was identified for Child E and Social Worker 1 visited Foster Carers 1, to assess its suitability and discuss Child E's history.

3.2.4 Three days later a re-integration plan was agreed at School 1 with Social Worker 1 and Child E, following which she was taken to visit the foster placement before the placement was made. Social Worker 1 moved Child E to the placement on the 13 July and she became accommodated under section 20 Children Act 1989. There is no recorded evidence that Looked After Child paperwork was completed with Mrs F, although it is recorded that Mrs F had given verbal consent to her daughter's accommodation.

3.2.5 On 19 July 2010 the Fostering Link Worker e-mailed Social Worker 1 to say that the placement was breaking down. It subsequently ended on 21 July when the foster carer told Social Worker 1 that Child E was refusing to come out of her room and wanted to see her mother. Social Worker 1 spoke to Child E over the telephone, but subsequently Child E climbed out of the window and left the placement. Later that day Mrs F confirmed that Child E was at the family home and refusing to go back to the placement. The foster placement was closed on 23 July 2010.

3.2.6 On 9 August 2010 Child E was taken to the Accident and Emergency Department (A&E) in Woolwich by her mother at 10.39pm, with what appeared to be a fainting episode. She had been found collapsed on the floor by friends. She denied using alcohol or drugs and was later discharged from hospital.

3.2.7 On two occasions in September 2010 Child E was caught smoking in school and was referred to the Behaviour Improvement Programme. On 15 September Child E assaulted a member of school staff and the police were called. On the following day Child E was excluded from school for damaging a room after she was caught smoking. During this time Social Worker 1 confirmed with the school that Mrs F was attending parenting classes, but in light of these incidents, the school convened a Professionals Meeting on 27 September 2010 chaired by a representative from the Behaviour and Attendance Team. The CAMHS Operational Manager was at the meeting and agreed that CAMHS would undertake an assessment of Child E's mental health and bereavement issues. School 2 also agreed to offer Child E a place because she had been permanently excluded from School 1. On 30 September 2010 Mrs F received a letter offering Child E a CAMHS appointment on 11 October 2010.

3.2.8 On 5 October 2010 Child E was reported missing to the police by Mrs F when she did not return home by 8.30pm. Child E returned home the following day having been collected by her mother from Aunt Z's house. The police visited the household the next day to de-brief Child E. She was described by police officers as "rude" and reported she had been staying with a young friend.

3.2.9 The following day, Social Worker 1 took Child E and Mrs F to a meeting at School 2 and it was agreed she would become a pupil there from 15 October 2010.

3.2.10 On 18 October 2010 a Child in Need meeting took place. It was agreed:

(i) Child E to continue to attend School 2
(ii) Mrs F to continue to attend her parenting group
(iii) CAMHS appointments to be kept by Child E
(iv) Social Worker 1 and her social work student to provide support to Child E
(v) Child E's befriender to provide a trip at half-term
(vi) a Child In Need meeting to be convened if there was any "slippage" in the plan.

This meeting was followed up by a Social Worker home visit the next day.

3.2.11 During late October and November 2010 the student social worker had significant contact with Child E and Mrs F. On the 27 October she visited Child E and took her out. There is evidence that the student social worker undertook direct work with Child E over a number of months. On this occasion the social work student noted that Child E was vigilant around other young people, but happy to talk about her likes and dislikes. The student social worker also visited Child E who said she was enjoying School 2. She spoke about the loss of her grandmother and said that she did not see living at home as a problem. A session between Mrs F and the student social worker focussed on Mrs F's parenting, her low mood, bereavement, and keeping Child E safe (including the risks of the internet and online grooming).

3.2.12 A further home visit on 11 November involved Mrs F who said she had finished her parenting course, but during a 1:1 conversation with Child E, she declined the

offer of engaging in life story work.

3.2.13 Child E was excluded from School 2 on 24 October, and 16/17 November 2010, as it was felt by the School that she posed a Health and Safety risk. A re-integration meeting took place on 18 November 2010, which Mrs F attended with the student social worker, and Child E. It was agreed that Child E would complete her Year 8 schooling at School 2, and the possibility of a statutory assessment of special educational needs (SEN) being undertaken, was raised.

3.2.14 The student social worker visited Mrs F on 24 November 2010 and reminded her about a CAMHS appointment the following week. Child E was at home and said she had again been excluded from School 2 for 2.5 days due to verbal abuse and threatening behaviour.

3.2.15 The student social worker collected Child E from home on 29 November 2010. Child E was described as "dishevelled" and was bored because of a school exclusion. She said she realised she had anger issues and that was why she had been excluded. A re-integration meeting took place that same day which reported that the SEN statutory assessment process would be triggered if Child E's behaviour did not improve.

3.2.16 The student social worker saw Child E again on 8 December 2010, and met her outside School 2. Child E was outside smoking and when she saw the student social worker she ran off but they spoke later on the telephone.

3.3 December 2010 – September 2011: Unsettled Home Situation

3.3.1 On 13 December 2010, a Child in Need meeting took place. Child E's behaviour at School 2 was described as disruptive and staff felt that she needed a more therapeutic environment. More positively, Mrs F was said to have shown a commitment to parenting and a CAMHS appointment was due the following week; the student social worker was also to continue her work with Child E.

3.3.2 On 14 December 2010 there was a telephone call between the student social worker and Mrs F who expressed concern because Child E was staying out late at night and associating with older men. The student social worker visited the family home the following day and found it to be "messy and slightly dirty". Child E, one of her siblings and Mrs F were there and all looked tired. The student social worker talked to Child E about the risks of staying out late and associating with older men. On the same day Mrs F sought support from a health practitioner to help her cope.

3.3.3 On 16 December 2010 the student social worker went to the family home to take Child E to her 3rd CAMHS appointment but Child E refused to go. The following day CAMHS telephoned Social Worker 1 regarding the missed appointment and it was agreed that CAMHS would arrange to meet with Mrs F alone in the New Year.

3.3.4 On the 23 December 2010 the student social worker telephoned Mrs F. and was informed that the boiler had broken. The Housing Association had already been notified and had been to the house to look. There were further telephone calls to Mrs F on 29 and 31 December 2010.

3.3.5 On 4 January 2011 the student social worker visited the home and found it unkempt and still without heating. Child E told the student social worker that she

was happy to return to School 2 but was worried about being bullied. She also said that over Christmas there had been adults drinking alcohol which she was offered but refused.

3.3.6 The student social worker telephoned Child E on three consecutive days (5, 6, 7 January 2011) to persuade her to attend school but she refused. She noted her concerns about Mrs F's parenting of Child E at that time, and on 11 January Social Worker 1 confirmed that she would "continue to visit and support [her] student in her work". The student social worker subsequently visited the family home that day, but there was no reply (Child E having returned to school on that day).

3.3.7 On 17 January 2011, the student social worker visited Child E at School 2. There had been a fight between Child E and another student and Child E was excluded for 1.5 days. The student social worker spoke to Mrs F the following day who advised that Child E had bruising to her stomach and legs from the fight. The student social worker made an appointment for Child E with the GP and then took Mrs F and Child E to a reintegration meeting at the school. At the meeting Child E said she would not be returning to School 2 and that her mother supported this.

3.3.8 Between 24 January and 2 February 2011 the efforts of the student social worker and staff at School 2 were focussed on getting Child E to return to school. She did go into school on 24 January 2011, but walked out two days later after being given a detention for disruptive behaviour. This was the last time she attended School 2. The School refused to have Child E back until there had been a re-integration meeting with her mother but was unable to contact Mrs F. The student social worker also tried unsuccessfully to persuade Mrs F to attend a meeting at the school.

3.3.9 On 7 February 2011 a Child in Need meeting took place. Social Worker 1 was not able to attend, nor a representative from CAMHS. Neither Mrs F or Child E were present. The meeting identified the following concerns:

- A lack of guidance and boundaries at home resulting in Child E not being kept safe (School 2 and the Family Centre felt that the s47 threshold had been met)
- Mrs F's lack of availability: she had made good progress but had been difficult to contact and was not currently engaging with services
- Child E was not attending school and her behaviour was not improving
- Child E's relationship with her mother caring but controlling
- Child E mixing with older people and the risk of Child E being exploited
- The history and difficulties experienced by the wider family.

It was agreed that the statutory assessment of Statement of Educational Needs (SEN) should be started, and for "the core assessment, Protection Plan to be put into the SEN plan".

3.3.10 On the following day the student social worker had supervision. The decision was "Continue to visit and support. Not CP. Social worker to have a discussion with the school re this… being in care would not hold Child E".

3.3.11 The student social worker visited Child E at home the following day. Mrs F said Child E had been staying out late and mixing with people from an older age group she had met at school 2. There is evidence that the student social worker was

able to engage Child E who said she had tried “weed” and knew that “skunk” was stronger. The student social worker gave her some leaflets and provided other information about the misuse of drugs.

3.3.12 During March 2011 the student social worker continued to have significant involvement with Child E and her mother. On 1 March 2011 Child E was arrested for spitting in the face of a 12-year -old boy and pushing him to the floor. Mrs F attended the police station as appropriate adult. The police decided that it was not in the public interest to proceed with the matter. Following this the student social worker made an unannounced visit to the family home on 3 March 2011. She discussed the statutory assessment SEN process with Child E and her response was described as “resistant”. She had already missed an appointment in relation to the SEN assessment.

3.3.13 On 8 March 2011 Child E was arrested for further assaulting the same 12 year old boy she had assaulted 5 days previously. Mrs F attended the police station as appropriate adult. Child E was bailed pending further Police enquiries.

3.3.14 On 17 March 2011 Child E and Mrs F were taken by the student social worker to their appointment with the Educational Psychologist in connection with the statutory assessment process. There was a follow up appointment for 24 March 2011 but unfortunately Child E and her Mother did not attend, despite the student social worker’s attempts to facilitate this.

3.3.15 On 30 March 2011 the Youth Inclusion Support Panel advised that Child E was subject to a Police Electronic Notification as a result of the assault she had been charged with, and the following day the police attended the family home due to reported cannabis use. On the same day, CSC received a MERLIN notification from the Police about Child E going missing on 25/26 March.

3.3.16 A Child in Need Meeting took place on 4 April 2011. Mrs F described Child E as being out of control. It was reported that the SEN statutory assessment process was underway but that Child E had not been attending school. The plan from the meeting was as follows:

- Social worker 1 to arrange a family meeting to discuss Child E’s welfare (as the student social worker was due to leave shortly the case would revert to social worker 1)
- A ‘back to school’ meeting to be arranged in the same week to facilitate Child E’s return to School 2 after Easter (the Educational Psychologist had suggested a gradual return)
- Enquiries to be made regarding a parenting group for Mrs F
- Child E’s statutory assessment for SEN to continue
- Child E’s school attendance to be properly recorded
- A folder of meeting minutes to be provided for Mrs F

Social Worker 1 also had supervision on this day and it was agreed she would continue to home visit and support the Child In Need plan.

3.3.17 During the remainder of April meetings were held in line with the Child in Need plan. A re-integration meeting was arranged at School 2 for 7 April 2011, however neither Child E nor Mrs F attended, and on the next day the school expressed its view that Child E was at risk of significant harm.

On 12 April 2011 a Family Meeting took place attended by Aunt R, Aunt W, Mrs F and some other family members, however the outcome of the meeting was not recorded.

3.3.18 On 21 April 2011 Child E failed to attend the police station in relation to the charge of assault on 8 March 2011 against the 12 year old boy.

3.3.19 On 28 April the student social worker took Child E to the GP because she had had a persistent cough since Christmas. Child E said they had had no food in the house for two weeks, although food vouchers had been provided to Mrs F by CSC earlier in the month.

