Executive Summary of the Serious Case Review into the services provided for young person ‘B’ during the period March 1993 – February 2007

BROMLEY SAFEGUARDING CHILDREN BOARD

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PREFACE

This report is the Executive Summary of the overview report containing the findings of the Serious Case Review (SCR) conducted by Bromley Local Safeguarding Children Board (LSCB).

The LSCB SCR draws on the findings of individual management reviews conducted within all of the agencies who provided services for ‘B’.

This summary contains the following:

1. **An overview of the circumstances leading to the death of ‘B’ and the decision to establish the SCR.**
2. **The terms of reference of the review**
3. **A list of the agencies involved**
4. **A list of key events**
5. **An evaluation of the services provided and the main findings of the review**
6. **A summary of the recommendations made by the individual management reviews and the LSCB.**

The recommendations have been set out in detail in an action plan. The LSCB is responsible for ensuring that they are implemented by the agencies concerned and by the board itself.

Copies of the SCR overview report and supporting documents are submitted to central government bodies for scrutiny.

1 INTRODUCTION

1.1 This report was produced by Bromley Safeguarding Children Board (BSCB) in order to fulfil the requirements of Chapter 8 of the *Working Together* guidance.[1] This guidance sets out the arrangements for the local inter-agency review of child protection cases where a child has died and abuse or neglect is considered to be a factor in the death and there are important lessons for the local network of agencies with child protection responsibilities. The detailed current arrangements for review of cases by authorities in London are contained in the London Child Protection Procedures.

1.2 The purpose of the report is to review the involvement of agencies with the young person 'B' and her family and to highlight any significant findings with the objective of improving local child protection practice. This is the LSCB overview report on the case which is designed to summarise and complement the findings of the individual agency management reviews.

1.3 'B' was born in born in April 1990 and died in February 2007. The circumstances of B's death are that she was found hanging from a skylight window in the bathroom of her family home. At that time 'B' was living with her mother and her half brother (aged 4½). Her younger sister was living with her father (who is also the father or 'B'). The death has been treated as a suicide. The night before there had been a family dispute in which 'B' had been hurt but her minor injuries proved to be unrelated to the cause of her death.

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v Department of Health, Home Office, Welsh Office, Department for Education and Employment, *Working Together to safeguard children*,*2006*

1.4 In the aftermath of the death it was recognised that ‘B’ and her family had had contact with a number agencies in Bromley and in other boroughs and that ‘B’ had been referred on a number of occasions because of concerns about depression. It was agreed by the Local Safeguarding Children Board that the circumstances of B’s death fell within the parameters of cases requiring a serious case review (SCR).

2 SCOPE, FOCUS AND TERMS OF REFERENCE OF THE REVIEW

2.1 The *Working Together* guidance makes the local safeguarding children board responsible for determining the scope and terms of reference for a review in the light of the circumstances of the particular case. The LSCB agreed that the terms of reference for the SCR would follow those set out in the London child protection procedures and also address a series of questions specific to the case. The overall terms of reference are as follows:

- to draw together a full picture of the services provided;
- to establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children
- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and hence improve inter-agency working and better safeguard children

2.2 The specific additional issues which the SCR was asked to address are set out below:

The review will examine the services offered to ‘B’ and her family from 1993 with the aim of identifying any systemic weaknesses arising from the way that agencies worked together to provide for B’s safeguarding.

1) The family have been known to agencies in Croydon, Bromley and Greenwich. Was adequate information passed between agencies

and boroughs to ensure that any vulnerability the family had were identified and addressed?

2) The family presented with housing difficulties in Bromley. Did Bromley children's social care and housing departments work together effectively to address this issue?
3) Did Bromley Social Care's assessment of the family in July 2003 adequately address the needs of the children?
4) Was Bromley Education Welfare Service's response to the family adequate?
5) Was there sufficient follow up by Mayday hospital of B's overdose on 12.12.06 and was the response from Children's Social Care adequate.

What lessons can be learnt to improve the way agencies work together in Bromley to safeguard vulnerable families?

The time period covered by the review was March 1993 – 2007.

2.3 In order to satisfy these terms of reference, the agency management reviews have evaluated whether the approach adopted by individual agencies met the standards laid down in government guidance, internal procedures and current professional standards. The LSCB SCR overview report examines the way in which agencies worked together to meet B's needs, examining in detail the planning, co-ordination and delivery of services provided. Its responsibility is to determine whether everything that could reasonably have been done was done to minimise risk to 'B' regardless of the specific circumstances in which she died.