3.3.20 On 5 May 2011 Social Worker 1 telephoned Mrs F, who said Child E was staying at Aunt R's house. Social Worker 1 telephoned Aunt R the following day to remind her of Child E's appointment with the Educational Psychologist.

3.3.21 With regard to Child E's schooling, Social Worker 1 telephoned Mrs F on 26 May and confirmed she had agreed with School 2 that Child E was to return there on a reduced programme from 13 June 2011.

3.3.22 On 6 June 2011 Social Worker 1 was told that Child E was staying with Aunt R over the half term. A Child in Need meeting took place that same day but family members including Mrs F and Child E did not attend despite a supervision decision of 12 May 2011 that they should attend. Case recording indicates that the meeting discussed the progress of the SEN statutory assessment process and that the meeting was informed that Child E was functioning educationally at the age of an 8 year old (she was 13 years and 7 months at this time).

3.3.23 On 8 June Social Worker 1 telephoned Aunt R, as she was unable to make contact with Mrs F. Aunt R agreed to take Child E to School 2 on 13 June 2011 and was also invited to the next CIN meeting.

3.3.24 On 14 June 2011 the same caller as had previously contacted EDT, called EDT for a second time to tell them of their concerns about Mrs F's lifestyle and the impact it was having on Child E. This information was passed on to Social Worker 1.

3.3.25 On 15 June 2011 Child E was arrested at Aunt R's house in relation to the assault charge on 8 March 2011 and her failure to report to the police station. Mrs F attended the Police station to act as the appropriate adult. Child E subsequently appeared in court on 22 June 2011 in relation to the assault charges of 8 March 2011. She was bailed on condition that she did not have any contact with the victim and was due to appear in court again on 5 September 2011. Aunt R and Mrs F went to court with Child E and then went to see Social Worker 1. On 26 June 2011 the police decided to take no further action on a case in which Child E had been named as a suspect in the theft of a mobile telephone from a young person with learning difficulties. The case was dropped because there were too many evidential issues to prevent it progressing to court.

3.3.26 On 8 August 2011 Child E was provided with £10 food vouchers because her mother was at home in bed with a bad back. The following day Uncle P telephoned Social Worker 1 to say that Mrs F had been threatened with eviction. Social Worker 1 subsequently spoke with the Housing Department who confirmed that they had now been paid the rent by the Housing Benefit department, but that there were still issues about the condition of the home. Social Worker 1 visited

jointly with a Housing Officer on 24 August 2011 and spoke to Mrs F about the rent arrears, water rates arrears and the poor condition of the home. Following this, on 26 August 2011 Child E went into the social work office to ask for food vouchers. Social Worker 1 went home with her to verify that there was no food, and gave £15 in vouchers and £10 in cash for the electricity.

3.4 September 2011- April 2012: Child E Starts to go Missing

3.4.1 On 5 September 2011 Child E failed to appear at court in relation to the assault charge on 8 March 2011 and was arrested the following day. She was released on bail, to appear in court again on 28 September 2011.

3.4.2 On 8 September 2011 Child E went to the social work office and was provided with £10 food vouchers. Child E reported some potential safeguarding concerns at home which Social Worker 1 discussed with her managers. Following this discussion it was agreed that Child E was to stay living with her family.

3.4.3 On 13 September 2011 the police were called to Tesco's at 7pm by one of Child E's siblings to say that Child E had locked herself in the toilets after another girl had chased her and cut off some of her hair. The Police attended and both Child E and her friend said they did not want the Police involved, so the police officer took both girls home.

3.4.4 On 28 September 2011 Child E appeared at Juvenile Court in relation to the assault and was given bail on condition that she did not have any contact with the victim, attended an appointment with YOT for an assessment on 30 September 2011, and returned to court on 19 October 2011.

3.4.5 On 7 October Social Worker 1 and the social worker for one of Child E's siblings did a joint visit to the family home. They did not go into the house as the whole family was ill. Mrs F asked for food vouchers. Concerns were recorded about pressures in the household as Child E's siblings were also living there, along with one of their partners; Child E was still not attending school.

3.4.6 On 12 October 2011 Social Worker 1 telephoned Mrs F to remind her of Child E's YOT appointment the following day. The following day, Social Worker 1 made a joint visit to the home with the YOT worker. This led to the YOT worker completing an ASSET assessment (which included a vulnerability assessment of Child E) on 18 October 2011. The SEN statutory assessment was ongoing and this was also discussed with Mrs F.

3.4.7 On 19 October 2011 Child E appeared at Juvenile court regarding the charges of assault. She was made the subject of a Youth Rehabilitation Order until 18 April 2012 with a requirement of 20 hours of activity over 5 days. Her Education Placement was stated as School 2.

3.4.8 During early November Mrs F sought support for herself from health practitioners.

3.4.9 On 4 November Child E was arrested for failure to attend the Magistrates court for trial and was detained for trial. Subsequently on 15 November the YOT Community Reparation Form was completed, and Child E was assessed as being a low risk of reoffending, but with medium vulnerability risk. Her activity was to be at a local Neighbourhood Centre. Child E failed to attend her appointment there on 17 November 2011, and a Formal Warning letter was sent to her. The YOT worker also telephoned Social Worker 1 about this and explained that due to

difficult home circumstances, Child E would not be likely to get to this centre and so asked for a placement nearer to home to better support Child E.

3.4.10 On 21 November 2011 Social Worker 1 telephoned Aunt R, who said that Child E had been staying with her for a few days but had gone missing the previous night; she thought she may be in Kent with a female friend. As Aunt R contacted the Police to report Child E as missing, she arrived back at Aunt R's house. A CSC record of supervision that day confirms the decision was made that a Legal Planning Meeting should take place. It was felt that Child E was vulnerable to criminality, and that home "cannot support her placement".

3.4.11 On 27 November 2011 Child E was taken to the police station by Aunt R, who said she could no longer care for her. Child E refused to go into care and said she wanted to go home. The Police said they would make a welfare visit to Mrs F. The following day Mrs F went to the social work office with another of her children and confirmed that Child E was at home. Mrs F also confirmed that Aunt R had been in a relationship with Mr H for 6 months. Social Worker 1 discussed placement options for Child E, but Mrs F said she did not think it would work unless Child E lived at home.

3.4.12 On 6 December 2011 a Professionals Meeting took place attended by Social Worker 1. The risks to Child E at that time were noted to be:

- Going missing from home
- Parental care
- Not attending Education
- Engaged in risky social relationships
- Police concern about Child E being groomed for prostitution and the role of a named adult in this
- Other people living in the household
- Mrs F not agreeing to Child E being placed in alternative accommodation

The recommendation of the meeting was that CSC would seek legal advice on available options to safeguard Child E's welfare. It was the view of those at the meeting that this could not be done by Child E remaining at home. Social Worker 1 was to request, via her senior manager, that legal advice was sought.

3.4.13 The Education chronology states that those at the meeting were told that legal proceedings had been initiated in relation to Child E's non-attendance at school. The SEN statutory assessment report had been finalised and School 3, a local Bexley SEN school, had been named but it was "felt to be inappropriate". Both School 1 and School 2 had hoped that a School in Kent would be the named school on the grounds that "it would take her away from Bexley for a significant part of the week and provide a more therapeutic environment".

3.4.14 On 16 December 2011 Mrs F and Child E went into the social work office. It is recorded that "she looked well". Mrs F was given food vouchers as she had not had any benefits for 4 weeks, and she said her oven was not working. When Social Worker 1 made an unannounced home visit on 22 December the welfare benefits issue and broken oven had both been resolved.

3.4.15 On 3 January 2012 Child E was reported missing to the Police at 9.29pm by her mother. Child E had left home two days earlier to stay overnight with her friend but had not returned. There had been some text messages exchanged between Mrs F and Child E but Child E was no longer replying to them and this was making Mrs F worried.

3.4.16 On 4 January 2012 the Police found Child E in Kent with her friend and took her back to her mother's home at 1.15pm. The Police attempted to talk to Child E on the car journey home, but she "refused to engage with them" and would only say that she intended to go back to her friend. That same day Social Worker 1, telephoned Mrs F to discuss Child E being missing to be advised that Child E had run away again. Mrs F consented to Child E being placed in foster care, although Social Worker 1 had some reservations about this because she was concerned that Child E would not cope in a foster placement and would continue to run away to home.

3.4.17 On 5 January 2012 Mrs F reported Child E missing to the Police and that she thought Child E might have returned to an address in Kent. The Police subsequently found Child E there, hiding under a duvet and returned her home. Her friend Child X was arrested for harbouring her. Social Worker 1 visited the following day.

3.4.18 On 10 January 2012 Child E was reported missing to the Police by her mother at 00.46am. The Police found her four days later at 8pm in the stairwell at Sainsbury's car park with others. She was taken home and said she had had a row with her mother and had been staying with her Nan in Plumstead, Mr H's mother.

3.4.19 During the time that Child E was missing, Social Worker 1 took Mrs F to see School 3 as identified through the SEN process. Mrs F talked about Aunt R's relationship with Mr H and said that she was sure he was Child E's father and that she had recently told Child E this.

3.4.20 On 17 January 2012 the social worker for Child X had an initial telephone conversation with Social Worker 1 to discuss Child E and Child X going missing together. The social worker said that Child X had been moved from her address in Kent.

3.4.21 The following day Child E and Child X were stopped by the Police outside a train station. Whilst the Police Officers were talking to the two girls, a woman came over to them and said she was Child E's grandmother. She told Child X to keep away from Child E as she was worried about her running away and using drugs. Child E did not deny using drugs, but the Police officers searched her and she had no drugs on her. The Police completed a MERLIN report about the incident, which was received by the social worker on 24 January 2012.

3.4.22 On 20 January 2012 Social Worker 1 telephoned Mrs F, who told her that Child E had been missing since the previous evening, but she had not reported it to the Police. Child E had stolen her laptop and sold it for £150. The same day the YOT worker completed an ASSET assessment identifying Child E as medium vulnerability risk.

3.4.23 On 27 January 2012 Child E went to the social work office to collect food vouchers. Social Worker 1 spoke to Child E about her risky behaviour, but Child E "didn't see this" and denied that she was sexually active.

3.4.24 On 31 January 2012 Child E was stopped in Woolwich at 3.40pm as she was with Child X and two older males who it was recorded "looked like street drinkers". Child E said that the two men were family friends and one swung her around. Both men were known to the Police.

3.4.25 On 1 February 2012 School 3 advised the YOT that Child E had not been enrolled at school because she had failed to attend an admissions interview.

3.4.26 On 2 February 2012, just after midnight, the Police noticed Child E with a large group of males (on CCTV) in Plumstead High Street being followed by a car. It was discovered that Mrs F was in the car as she had gone out looking for Child E when she had failed to return home. She said she knew the males in the group. Child E was spoken to by the Police Officers and was taken home by her mother.

3.4.27 The following evening, Child E was reported missing to the Police by her mother at 10.11pm. She told them that this was a "regular occurrence" and that she had been told by Social Worker 1 to report Child E missing to the Police. Child E was found by the police at 1.30am on 6 February 2012 in London and they telephoned Mrs F to let her know. However Mrs F did not appear to be able to care for her daughter at that time and so on the advice of Mrs F, the Police took Child E to Uncle P's house. Child E told the Police Officers that she had been home several times since 3 February 2012 but her mother had not been at home. There was a telephone conversation between Uncle P and Social Worker 1 later that day when he advised that Child E had been placed with him by the Police. Another of Child E's siblings was also staying with him at that time.

3.4.28 A telephone conversation also took place on 6 February 2012 between Social Worker 1, and a DS from the police Child Abuse Investigation Team (CAIT). Social Worker 1 told the DS that Child E was not currently subject to a child protection plan "and at this moment SSD did not feel a plan would benefit the subject or her mother". The Police recorded that it had been "agreed this matter would remain a single agency investigation by SSD at this time and that the social worker would discuss the matter further with her manager". The CAIT officer considered this to be a strategy discussion, but there is no indication that CSC had this understanding.

3.4.29 Following this discussion, Child E was accommodated on 10 February 2012 under section 20 of the 1989 Children Act and was placed with Bexley foster carers (Foster Carers 2), living in Kent. The CSC chronology states that a s47 investigation had commenced that day, but not progressed, as Child E had become accommodated and was now in the care of foster carers.

3.4.30 On 13 February 2012 Foster Carers 2 telephoned Social Worker 1 to say that Child E was distressed about not being able to smoke and was trying to leave the placement. Social Worker 1 advised the Foster Carers 2 to allow some smoking, and work to reduce it. By 15 February 2012 Child E was "much more settled".

3.4.31 On 17 February 2012 Foster Carers 2 reported Child E missing to the Police after she had jumped out of the foster carer's car. Social Worker 1 spoke to Child E and tried unsuccessfully to contact Mrs F, but did have a telephone conversation with Uncle P, advising him that Child E was not to stay with him. Uncle P later contacted Social Worker 1 to let her know that Child E had arrived at his flat. Later that evening Child E was returned to Foster Carers 2 by Social Worker 1, and whilst at the placement, also completed a Personal Education Plan (PEP),

with the intention that she would seek a school placement for Child E in Kent.

3.4.32 On 20 February 2012 Kent Health services received a letter from the London Borough of Bexley notifying them that Child E had been placed in their authority. There was no Initial Health Assessment Form or consent by Mrs F for a health assessment.

3.4.33 On 29 February 2012, Child E was reported missing to the Police CAIT at 10.44am. It was agreed that this would remain a single agency matter "unless further concerns raised". The decision by the Police was "no further action".

3.4.34 On 2 March 2012 Child E attended her Looked After Children (LAC) Review but insisted that she wanted to leave the placement. The written record of the meeting confirmed:

- Social Worker 1 would liaise with the LAC nurse to ensure completion of Child E's Health Assessment as soon as possible, and to discuss sexual health counselling for Child E
- A dental appointment was booked for 22.3.1
- An optician's appointment was booked for 8.3.12
- Social Worker 1 to arrange for a substance misuse worker to meet with Child E to offer preventative work
- Looked After Children Education (LACE) team to liaise with Kent Education department regarding securing an EBD school placement for Child E
- Social Worker 1 to assess the viability of Child E spending one weekend a month with Uncle P and having contact with her mother at the same time.

3.4.35 On 5 March 2012 Social Worker 1 contacted the LAC Nurse about the health assessment. She was also advised by the Kent Education department that their in-house provision was full and that papers had been sent to an independent school to comply with Child E's statement of educational needs.

3.4.36 Child E spent the weekend of 17/18 March 2012 with her mother as arranged by Social Worker 1 but did not return to the Foster Carers 2 and when the carers went to the family home to collect Child E no-one was there. Child E was found in Belvedere at 2.11am on 23 March 2012.

3.4.37 On 21 March 2012 Social Worker 1 telephoned Foster Carers 2. The Foster Carers 2 said Child E had been "difficult and abusive" and they wanted to end the placement. Social Worker 1 made a referral to the Children's Placement Service.

3.4.38 On Monday 26 March 2012 Child E went missing from her placement with Foster Carers 2. It transpired that Child E was at Mrs F's house, although she herself had not been at home for a week and had not known Child E was missing.

3.4.39 On that same day Social Worker 1 e-mailed the Children's Placement Service (CPS) to express concern about the suitability of Foster Carers 2 and to make a request for a residential placement. The CPS Manager emailed the Head of Service and suggested for Child E to be discussed at the Placement Panel meeting three days later.

3.4.40 On Wednesday 28 March 2012 a Missing Person Strategy Meeting was held in Bexley, chaired by an Independent Reviewing Officer and attended by Social Worker 1, a DS from Bexleyheath Police, a Placement Officer from the CPS, and

a Missing Persons Officer from the Kent and Thanet Police Unit. It was noted that Child E had been missing since 21 March 2012 and that the placement with Foster Carers 2 was to end on 30 March 2012. The recorded outcomes of the meeting were that:

- Responsibility for Child E was to revert to Bexley Police and that they would visit the family members that day. Child E's MISPER status would be increased from medium to high risk (however a MERLIN PAC was completed the following day and Child E was assessed as being at medium risk)
- CSC would request an Independent Fostering Agency (IFA) foster placement for Child E
- YOT would contact Child E, to action the outstanding activity requirement
- CPS would liaise with the Head Teacher of the LAC Virtual School
- Social worker 1 would action outstanding tasks from the LAC review on 2 March 2012
- A further Strategy Meeting would take place on 16 April 2012

3.4.41 On 30 March 2012, the Police found Child E at 3.05pm outside the Woolwich Centre in London and took her to Woolwich Police station. Foster Carers 2 were telephoned, but said they were unable to have Child E back as they were going on holiday in a few hours. The placement was already planned to end that day as the carers had previously given notice. The Police contacted CSC who arranged a temporary IFA foster placement in Kent. Child E was collected and taken there by Kent Police as Bexleyheath Police did not have the resources to take her.

3.4.42 On 5 April 2012 an Initial Placement meeting was held at the Safehouses IFA placement with Foster Carers 3 and Child E. The Safehouses IMR recorded that, "the carers reported that only education was discussed in any depth, and they were not left with any paperwork. They felt no significant plans were finalised and they felt unclear".

3.4.43 On 10 April 2012 Social Worker 1 visited Child E at Foster Carers 3. Child E was said to be "adapting" and as the placement was on a farm with animals, Child E was helping out. The YOT worker used this activity to fulfil the outstanding 5 hours activity requirement ("reparation activity") of Child E's Youth Rehabilitation Order.

3.4.44 During early April Mrs F had sought health support for herself due to problems at home.

3.4.45 On 12 April 2012 Child E's case was considered at the CSC Placement Panel and it was agreed that it would be reviewed in 6 months. Later that day Child E went missing. Child E was contacted by telephone and said she was in Woolwich. The Police were informed. The following day Kent Police requested the Metropolitan Police Service visit Mrs F's house to see if Child E was there, but there is no evidence that this visit took place.

3.5 April 2012 – 29 June 2012 - Increasing concerns regarding Child E

3.5.1 Two days later, on 14 April 2102, Foster Carers 3 emailed Social Worker 1 to say that Child E was still missing but that she had told them that she might be pregnant. They had found aerosols in her room and she had told them that she drank alcohol and smoked drugs. They had checked her Facebook account and discovered that she had been in touch with a 20-year old man. She stated on

Facebook that she had first had sex when she was 8 years old.

3.5.2 On 16 April 2012 the Foster Carers 3 telephoned and e-mailed Social Worker 1 to let her know that they had collected Child E from Orpington the previous evening. Foster Carers 3 arranged for the GP to visit Child E the following day at the foster placement. Child E told the GP that she had had unprotected sex recently and that she thought she might be pregnant. She also told the GP about being missing and said that she had been drinking, smoking and sniffing aerosols. The GP agreed to arrange for a hospital pregnancy test and to make a referral to CAMHS.

3.5.3 On 18 April 2012, the results of the hospital pregnancy test came back negative. On the same day, Bexley CAMHS accepted the referral made by the GP.

3.5.4 On 19 April 2012, Social Worker 1 reported to the police that Child E was missing from her foster placement. The Carers said she had gone to Orpington and that they had been unable to stop her going. She was still using aerosols and "can't sit still".

3.5.5 The following day, Safehouses IFA, advised they wanted to end the placement as they felt Child E could not be safely managed there and her placement was having a negative impact on the other young person in placement. Social Worker 1 was of the view that Foster Carers 3 were building a relationship with Child E, and with the CAMHS appointment booked, the placement should continue, however she sought consent from the Head of Service for a residential placement for Child E, as this second foster placement had failed to contain Child E.

3.5.6 The Placement Manager in the CPS identified a suitable Residential Placement for Child E. It was small with just 4 beds, owned and run by Ethelbert Children's Services. The referral confirmed Child E's vulnerability and significant needs, highlighting that she was not engaging in education and had been statemented due to her emotional and behavioural needs, and that she attends CAMHS. Her absconding behaviour was stated, and the belief that she gravitated to the Woolwich area. It was confirmed that she used aerosols, cannabis and other substances, which impacted on her moods and behaviour. Later that day a decision was made to place Child E at the residential placement. This was followed up by a written referral that was e-mailed to Ethelbert Children's Services, by the Placements Manager from the CPS, stating that "Child E had a long history of going missing. A vulnerable young person. It is likely she has been sexually exploited. She requires a high level of support and care".

3.5.7 Social Worker 1 subsequently telephoned the Residential Social Worker (MH RSW 1) at the Residential Placement and explained that Child E was to be placed at the Residential Placement but was currently missing. Social worker 1 provided Child E's mobile telephone number, her own telephone number, and a number for EDT for out of hours support.

3.5.8 MH RSW 1 telephoned Child E at 5.14pm, encouraging her to come to the Residential Placement. Child E said she was at her cousin's house and would call him back in an hour. Meanwhile, MH RSW 1 telephoned Social Worker 1 to inform her that he had made contact with Child E and arrangements were made for Foster Carers 3 to take Child E's belongings to the Residential Placement.

3.5.9 MH RSW 1 telephoned Child E several times that evening in an attempt to get her to the Residential Placement, without success. He then spoke to EDT SW 1.

There is disparity in accounts given in relation to this conversation as MH RSW 1 said he was advised to stop calling Child E as the Police would bring her to the Residential Placement when they found her. In interview, he told the IMR author that he was concerned at being told to stop contacting Child E as he "had hoped that continued engagement and rapport building may be better support for her safety by gaining trust in the placement". However EDT has no record of this conversation.

3.5.10 The following day, Saturday 21 April 2012, Foster Carers 3, telephoned the Residential Placement, to speak to Child E as they had had a message from Child E to say that she was now there. MH RSW 1 telephoned Child E and advised her to go to the police station, and that they would bring her to the Placement. Child E said she did not want to be brought there by the Police.

3.5.11 On 24 April 2012, Child E was arrested for criminal damage, assault and racially aggravated assault on a member of residential staff. Child E and another resident had been misusing aerosols and had become disruptive and started damaging property. A member of staff called the Police, and Child E had punched a male member of staff in the face. The Police arrived at 9.43pm and arrested the other resident and took her out to the Police car. Child E meanwhile went up to her bedroom, smashed the first floor window and tried to escape by standing on the roof of the ground floor bay window. MH RSW 2 showed the Police to Child E's bedroom and went over to the window and pulled her back into the room. MH RSW 2 was clear that Child E was not threatening to jump or to hurt herself. She was of the view that Child E wanted to show her solidarity to the other resident by this behaviour. Child E was then arrested

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3.5.12 The Police telephoned the Residential Placement at 11.05pm and asked for a member of staff to attend the police station to act as appropriate adult for the interviews. Child E was kept in police custody overnight, as there was no appropriate adult available because the staff on duty had been involved in the incident. MH RSW 3, attended the police station the following day to act as appropriate adult. He returned to the Residential Placement at 1.30pm without Child E, saying that the Police had detained her to appear in court the following day, 26 April 2012.

3.5.13 On 25 April 2012, Social Worker 1 attended a Placement Planning meeting at the Residential Placement. Notes taken by the staff indicated there were "no restrictions on contact with family…whereabouts of one of Child E's sibling and mother were unknown".

3.5.14 A risk assessment was completed by a member of staff at the Residential Placement that day on stranger danger, absconding, unprotected intercourse, substance misuse, and criminal behaviour. No risk assessment was undertaken in relation to sexual exploitation, although the absconding risk assessment noted, "placing herself at risk of being sexually exploited".

3.5.15 On 26 April 2012, Child E appeared in court, accompanied by MH RSW 1 and was remanded to the care of the local authority by the court and taken back to the Placement by MH RSW1. Social Worker 1 telephoned the Residential Placement and expressed her "unhappiness about Child E being detained in custody for two nights". There is no evidence that she raised this matter with the Police.

3.5.16 On 30 April 2012, Social Worker 1, made a referral to the police, expressing concern that Child E was the victim of sexual exploitation and that she might be

pregnant and the father was said to be a 20-year old male. The Police chronology recorded that "Police had attempted unsuccessfully to speak to Child E" due to her absences from the placement.

3.5.17 A Missing Person Strategy Meeting took place on 9 May 2012 as a result of the referral from Social Worker 1 to the Police. The CSC record of the meeting noted that since being placed at the Residential Placement, Child E had only spent 3 nights there and was going out with another female resident, also a Bexley LAC. There were concerns about drug use and predatory males. The recommendations of the meeting included:

(i) a decision to move the other resident to another placement
(ii) that Social Worker 1 would liaise with Greenwich LA about securing Breakthough education provision for Child E
(iii) Bexley Police "to ensure that efforts to find Child E are co-ordinated with Greenwich Police."

3.5.18 On 11 May 2012 Child E and her keyworker attended a meeting at Breakthrough alternative education provision. She started attending there on 21 May 2012 and attended on 9 occasions.

3.5.19 On Tuesday 14 May 2012 Child E left the Residential Placement at 10pm with a resident to meet the resident's mother at a nearby train station. They were brought back to the Residential Placement by an officer from the Sapphire Unit (a special unit set up by the Police in September 2009 to improve victim care and levels of investigation into specific types of offences) after Child E had presented at the Police station at 2.04am that morning to say that her friend had suffered a serious assault.

3.5.20 On 17 May 2012 Child E asked for a private conversation with MH RSW 1. Her pocket money had been delayed as a sanction for her behaviour in the home. She was unhappy about this. Whilst talking to him, she said she "had been getting urges to hurt someone or kill herself" and said her life had been "shitty and was not worth living". She said she found comfort in smoking weed and had spent her time with the friend in the residential in the past few weeks, looking for weed or looking for money to buy weed, as this was the only thing that could make her forget. MH RSW 1 asked Child E to reflect on how she could change her situation, reminded her that she had wanted to return to education but given the opportunity she had not, and changed her sanction so that she would vacuum the floors rather than have her pocket money delayed.

3.5.21 On 18 May 2012 Child E was arrested for travelling on a train without a ticket or any money. She was arrested in Colchester, detained in custody overnight and appeared in court the following day. She was supported in court by MH RSW 1 and granted bail, on the condition that she stayed at the Residential Placement and remained there between the hours of 6pm-6am.

3.5.22 A further Strategy Meeting took place on the same day attended by two Police officers. It is recorded in the Ethelbert Homes IMR that the meeting was called because of concern about the "Brixton Incident", Child E's frequent absconding and the risks to both her and another resident. It also records that a pregnancy test was negative, and that the other resident would be moved to another placement within 2 weeks.

3.5.23 On 21 May 2012, a second LAC Review took place at the Residential Placement.

There were 9 recommendations (some outstanding from the previous review), including a recommendation that as Social Worker 1 was due to leave, the Chair would speak to the Service Manager to ensure that a new social worker was allocated.

3.5.24 On 24 May 2012, a meeting took place between Social Worker 1 and CAMHS to discuss the impact that the departure of Social Worker 1 might have on Child E. Social Worker 1 had planned a farewell lunch with Child E.

3.5.25 On 25 May 2102 Child E failed to attend court and a warrant was issued for her arrest. Four days later, a YOT worker went to the Residential Placement to talk to Child E about the warrant, but she ran away. The Residential placement was told that the curfew had been lifted but was advised to take Child E to the police station before she was arrested on the warrant, and to contact her solicitor. She also left a message for Social Worker 1 on 30 May 2012, asking her to telephone her about the warrant.

3.5.26 The following day, 31 May 2012, Child E was arrested and appeared at East London Juvenile Court for failing to appear in court and in relation to the assault and criminal damage charges at the residential unit. A Youth Rehabilitation Order was made. Social Worker 1"expressed concern" that Child E had spent the day in custody without any support from an appropriate adult and challenged the manager of the Residential Placement about this. According to the CSC records "they stated that they did not have staff available but keyworker to attend court with her later".

3.5.27 On 6 June 2012, Social Worker 1 left the local authority. A social worker was allocated to Child E but unfortunately went on sick leave shortly after being allocated the case. It transpired that the newly allocated social worker was in the early stages of pregnancy and the Manager decided to allocate a different social worker so that Child E could form a relationship with a social worker who would not be going on maternity leave in the coming months. The senior social worker for Social Worker 1 had social work responsibility for Child E until Social Worker 2 became Child E's allocated social worker on 25 June 2012. The same senior social worker was the line manager for Social Worker 2, which ensured social work continuity for Child E.

3.5.28 By 18 June 2012, during a time that Child E was missing from care, the Police noted that they were unable to locate Mrs F, as she seemed to have moved to a new address.

3.5.29 On 22 June 2012 Child E went missing for the last time. She had been at The Residential Placement for 62 days and during that time she was reported missing on 41 occasions. However, the majority of these episodes involved Child E being missing late evening through to the early hours of the morning in the company of another resident of the Unit.

3.5.30 On the 29 June 2012, Child E's body was found outside the home of Mr H. She was taken to Hospital in Woolwich, accompanied by Mr H in the ambulance where she was declared dead at 6.50am. The initial post mortem showed no organic cause of death and there were no signs of trauma or assault. Toxicology tests have proved inconclusive and the cause of death is unexplained

4.0 ANALYSIS OF PRACTICE IN RELATION TO THE TERMS OF REFERENCE

Working Together 2010 outlines matters to be addressed by IMR authors and by

the overview author in their reports. In addition, the SCRP has agreed some specific questions to be addressed in this particular review. These have been grouped together where there is any commonality to avoid unnecessary repetition. Issues relating to compliance/non compliance with procedures, communication, information sharing and cross border engagement are analysed under each main heading, rather than separate sections on these at the end of the report.

4.1 ASSESSMENT

4.1.1 **Generally: What were the key relevant points/opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way? Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments.**

4.1.2 **Specifically: Given the history of care proceedings, should Child E have been allowed to return to the care of her mother after her grandmother's death? If so, should a child protection plan have been put in place?**

4.1.3 Child E had been living with her maternal grandmother under a Residence Order since June 2005, and her case had been closed to CSC in December 2006. Therefore CSC was not in a position to "allow" or "not allow" Child E to return to live with her mother, as they had no statutory involvement.

4.1.4 Although CSC had not had any involvement with Child E since the conclusion of the care proceedings, there had been on-going involvement with her mother and her siblings. At the time Child E moved back home in December 2009 one of her older siblings was living there and was an open case and deemed to be a Child in Need (section 17). Another sibling was subject to a Care Order, and although placed in a residential setting, was spending time in the family home. CSC did therefore have some understanding of the family functioning and whether the historical concerns remained. However, this information was not formulated into a formal assessment.

4.1.5 Child E's return to live with her mother in December 2009, following her grandmother's death, was a key point at which a core assessment should have been undertaken in order to inform decision making and it is concerning that no formal assessment of Child E was undertaken given the complexity of the family and the history as already known to CSC. Any assessment should have included consideration of any risks posed by others, and taken into account Child E's history, her views and those of her family, along with other professionals. It would have been an opportunity to focus on Child E and identify her needs, including where she could live, and the need for emotional support to cope with the loss of her grandmother. Consideration was not given to Child E living anywhere else, other than with her mother, although Child E expressed her strong wish to live with her mother.

4.1.6 In appraising practice at this point it did fall short of the expected standard. This matter was explored by the CSC IMR author in interviews with both Social Worker 1 and her supervisor, the Senior Social Worker. The former could not recall why an Initial Assessment was not completed. The IMR author commented "it does not appear that this (completing an Initial Assessment) was raised by the SSW in supervision, although in interview the SSW did say that she felt the case should have been more fully assessed but she felt she was not listened to by Social

Worker 1 who had "fixed views". This points to a divergence of view between the social worker and supervisor that was not acknowledged and resolved through supervision and management oversight. The IMR author further stated that "there is no record of the senior social worker's decision on the system to say that she instructed an IA or CA to be completed, nor is it referred to in supervision summaries". What it suggests is that there was no management supervision "grip" on the case. The matter of management oversight and supervision is discussed further in the report (section 4.9).

4.1.7 In seeking to establish what influenced the lack of assessment it is helpful to look beyond the individual and consider it from a 'systems perspective, examining whether processes or thinking influenced the outcome. Considering this from a "process" point of view, when Child E moved home, no new referral was opened for her and this may have influenced subsequent practice. If a referral had been opened it would have triggered the need to complete an Assessment. In a process driven system this could offer one explanation of why an assessment was not triggered.

4.1.8 A further explanation to account for the lack of formal assessment may also be the human element that might have influenced thinking about the case and what action was needed. There is clear evidence that this was a complex family to work with and there had been longstanding involvement with professionals in CSC and other agencies. One of the consequences of this relationship, expressed by CSC staff, was that they had been left feeling "disempowered" and "stuck" in relation to this family.

4.1.9 Whilst the CSC IMR confirms that supervision took place, a family situation of this complexity requires robust supervision and management oversight providing support and challenge. An element of this includes support to enable staff to complete a Core Assessment, as the basis for making appropriate plans for Child E. One solution in a family such as this with a history of social care intervention is for someone new to look at the case with a "fresh pair of eyes", and to allocate a new social worker. However, this is also balanced with the continuity of social work intervention experience by this family. In some respects the involvement of the student social worker did bring a "fresh pair of eyes" and did provide new energy to the case, but the lack of robust supervision resulted in a Core Assessment still not being formally recorded, despite an expectation that this was what the student social worker was going to do.

4.1.10 **Should there have been a child protection plan?**

Coming back to the question posed in the terms of reference about whether or not Child E should have been subject to a child protection plan in December 2009, it is not possible to say whether an assessment at that stage would have triggered a child protection conference and plan.

4.2 CHILD E AS A CHILD IN NEED

4.2.1 **Specifically: How effective were child in need planning and interventions, including risk management, education provision and helping Child E come to terms with her grandmother's death?**

4.2.2 Child E remained a Child in Need, living at home from December 2009 until 10 February 2012, apart from a very brief spell as a Looked after Child (in July 2010) which lasted only a matter of days when she absconded from the placement**.**

4.2.3 Upon returning to her mother's care Child E's behaviour quickly deteriorated. There is evidence that staff at the school did their best to contain and help her, and likewise School 2. Although the allocated Social Worker also appeared to try to provide support, it is clear that she struggled to focus on Child E's needs and was distracted by the competing complexity of need within the family. The period when the student social worker was involved did demonstrate a focus on Child E, and a sense that things were getting done, although it should be acknowledged that even with this considerable focus, Child E's situation continued to deteriorate.

4.2.4 A number of Child in Need meetings did take place, but the absence of a written Core Assessment and a written Child in Need Plan diminished a common sense of purpose and direction across agencies. There were also Professionals Meetings, but it is not clear if the difference in purpose between these and Child in Need meetings were commonly understood across all agencies. An emerging feature was the view of professionals (other than CSC) that Child E was at risk of significant harm whilst in her mother's care and that the situation should have been seen as child protection. There is evidence of an on-going tension between CSC and the other agencies about thresholds and the most appropriate way to manage the risks, which remained unresolved until Child E became a looked after child in February 2012. This points to ineffective inter-agency communication, during this period, that was not acknowledged and addressed, either informally, or formally, through use of the LSCB escalation process.

4.2.5 During the period December 2009 to February 2012, a total of 10 Child in Need meetings took place, mostly chaired by the social worker. Although there were notes for these meetings, there were only records of minutes being taken and circulated for one, and not having a formal minute of meetings does not meet the expected standard of practice. This may have had an adverse impact on the effectiveness of planning amongst the agencies.

4.2.6 The CSC IMR author was not able to locate a Child in Need plan as a stand-alone document, though there were references to tasks and actions in the social workers notes. The IMR author concluded, there is no "written plan…there is no clear statement of what is to be achieved, no timescales and no effective evaluation of progress of the plan against measurable outcomes. The CIN meetings do not include analysis of risk that would inform planning". Although there was the lack of an overarching Child in Need plan and risk assessment, agencies were providing a range of services but were often responding to crises. However there is evidence from the chronology that there was clarity about some outcomes that were to be achieved from the notes of the Child in Need meetings.

4.2.7 **The effectiveness of Education provision**

4.2.8 There is evidence of good practice by School 1 in trying to keep Child E in school, engaging with her mother, informing CSC regularly of what was happening, instigating professionals meetings, referring Child E to the Behaviour Improvement Programme Centre and CAMHS and showing persistence in following this through by involving CAMHS in a subsequent Professionals Meeting, which resulted in them agreeing to undertake an assessment on Child E.

4.2.9 They were also very prompt in triggering a Professionals Meeting on 27 September 2010, after Child E had assaulted a member of staff. They ensured that the appropriate professionals attended (although Social Worker 1 did not

attend, and it is not clear whether/not she was invited) and it was as a consequence of this meeting that Child E was offered a place at School 2.

4.2.10 There is evidence that professionals at School 2 were committed to trying to keep Child E in education, but despite their specialist remit, they struggled to keep her in school and her deteriorating behaviour resulted in several periods of exclusion and eventually in her not attending the specialist school at all.

4.2.11 There is also evidence of good practice by the student social worker who demonstrated a commitment to trying to meet Child E's educational needs, taking her to school, SEN appointments and also re-integration meetings.

4.2.12 Although undertaking a statement of special educational needs (SEN) statutory assessment was first mentioned in November 2010 by School 1 it was not until the Child in Need meeting in February 2011 that it was agreed that the SEN assessment process should be initiated. This delay was not in Child E's interests.

4.2.13 During the 17-month period between her last day at School 2 and her death, various actions had been agreed and attempted to try and get Child E back into education. However, the only educational input she had during that time was 9 days attendance at Breakthrough from 21 May 2012 onwards, when she had become a looked after child.

4.2.14 Effectiveness of CIN planning in helping Child E come to terms with her grandmother's death

4.2.15 The issues already identified regarding the lack of effectiveness of Child in Need planning in respect of Child E will also have impacted upon the ability of professionals to respond effectively to her therapeutic needs in response to her grandmother's death.

4.2.16 There is research[2] to indicate that there are factors which increase the potential for children and young people to experience a poor adaptation to the death of a parent/parent figure, including, losing a parent suddenly; loss of a mother; less cohesive families; families with a large number of stressors. Some of these were features in Child E's life and provided an indication that she would more likely struggle to adapt to the death of her grandmother. It is telling that whilst she was at the Residential Placement she shared her feelings, saying that she still missed her Grandmother (who had died 3 years earlier) and that she had kept her Grandmother's handbag, with a bus pass inside; "the bag was kept centre stage in Child E's bedroom. Child E had her Nan's nightdress which she wore to bed".

4.2.17 Although there were obvious deficits in the effectiveness of Child in Need planning in response to Child E's needs, there is evidence to suggest that Child E's need for bereavement support was acknowledged and recognised from the start of work with Child E. The first Child in Need meeting was attended by a representative from a mentoring and befriending service who later offered some support to Child E and there were attempts to engage Child E in counselling, albeit she was reluctant to do so.

4.3 Domestic Abuse, Substance Misuse and Parental Mental Health Problems:

[2] Worden, W (1996) Children and Grief: when a parent dies. New York: Guildford Press

How far were these issues understood in relation to both Child E and her mother, and in relation to Child E's violent and offending behaviour?

4.3.1 In the latest biennial Review of Serious Case Reviews[3] data again reinforces the significance of the inter-relationship between domestic violence/abuse, mental ill health and substance misuse:

4.3.2 "*At least one of these characteristics was evident in the lives of families at the centre of serious case reviews in 86% of the cases. Almost two thirds of the cases featured domestic violence, and parental ill health was identified in 60% of cases. Parental substance misuse was evident in 42% of cases. All three factors were present in just over one fifth of the cases and, as in our previous biennial reviews, we argue that it is the combination of these factors which is particularly "toxic"."*

4.3.3 It seems clear that drug and alcohol abuse was a feature of this complex family and that for both Mrs F and her daughter Child E, there was an inter relationship between this and their relationship with each other. There seems to be a link between Mrs F's substance misuse and her low mood, resulting in either a feeling that she did not have the capacity to parent Child E or that she could not cope. It was as a response to the former that Child E first became accommodated in July 2010, and as a response to the latter that she became accommodated for the second time in February 2012. Seen from this perspective both periods of accommodation were a reactive response to Mrs F's requests and the focus regarding accommodating Child E was on the needs of the adult and not the child.

4.3.4 There is evidence that following Child E's return to live with her mother in December 2009, two concerns arose about potential substance misuse quite quickly: the first mention of Child E sniffing aerosols was in January 2010. Less than a month later the school contacted Child E's mother to say that Child E had been found misusing aerosols. On 9 August 2010 Child E was taken to A&E late one evening (10.37pm) with what was described as a "fainting episode". It is recorded in health records that she "denied using alcohol or drugs". There is no evidence that these two incidents, which may have been indicative of the onset of drug use, were discussed with Child E or her mother by Social Worker 1, despite the fact that Child E was twelve years old at that time. There was evidence that the student social worker had subsequently discussed with Child E, her substance misuse and the risks attached.

4.3.5 Alongside the concerns regarding possible substance misuse, concerns also arose regarding Child E's behaviour, including violent outbursts ending with criminal charges and defiance towards the status quo, non-attendance at school and other appointments, court appearances and running away.

4.3.6 What appears to have been missing during the period under review is a coherent assessment by all professionals about what was going on in this family as a whole, and what the impact was on each of the children.

4.3.7 In using the recent research from Brandon et al there are several indicators that point, with the benefit of hindsight, that Child E was particularly vulnerable:

[3] Brandon. M. et al, New Learning from serious case reviews: a two year report for 2009-2011, DfE-RR226

- One in five Serious Case Reviews relate to large families
- Where there were siblings, and birth order could be determined, around two thirds of cases in the biennial reviews identified heightened vulnerability for the youngest child
- 13% of children had been the subject of a plan in the past. This proportion has remained constant over time and shows that risks of serious harm can be enduring

4.3.8 The missed opportunities to undertake an assessment of Child E's needs throughout the period under review meant that the extent of her drug taking and solvent abuse and the impact they had on her behaviour were not fully understood.

4.3.9 It is concerning to read the CSC Placement Manager's description of Child E to Ethelbert Children's Services in April 2012, when looking for an emergency residential placement. She was described as being very vulnerable and not engaging in education and being statemented with emotional and behavioural needs. It said she 'attends CAMHS' (although this was not accurate, as she was not attending). It confirmed she was misusing a range of substances and aerosols which impacted on her moods and behaviour. It also confirmed "She needs nurturing and boundaries to support her individual needs".

4.3.10 Similarly, the suspected extent of Mrs F's drug use and its impact on her capacity to parent appears to have been minimised. There is no evidence that the social workers involved contacted Mrs F's GP for information about her mental health or suspected drug use in order to assess the potential impact of this on her ability to parent Child E. What is of concern is the lack of any professional curiosity about this, even in the light of telephone calls to EDT raising concerns, as well as the frequent provision of vouchers to the family and the reasons why their benefits needed supplementing.

4.4 How well were issues of mental health and substance misuse understood and acted upon to keep Child E safe?

4.4.1 There were attempts to try to respond to the growing concerns regarding Child E's emotional state by Social Worker 1 and School 1 who both made referrals to CAMHS. However, neither of these referrals led to the provision of any support, as CAMHS did not accept them because the eligibility criteria had not been met.

4.4.2 School 1 was persistent in seeking to gain support for Child E from CAMHS and made a further referral, but was again advised that Child E did not meet the eligibility criteria. Despite this they continued to pursue mental health input for Child E through CAMHS, inviting them to subsequent professionals meetings. It was this persistence that led to the eventual attendance of CAMHS and to an agreement for CAMHS to undertake an assessment of Child E's mental health and any bereavement issues.

4.4.3 In the event, however, Child E was not seen by CAMHS as she failed to attend any of the three appointments offered despite the best efforts of the student social worker to try to get her to appointments. CAMHS closed the case in May 2011.

4.4.4 Child E was again referred to CAMHS when she was Looked After and placed in an IFA foster placement in Kent. Foster Carers 3 GP referred Child E to Bexley CAMHS, who offered a service to support the foster carers despite the fact that

Child E was living in a different area. This practice by the carers, the GP and Bexley CAMHS met the standard expected and showed sensitivity to Child E's needs. Unfortunately this Service did not come to fruition because the placement was terminated and Child E moved.

4.4.5 A CAMHS assessment of Child E never did take place, despite the efforts of many professionals to advocate for her to be able to access the Service.

4.5 What was the quality of all the Looked After arrangements, including the management of placement breakdowns, given Child E's various behavioural difficulties?

4.5.1 In the same way that there was a lack of a focussed recorded assessment when Child E was a Child in Need, this pattern continued during the periods when she was Looked After. Looked After Children statutory Reviews were held within timescales, as were strategy meetings regarding Child E going missing. One of the most significant issues was the lack of a written Care Plan, which should have demonstrated a clear understanding of why Child E was in care, with identified and achievable outcomes, with clear timescales. There does not appear to be any justifiable explanation for why no formal Care Plan was made, given the statutory requirements that frame Looked After services. The July 2012 Ofsted Inspection[4] highlighted care plans as an area requiring improvement, stipulating that all looked after children must have an up to date care plan within three months of the publication of the July 2012 inspection report.

4.5.2 There is no evidence that Child E was seen regularly by the social worker as a looked after child and that statutory visiting requirements were met, albeit effective visiting would have been significantly affected by Child E's continued absconding. Just prior to her death her long term social worker left and the newly allocated social worker was not able to meet Child E due to her absconding behaviour.

4.5.3 Appropriate Placement Planning meetings took place when Child E was placed in the Foster Carer and Residential Placements, there is little evidence that they were seen as opportunities to share information about what was known about Child E's past experiences and her needs. Whilst it would be easy to focus on CSC, other professionals involved did not escalate matters in the way that would have been expected of those with corporate parenting responsibilities. For example, one would have expected Safehouses and Ethelbert Homes to escalate these matters formally if they had concerns about information sharing. There is evidence of ineffective communication and information sharing between all the agencies and most of the professionals involved with Child E as a Looked After child. No particular agency stands out, but communication and information sharing fell below the expected standard.

4.5.4 The ineffective information sharing did have an impact on outcomes for Child E. As the Safehouses IMR author commented that, "had the referral been accurate, up to date and more detailed, with reference to issues around a complex family history, challenging behaviour, including alcohol and drug use, Safehouses would not have matched Child E with these carers, and most likely would not have been able to offer a placement." The events around this referral, the judgements made by all those involved regarding the decision to place, were flawed. The decision

[4] Inspection of Safeguarding and Looked After Children's Services, Ofsted and Care Quality Commission, 24 August 2012.

was based on incomplete information sharing, inaccuracies and gaps in the referral detail, and subsequently on matching, thus placing a child with carers who were not able to provide the surveillance required. Although these carers did provide some good care to Child E.

4.5.5 The same can be said of the placement in the Residential Placement, Child E was placed without a written Care Plan or sufficient information about whether it was safe for her to have contact with family members. However, this placement were given full details of history and risks re Child E.

4.5.6 When professionals had the opportunity, which were limited due to her absconding behaviour, to engage with Child E they did. For example, there was a long conversation between the Independent Reviewing Officer and Child E before the May 2012 LAC review which influenced the care planning regarding moving another Bexley child out of that placement, when the original intention was to move Child E. This was in response to Child E's expressed wish to be allowed to settle in this placement as she expressed the view she was beginning to work with her keyworker there. There is also record of foster carers 3 engaging with Child E and seeking her views and an example used in this report when a residential worker spoke with Child E and found out her views re grandmother.

4.5.7 The YOT IMR confirms the YOT worker had a lengthy conversation with Child E on 21 June 2012 during which she was 'open' and shared significant details about her concerns and feelings. During the time Child E was in care she was missing for substantial periods which makes it difficult for the engagement discussed in this sentence. This resonates with the July 2012 Ofsted Inspection, which noted that, "There is often limited focus on the voice of the children and assessments do not always make full use of historical information".

4.5.8 It was good practice that when Child E was first accommodated on 13th July 2010 the social worker visited the foster placement and accepted it. Child E was then taken to visit the placement on the 12th before moving in the next day.

4.5.9 Child E's second period of section 20 accommodation was triggered after she had been missing for two days and was found by the Police. The Police telephoned her mother but it was quickly established that she had been drinking and she told the Police that Child E could be taken to her Uncle P's, which is what they did. It is not clear why the police did not contact the CSC EDT at this point. The Police chronology indicates that later that day, there was a telephone Strategy Discussion between a member of the CAIT team and Social Worker 1. It was discussed that Uncle P had a conviction and that one of Child E's siblings was also living in the house. Although a Strategy Discussion document was opened on the Social Care database it was not completed, as Child E was taken that day to Foster Carers 2 in Ramsgate, Kent.

4.5.10 It is the author's view that it was not good practice for the Police to take Child E to Uncle P's without involving CSC, or that a section 47 enquiry did not take place.

4.5.11 Child E's placement with Foster Carers 2 was short lived. She had run away from the Placement within a week of being placed and after a further incident of running away the Carers terminated the placement because Child E had been "difficult and abusive". This was the second placement for Child E that had broken down where a disruption meeting did not take place. Had a disruption meeting taken place it could have served to hold the placement, or as a minimum would have offered the opportunity to consider Child E's needs to inform future

placement planning.

4.5.12 The circumstances of Child E's next placement, also raises concern. She was found in Woolwich and transferred to Foster Carers 3 by Kent police, who agreed to collect her from Woolwich police station as the Woolwich police did not have the resources to take her. This is unsatisfactory practice and a less than ideal way of introducing a fourteen year old to foster carers, although clearly there were contributory factors that informed this decision, including a lack of resources.

4.5.13 There is evidence that Foster Carers 3 did engage with Child E, as far as they were able to. They responded to her needs and were diligent and caring, even contacting their own GP, who made a home visit and made a referral to CAMHS.

4.5.14 This placement ended because of Child E's risk taking behaviour and an emergency residential placement was found for her. The way that Child E had to find her own way to the placement and have her identity verified was unacceptable practice. It is the author's view she should have been collected from the police station and taken to the placement by an EDT worker.

4.5.15 There is no evidence that Child E had a LAC health assessment as required. This was because of an issue related to the lack of consent from her mother, but, given her age, Child E could have provided her own consent, though it is quite likely that she would not have engaged in this given her reluctance to engage generally.

4.5.16 It should be noted that even though Child E did not have the required health assessment, health notifications were made in an appropriate and timely way by health services in Bexley to those in Kent.

4.5.17 Child E was kept in custody for a total of 3 nights in a police cell (on 2 separate occasions) whilst she was Looked After in Residential care. This falls short of expected practice for a 14 year old to be held for prolonged periods in a police cell.

4.6 Were there any significant issues relating to culture, diversity, race, religion and disability

4.6.1 There was evidence that this was a family that had a culture of inter-generational pattern of abusive relationships, mental health problems and neglect, both physical and emotional.

4.6.2 Against this backdrop in the extended family it is not surprising that Child E's behaviour began to mirror some of the behaviours that she was exposed to in her everyday life**.** It is of note that Child E was convicted of racially aggravated assault in relation to a member of staff at The Residential Placement on 24 April 2012.

4.6.3 There are no known issues related to disability.

4.7 How effective was the Missing Person Protocol and its implementation? Were the risks to Child E of sexual abuse and/or sexual exploitation effectively considered?

4.7.1 *"Going missing is a key indicator that a child might be in great danger. When children go missing, they are at very serious risk of physical abuse, sexual*

exploitation….Going missing is a key indicator that something is not right in a child's life. It must be seen as a cry for help and always trigger early help. [5]"

4.7.2 In Child E's case, there is evidence that attempts were made to follow the Missing From Care and Sexual Exploitation procedures. There is evidence of a passive attitude towards Child E, perhaps because professionals struggled to understand what to do in light of the increasing concerns.

4.7.3 The Bexley Children Missing from Care protocol sets out clearly the responsibility of CSC if a child goes missing from care or if it believed that there is a risk of them absconding. This includes the completion of a risk assessment, using the LSCB agreed Risk Assessment Matrix. This risk matrix provides a framework in which to assess the young person's vulnerability and the risks they may be exposed to whilst missing. The CSC IMR author noted that, "There is no evidence that any risk assessments were completed although the social worker has said (in interview) that one was completed by hand and given to The Residential Placement". The Residential Placement did complete a risk assessment on Child E's absconding that was regularly reviewed, but it had limited effectiveness as it was not shared with any other agencies.

4.7.4 The Ofsted Inspection in July 2012 identified the need for risk assessments in all cases as an area for immediate improvement, stating that the local authority should: *"ensure all children who are at risk of going missing from care have a regularly reviewed risk assessment in line with the local authority's inter-agency protocol*". The Overview Author would support this in the light of the findings of this review.

4.7.5 The protocol also requires the Safeguarding Children Service to be notified within 24 hours and for a Missing Person Strategy Meeting to be convened within 5 working days if the young person remains missing. It was good practice that two multi-agency Missing Person Strategy Meetings did take place in respect of Child E.

4.7.6 The Police IMR noted that during 2012 Child E "started to become a regular MISPER". During the period that Child E was placed with foster carers in Kent, she went missing on several occasions. Kent police were involved in these missing person investigations and the view of the carers was that they were "very thorough". After the case was passed to the Metropolitan Police the carers were not contacted by the police until Child E went missing for the final time from their care**.**

4.7.7 There is an insight into what life was like for Child E at the time. When she arrived at the carers home on the 30 March 2012, they described her as "thin, frightened and without any belongings". At times during her 22 day placement with them, she said she wanted to be cared for and to feel safe, at other times, however, she was "confused about what she wanted, was angry, frustrated and at times, hated herself". The carers felt that she needed "expert therapeutic help to stabilise her, before any placement in a family would work".

4.7.8 During the time Child E was placed at the Residential Placement (April –June 2012), her behaviour was beyond her own control and placing her at risk of

[5] Report from the Joint Enquiry Into Children Who Go Missing from Care: APPG for Runaway and Missing Children and Adults and the APPG for looked after Children and Care Leavers. June 2012.

significant harm. Much of her absconding was done with another resident and there is evidence that they ran away to look for drugs. A residential worker reported that Child E had "isolated herself in her relationship with [this resident] which had developed a pattern of prolific absconding, until the early hours of the morning which led to them sleeping during the day and it was apparent to residential staff that Child E had drug misuse difficulties: they had smelt cannabis on her clothing and she had presented as under the influence of substances".

4.7.9 The most significant incident that gives us an insight into Child E's life and the risks she faced was the incident in Brixton on 15 May 2012, when Child E had absconded with the same resident. They went to Brixton in search of drugs and her friend was allegedly assaulted by an adult male. This incident really seemed to bring home to Child E the dangers she was exposing herself to.

4.7.10 During the 62 days that Child E was in the Residential Placement she was reported missing to the Police on 41 occasions although many were of a few hours duration and 'unauthorised absences'. It may be that the Police became complacent about this and saw it as part of Child E's way of life: They may also have become desensitised to the risks she was exposed to, including the risk of sexual exploitation. Although the "Brixton incident" was taken seriously and responded to by the Police there is evidence that, on occasions, they did not proactively look for her when she was missing for periods of several days, assuming she had gone to her mother's. The Residential Placement's attitude to Child E's prolific running away seems to have been mechanistic and process driven: ensuring that the necessary people were informed, but little sense of engagement with Child E to try to ameliorate the situation.

4.7.11 The recent All Party Parliamentary Groups (APPG) Inquiry into Children Missing from Care highlights the quandary of care homes either under or over reporting children missing from their care and the impact it can have on the Police response: *"As patterns of grooming for sexual exploitation and other harms such as drug taking or involvement in gangs often involve relatively short periods of being away from the care placement, it is crucial that care staff and other local services are alert to these dangers and informed when a young person's pattern of behaviour indicates risk. Yet an over–reporting of missing incidents to the Police runs the risk of a downgrading of the response from local forces as they tire of being used as a "taxi service" for children's homes".* The final comment resonates with this case and it may be that this is what happened in Child E's case.

4.7.12 LSCB protocols on Missing Children and Sexual Exploitation are generally being complied with but what is needed is better multi-agency working to really understand the issues. The APPR Inquiry recommended an approach similar to the Multi-Agency Risk Assessment Conference (MARAC) Model, which is victim focussed. "*Such a system would bring that relationship together, so that you can get Police officers and workers from care homes working together to understand the issue".*

4.8 How well was the complex family network understood and taken into account of in the work with Child E?

4.8.1 There is limited evidence throughout the review period, that agencies understood and had taken account of the complexities of Child E's extended family network during their work with Child E. Instead there was a sense of professionals feeling overwhelmed working with this complex and non-compliant family.

4.8.2 The impact that the behaviour of other members of this complex family had on Child E and Mrs F needed to be carefully considered. Different family members were staying in the household at various times.

4.8.3 The potential impact of this scenario was evidenced in one of Child E's conversations with Social Worker 1 when she raised concerns at home. Social Worker 1 discussed this with her Managers and it was agreed that Child E was to stay at home. It is difficult to understand why Child E's expressed concerns did not trigger a Section 47 investigation as it would appear that there were potential safeguarding issues.

4.8.4 There were also indications that agencies did not take sufficient account of the functioning of the extended family in planning for Child E. Instead, agencies appeared to respond to the continuing crisis without effective planning, on occasions placing her with potentially inappropriate adults.

4.8.5 The Children's Social Care Emergency Duty Team (EDT) was involved several times during the period under review. They received a telephone call on two separate occasions in 2010 and 2011 from a regular caller to the EDT service, expressing concern about Child E's welfare. Whilst EDT appropriately referred the information to the daytime teams, this was done in the context of the callers presentation (slurred speech and mixed up timescales), which led EDT to conclude that the information was linked to the caller's mental ill health (this caller regularly contacts the EDT service). This suggests a fixed view of the family and a potential de-sensitisation to the possibility of safeguarding issues that may have been present.

4.9 Management Oversight and Supervision

4.9.1 **Children's Social Care**

Between March 2010 and February 2012, a period of nearly two years, Child E's case was discussed in supervision on ten occasions. There is no record of supervision taking place after 23 February 2012 until the time of her death on 29 June 2012, when in fact she was presenting her most challenging behaviour and concerns about the risks she was exposing herself to, had reached a peak.

4.9.2 The CSC IMR report stated, "the (supervision) records that have been seen are brief with limited analysis and no evidence of reflective practice". There is evidence that there was a fixed view of the family within CSC that Child E should remain living with her mother when there was evidence both historical and current, that Mrs F was not able to be a protective parent. Perhaps more reflection in supervision could have considered the option that a thorough assessment of Child E's needs, including her views, might have enabled a properly planned placement to be made, that would have had a greater chance of lasting.

4.9.3 There is evidence that the Social Care Emergency Duty Team (EDT) played a passive role in relation to the concerns raised about Child E. The effectiveness of the service in responding to the needs of vulnerable and non-engaging young people like Child E, who run away from home or the care placement, needs further analysis. This includes reviewing the effectiveness of the supervision arrangements for EDT sessional childcare social workers, who "cover shortfalls on a sessional basis" but do not receive formal supervision in their EDT task role.

4.9.4 The July 2012 Ofsted inspection concluded that, "*the arrangements for monitoring and reporting on the quality of social work practice and management of front line*

practice is underdeveloped. Consequently the local authority's ability to satisfy itself that the children known to social care are adequately protected is underdeveloped".[6] In terms of addressing these concerns, it was noted by Ofsted in their inspection report that, "In the light of the findings of this inspection a number of the planned changes have been brought forward, including the creation of social work professional posts and additional support to strengthen the quality assurance arrangements".

4.9.5 **Safehouses**

During the 22-day placement at Safehouses, the carers were not visited by the supervising social worker or the manager from the agency. The IMR author is of the view that "closer oversight of the manager's role in this case may have been beneficial". It is of concern that a risk assessment, based on very limited information provided by CSC, was approved by the manager at the time of placement, rather than the lack of information itself being challenged.

4.9.6 Better supervision and support for the carers may have resulted in a manager from the agency intervening to facilitate better communication with CSC, and the Police, whereas, it was the carers who were left with this responsibility. A contributory factor to this may have been the fact that the supervising social worker left the agency shortly before the placement began, and the newly appointed support worker was on leave during the first part of the placement. The Team Manager was on leave during the early part of the placement but "covered the situation" during the latter part of the placement on her return from leave. The Team Manager did not receive any supervision within the organisation during the 22-day placement.

4.9.7 The author endorses the comment made by the IMR author that, "because of changes in Safehouses personnel involved, and based on the information that had been given at the time of referral, the agency as a whole did not focus strongly enough on the developing complexities of this particular case".

4.9.8 **The Residential Placement**

There is evidence from the Ethelbert Homes IMR that "there was a lack of robust management by Ethelbert Children's Services in respect of contact arrangements between Child E and her birth family. It may be understandable why residential workers made decisions in isolation supporting their sense of safety in knowing where Child E was (*this was in relation to members of staff taking Child E to stay with members of her family, without discussing this with the allocated social worker*) rather than her vulnerable situation in the community. This is coupled with the helplessness they expressed in interview and also lack of direction or any definition of contact from the LAC Review. However, the increased contact with her birth family led to Child E still not engaging with the Residential Placement and her education provision" (Ethelbert IMR). Staff at the Residential Provision need regular supervision as outlined in the recommendations of the Ethelbert Children's Services IMR report.

[6] Inspection of Safeguarding and Looked After Children's Services, Ofsted and Care Quality Commission, 24 August 2012.

4.10 Communication and Divergent Views

4.10.1 Generally speaking communication between agencies did not meet the expected standard of practice expected from Working Together 2010.[7] There is evidence that effective inter-agency communication was consistently lacking across all agencies. Where communication did take place, it was often procedurally driven (for example communication between the Residential Placement, the Police and CSC in relation to Child E going missing) and the underlying reason for the need to communicate effectively (in order to safeguard Child E) seems to have been lost.

4.10.2 There is evidence of divergence of views between professionals, both inter-agency and intra-agency, that went unresolved and there is no evidence of professionals attempting to address this, either informally, or formally through escalation, to ensure better outcomes for Child E. For example, the divergent views between professionals at the numerous Child in Need meetings which went unchallenged.

4.10.3 Similarly, it is the author's view that communication between staff at the Residential Placement and CSC, including the EDT service, was not effective. When Child E was first placed there, the residential worker tried to engage Child E through calling her on her mobile telephone, but was criticised for this by EDT, although he had been given Child E's mobile telephone number by Social Worker 1. On another occasion a member of staff had taken Child E to stay with her mother, but was criticised by the EDT social worker for doing so.

4.10.4 On 17 May 2012 Child E told her keyworker that she often had urges to hurt someone, or kill herself, and that life was not worth living. There is no evidence that this information was passed from the residential placement on to Social Worker 1 or any other professionals.

4.10.5 Communication between the Police, CSC (including EDT) and the Residential Placement was not conducive to producing good outcomes for Child E. For example, there were two occasions when Child E was detained in custody, as there was no appropriate adult to attend the Police station. Better inter-agency communication at this point could have been focussed on finding alternatives to detaining a vulnerable 14 year old in custody overnight.

4.10.6 Communication between Safehouses and CSC was not effective. The Safehouses IMR author commented that, "The lack of any face to face contact as a form of communication between the carers and the child with the agency or the local authority is a concern". In April 2012, there was a 3-day period when Child E disclosed her belief that she was pregnant, discarded empty aerosols and absconded. Safehouses telephoned CSC and requested an urgent meeting with the social worker, but the call was not returned or responded to and no meeting took place. The Safehouses IMR noted that there were "many occasions when e-mails and telephone calls to the social worker/CSC were not responded to. This was during normal office hours". These concerns should have been escalated by the IFA.

4.10.7 Whilst it is positive that the Safehouses carers shared their concerns about the risks of sexual exploitation with Kent police, based on what they had seen on Child E's Facebook account, it is not evident that they shared this information with their supervising social worker within the agency, or with Child E's social worker.

[7] Working Together, 2010.

4.10.8 There were occasions where communication did meet the required standard eg when Safehouses carers asked their GP to do a home visit when Child E thought she was pregnant and had returned after being missing.

5.0 KEY LEARNING POINTS AND EMERGING ISSUES

5.1 Working with Complex and Chaotic Families Over Time where Chronic Neglect and Non-Engagement with Professionals are Consistent Factors

5.1.1 *"Neglect is a background factor in the majority of serious case reviews (60%), and for children of all ages, not just the younger children. Although neglect is uncommon as the primary cause of death in children, it is a notable feature in the majority of deaths related to but not caused by maltreatment, including SUDI, and suicide, and in over a quarter of homicides and fatal physical assaults".*[8]

5.1.2 There is evidence that Child E had suffered chronic neglect over a long period of time, and that the impact of this on her when she returned home to live with her family was underestimated or not fully considered. The CSC IMR author's view was that the lack of recognition of the long term impact of neglect and emotional abuse did have an impact on professionals' ability to plan effectively for Child E as both a Child in Need and a Looked After Child and this resulted in paralysis and drift whilst a Child in Need case. This resonates with the finding of the July 2012 Ofsted Inspection that *"some cases have been allowed to drift, without managers recognising and dealing with issues swiftly".*[9]

5.1.3 For the professionals involved, being faced with such a large and complex family and all the "dramatic" incidents that seem to underpin their lives constantly must inevitably have evoked feelings of being overwhelmed.

5.1.4 There is a lesson emerging from this case as the family was not recognised and responded to as a "chaotic family" as defined by Marian Brandon[10] and in that sense Child E may have become one of the "invisible children" Brandon describes, resulting in her individual needs not being fully recognised.

5.1.5 There is a sense, conveyed verbally by some of the IMR authors to the Panel, that "It was too late for Child E in terms of breaking the cycle when her grandmother died" and the feeling of disempowerment that this had evoked in professionals working with this complex family.

5.1.6 Being a social worker to this family must have been a significant challenge that would require robust support in terms of good quality supervision and management oversight, but there is no evidence that this support was in place. Both Lord Laming and Professor Munro have emphasised in their separate reviews[11] the complexity and intensity of the task for frontline staff in protecting children and the need for excellent staff support and sufficient time to do the job properly.

5.1.7 A key learning point from this review is the importance of good quality supervision

[8] Brandon. M et al, New Learning from Serious Case Reviews: a two year report for 2009-2011, DfE, July 2012.

[9] Inspection of Safeguarding and Looked After Children's Services, Ofsted and Care Quality Commission, 24 August 2012, paragraph 72.

[10] Marion Brandon et al, Analysing Child Deaths and Serious injury through Abuse and Neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005.

[11] Lord Laming

that should have enabled the case to be examined with a "fresh pair of eyes", to fully assess Child E's needs and the risks she was exposed to, and to challenge social work practice.

5.2 "Hard to Help" Young People

5.2.1 One of the key challenges in this review: how professionals could engage better with children with a similar profile to Child E. There is no "quick-fix" solution to this, but it does require the LSCB to consider ways in which 'hard to help' children could be better engaged and listened to by professionals from all agencies.

5.2.2 In her biennial analysis of serious case reviews in the period 2003-2005, Marian Brandon *et al*[12] identified a group of adolescents she called "hard to help", some of whom had a long history of high level involvement from children's services and other specialist agencies.

5.2.3 Brandon goes on to point out that 'in most of these cases there had been pockets of excellent practice in past years, but by the time of the incident for many of these "'hard to help' children, little or no help was being offered because agencies appeared to have run out of helping strategies". These children had then often experienced what she terms "agency neglect", as professionals lost their way regarding the outcomes they were trying to achieve for the child, and the rigour, with which they pursued these outcomes. This seems to ring true for Child E. The social worker does seem to have lost her way, and any assessment she might have had about what was best for Child E was not written down, discussed or challenged, and was overshadowed by the family history and the competing needs of the other children and the mother herself. One of the key lessons for learning from this case, would be to use this understanding of "hard to help" children to look afresh at any other children who are Looked After in the Borough to ensure that their needs are being addressed in a robust and rigorous manner.

5.2.4 Although Child E may have been "hard to help" there were occasions when she "opened up" and talked to professionals, such as the student social worker, the foster carers, her IRO, the YOT worker and some members of staff at the Residential Placement. However, these opportunities did not result in any injection of energy into a multi-agency plan to ensure good outcomes for her. For example, just after the "Brixton incident", she asked to talk to a particular member of staff at the Residential Placement and told him how bad her life really was. There is no evidence that she was re-assured that what she had told him would be put to good use by the professionals who held corporate parenting responsibility for her to really try and change what was going on. The conversation, as presented in the IMR, turned on what she needed to do with her life and a re-negotiation of the fine about losing her pocket money.

5.3 Running Away and Exposure to the Risks of Sexual Exploitation

5.3.1 With the benefit of hindsight there is evidence that, although the Missing Person protocol was complied with, professionals had difficulty in understanding and managing Child E's escalating missing/absconding behaviour, particularly towards the end of her life. There is little evidence that any robust risk assessment was

[12] Marion Brandon *et al,* Analysing Child Deaths and Serious injury through Abuse and Neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005, page82, Department for Children Schools and Families, 2008

undertaken, including the risks of her being exploited sexually.

5.3.2 The recent Ofsted report on Missing Children[13] highlighted the need for "*tenacious partnership working" across agencies to safeguard children at risk of going missing".* One of the lessons for learning from this case is that, in the author's view, there was no evidence of such tenacity.

6.0 CONCLUSION

6.1 From Problems Comes Learning: the Nub of the Problem in This Case

6.1.1 The nub of the problem in this case seems to be that this was a complex and chaotic family that has been known to agencies for many years. Interventions were attempted in the past; including periods when the children were subject to a child protection plan, but even then, there was evidence that Child E's needs were eclipsed at times by those of her mother and her siblings. CSC did attempt to improve the outcomes for Child E by issuing care proceedings with a care plan for adoption, but even this action was thwarted by the views of the Children's Guardian and the court.

6.1.2 The use of robust supervision, combined with consideration of research on complex and neglectful families could have helped the social worker to "*differentiate those aspects of poor parenting that tend to be correlated with adverse outcomes for the child from the less damaging ones…Social workers need to make best use of evidence on how to help families change…This should include both evidence about the nature of effective working relationships, and of methods to use within these relationships to promote change".* [14]

6.1.3 Although Child E had four years when she appears to have had some sense of stability living with her grandmother, when this changed in December 2009, she returned to the family household. Not only was this still a chaotic and complex family, but the layers of complexity had deepened. However, what seems to have remained unchanged was Mrs F's capacity to meet Child E's needs, and the competing needs of the family.

6.2 What Might Have Been Done to Ensure Better Outcomes for Child E?

6.2.1 There are several pivotal points in this case where, if different action had been taken by professionals, there may have been a different and better outcome for Child E:

- If a thorough Core Assessment had been undertaken and completed, that considered Child E's needs and the best placement options
- If Legal advice had been provided through Legal Planning Meetings
- If consideration had been given to placing her in secure accommodation, under the welfare criteria, at the height of her absconding behaviour.

6.3 Could Child E's Death Have Been Predicted or Prevented?

6.3.1 The cause of Child E's death remains unknown, but there is no evidence to

[13] Missing Children, Ofsted, 8 February 2013
[14] Eileen Munro. The Munro review of Child Protection: The Child's Journey, February 2011

suggest that it could have been prevented.

There is evidence that at the time of her death Child E was living a high risk lifestyle and the risk of her coming to some harm was greater than would be normally expected for a fourteen year old. She had been missing and with hindsight it could have been considered that the next step in her care plan would have been consideration of "containment".

7.0 OVERVIEW REPORT RECOMMENDATIONS:

7.1 *"SCR recommendations are still very numerous and the endeavour to make them specific, achievable and measurable has resulted in a further proliferation of concrete and procedural tasks to be followed through. Part of the issue may lie with the skills and knowledge of those conducting the reviews but also with the need to distinguish between learning lessons and making recommendations. The best learning from serious case reviews may come from the process of carrying out the review".*[15]

7.2 **Missing Persons and Sexual Exploitation Protocols**

There is evidence that, despite protocols already being in place, that what is absent, is a real understanding of how going missing can be seen in the context of a child who has experienced a journey of chronic neglect spanning many years, as Child E had. The recent APPG report from the Joint Inquiry into children who go missing from care and the Ofsted report on Missing Children could be used to enhance learning and improve multi-agency practice in this area.

7.3 **Recommendation 1**

It is recommended that BSCB give consideration to ways of developing existing protocols to ensure a more robust response from all agencies when children go missing. **(***Outcome: Children who go missing regularly are addressed as a higher priority by all agencies, reducing the number and frequency of such episodes).*

7.4 **Outcomes for Child E as a Looked after Child**

There is evidence that there was a lack of focus in achieving good outcomes for Child E as a Looked After Child, and that her voice was not heard during the periods she was Looked After.

7.5 **Recommendation 2**

CSC to reassure the BSCB that the appropriate systems and guidance are in place to a) improve outcomes for children through robust assessment and care planning, and b) ensure that the Independent Reviewing Officer function in the borough provides a robust and effective challenge to delay in care plans being implemented. *(Outcome: care plans are in place, are more effective and there is evidence that drift has been reduced)*.

7.6 **Use of Escalation**

There is evidence of poor inter-agency communication and information sharing. It is important that agencies understand and use existing escalation procedures in order to resolve matters effectively.

7.7 **Recommendation 3**

Agencies to reassure the BSCB that problem-solving procedures are reviewed.

[15] Brandon. M. et al. New Learning from serious Case Reviews: a two year report for 2009-2011, DfE-RR226

Agencies to reassure the BSCB that the revised protocol is understood and used appropriately. *(Outcome: staff feel more confident that they are able to raise concerns about the actions of other agencies or staff in their own agencies in order to resolve matters of divergence effectively)*.

7.8 **The Effectiveness of the Emergency Duty Team in responding to vulnerable young people deemed to be Children in Need and Looked After who run away from home or the care placement**

There is evidence that the EDT did not respond in a way that ensured good outcomes for Child E, in the role as appropriate adult at the Police station and taking an active role in taking her to the agreed placement. There is a need to look at systemic issues underpinning the EDT service, including supervision, to ensure good practice, including inter-agency communication, are in place.

7.9 **Recommendation 4**

CSC to reassure the LSCB that the EDT service is able to respond effectively to the needs of vulnerable "hard to reach" young people whose running away from home or care placement triggers the involvement of EDT with other agencies such as the Police and care providers. *(Outcome: EDT is better able to respond to emergencies involving young people who are LAC and CIN, whether through direct help or the provision of advice and support to other agencies).*

7.10 **The Effectiveness of the Child in Need System**

There is evidence that the Child in Need system for children (section 17) is not effective and robust in ensuring good outcomes for children. There was evidence of a lack of assessment, planning, monitoring and review, and lack of a clear understanding by agencies of the purpose of Children in Need meetings. There was also evidence of poor recording of such meetings and actions being agreed and completed.

7.11 **Recommendation 5**

CSC to lead a review of the Children in Need procedures and processes to ensure all agencies have a more effective focus on the child's journey. *(Outcome: to ensure better outcomes for Children in Need, through improved assessment, planning and review).*

7.12 **Management Oversight and Supervision**

There is evidence in this case that there was no formal assessment of Child E during her time as a Child in Need or as a Looked After child. The case was complex and challenging because of the family history and dynamics and required robust supervision and case management to ensure a focus on achieving good outcomes for the child in the context of competing needs from other family members, both adult and siblings. Work is already underway on this through the Safeguarding Improvement Plan, so no specific recommendation will be made here, to avoid duplication.

7.13 **Understanding Complex and Non-Engaging Families where there is a history of chronic neglect, domestic abuse, substance misuse and mental health issues.**

The need for a greater understanding of the inter-relationships between these issues on parenting capacity has become evident through this review. The overview author is aware that concerns about this have been raised through another management review, and the SCRP endorse the importance of taking this matter forward. Therefore, no additional recommendation will be made about this, in order to avoid duplication.

APPENDIX 1

TERMS OF REFERENCE

1. Given the previous history of care proceedings should Child E have been allowed to return to her mother's care after her grandmother's death? If so, should a child protection plan have been put in place?

2. How effective were child in need planning and interventions, including risk management, education provision and helping Child E come to terms with her grandmother's death, from December 2009 to the point of her becoming looked after in February 2012?

3. How well were issues of mental health and substance misuse, both for Child E and her mother, understood and acted upon keeping Child E safe?

4. What was the quality of all looked after arrangements, including management of placement breakdowns, given Child E's various behavioural difficulties?

5. How effective was the missing person procedure and its implementation in this case?

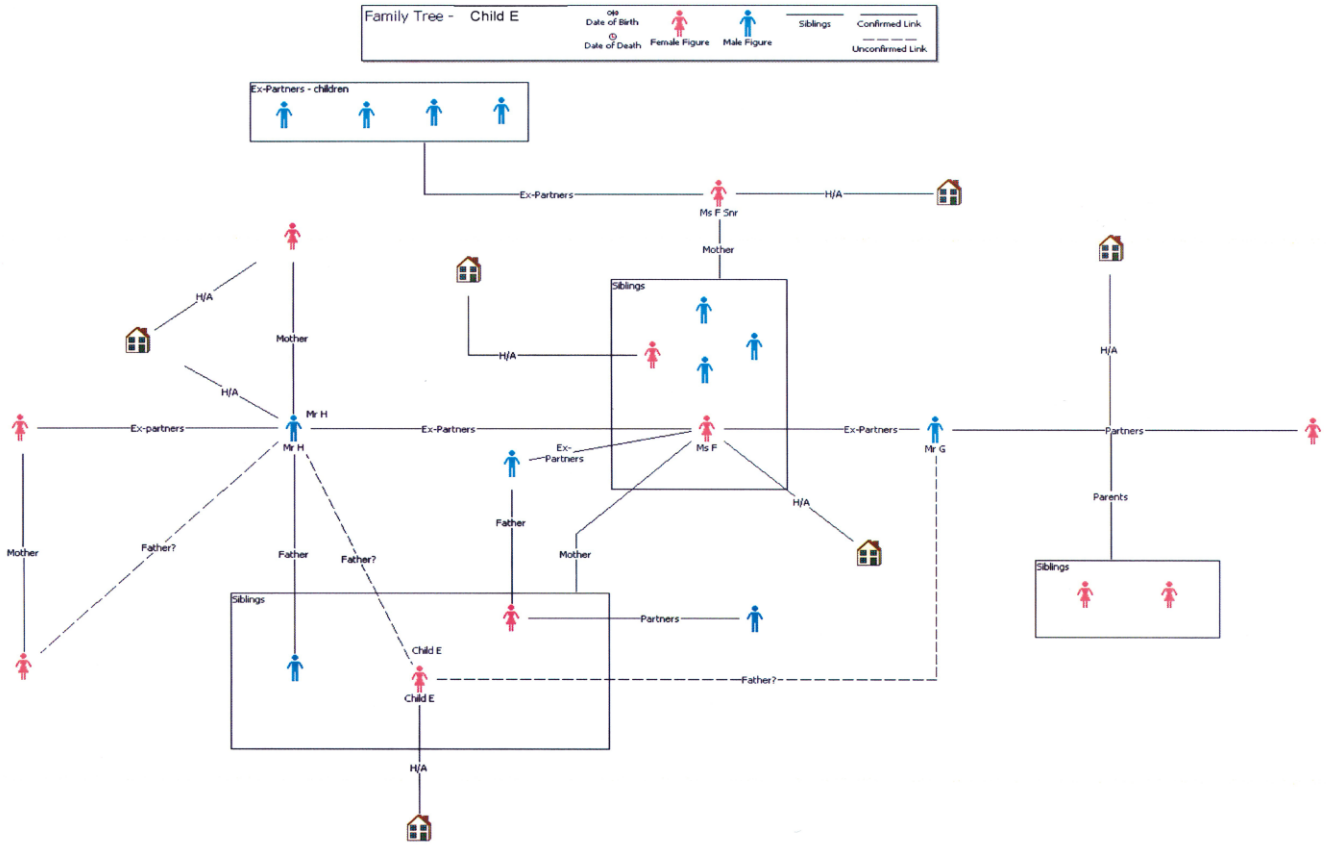
6. How well was Child E's violent/offending behaviour addressed?

7. How well was the complex family network including the roles of extended family and significant males understood and taken account of in all the work with Child E?

8. Were the risks of sexual abuse and/or sexual exploitation to Child E while she was missing from home and care effectively considered

APPENDIX 2

GENOGRAM:


Family Tree - Child E
Date of Birth
Date of Death
Female Figure
Male Figure
Siblings
Confirmed Link
Unconfirmed Link
Ex-Partners - children
Ex-Partners
Ms F Snr
H/A
Mother
Siblings
H/A
Mother
H/A
Mr H
Ex-partners
Mr H
Ex-Partners
Ms F
Ex-Partners
Mr G
Ex-Partners
Partners
Parents
Siblings
Father
Mother
Father?
Father
Father?
Siblings
Partners
Child E
Child E
Father?
H/A