3 AGENCIES INVOLVED

3.1 The following agencies (located in Bromley or members of Bromley Safeguarding Children Board) provided services to 'B' and her family within the period covered by the review and have provided information:

- Bromley Council Children's Social Care Services
- Bromley Primary Care Trust
- Oxleas NHS Foundation Trust
- Bromley Education Welfare Service
- Metropolitan Police Service
- Bromley Council Homeless Persons Unit
- Bromley Hospitals Trust

3.2 The following agencies outside of Bromley were also involved and have provided reports or information for the review:

- Croydon Primary Care Trust
- Croydon Children's Social Care and Education Welfare Services
- Croydon Mayday Healthcare Trust
- Lewisham University Hospital NHS Trust
- Greenwich school attendance advisory service

3.3 The SCR panel would have liked to obtain a family view about the services that they were offered. Unfortunately it has not been possible to obtain the family's perspective because they are not currently co-operating with agencies.

4 KEY EVENTS

'B' was born in April 1990. B's sister was born in March 1991 and her brother was born in November 2002.

The agencies have little additional information about their family backgrounds and there is no detailed information about extended family members.

Their mobility and repeated changes for schools were significant risk factors in these young people's lives. To protect confidentiality details of addresses and schools have not been included in this summary, however it is important to note that the family were known to services at 14 different addresses and may have stayed with friends and relatives at other addresses as well.

Both 'B' and her younger sister attended six different schools.

February 1993 – April 1994	Children's social services staff made two investigations because 'B' and her sister (aged 2 and 3) were left alone, though they were not physically harmed.
March 1995	B's mother was charged with neglect because she let the children wander alone in the street. She was given a short term nursery place for the children and additional support from a health visitor.
April 1995	'B' started attending school
June 1995	Bromley Education service wrote to B's mother about B's poor school attendance
September 1995	Bromley gave notice of intention to issue a school attendance order.
February 1998	'B' was attending a Croydon School but living at a Bromley address.
November 2000	The family were temporarily housed in a Bed and Breakfast Hotel
January 2001	Bromley Housing accepted a full rehousing duty under the homelessness legislation.
	'B' was referred to Bromley CAMHS (for the attention of the Child Psychiatrist). B's mother felt the concerns about 'B' related to the family's situation, her father had left two years previously. 'B' was reported to be happy to be referred to CAMHS. The appointment offered was not

	taken up and the case was closed.
January 2002	The family moved into temporary accommodation in South Norwood.
September 2002	B's mother telephoned CAMHS to say that 'B' had severe depression and needed to be seen urgently. The family were living in temporary accommodation and did not have a GP. B's mother was advised that as the case had been closed; 'B' would need to be re-referred, and to register with a GP as temporary patients.
November 2002	A referral was made from B's secondary school Croydon (Social Care and Education Welfare). 'B' had not returned to school this term, and B's sister had not started at secondary school.
November 2002	The Education Welfare Officer made unsuccessful visits in relation to B's non-attendance. She had still not returned to school that term.
November 2002	B's brother was born at the Mayday Hospital. There was a referral within the hospital the next day referring to 'possible child protection', but there is no record of what this was, how it was followed up or any outcome.
November 2002	B's brother was seen at the new birth visit. B's mother told her health visitor that she was in temporary accommodation having fled domestic violence. She said that she might need to take out an injunction if her partner found the family.
December 2002.	B's mother said that she had further difficulties with housing as the landlord had not paid the mortgage and the property was to be repossessed. This meant that the children would have to move again soon to further temporary accommodation.
January 2003	The Croydon EWO applied for a place at secondary school in Bromley for 'B' and her sister. The family had now been offered accommodation in Bromley by a Housing Association. B's mother subsequently decided that she wanted to send the girls back to secondary school in Croydon.
February 2003	Permanent accommodation was offered. The records state that the offer was refused. By the end of March a

	review of this decision had been completed confirming the grounds for refusing accommodation were not accepted and the duty to rehouse was now discharged. B's mother was now offered advice and assistance to secure accommodation in the private rented sector and also given notice of her right to further review through the County Court.
March 2003	Bromley education made four attempts during the month to contact B's mother
February and April 2003	B's brother was seen at Child Health Clinic and given his second and third immunisations. He had earlier had a normal developmental check at 8 weeks.
May 2003	'B' returned to school in Croydon after a gap of 8 months and her sister's name was added to the waiting list. The Education Welfare Service closed the case. On 25 June B's sister was admitted to the school.
July 2003	B's mother referred herself to Bromley Social Services. She said that 'B' was feeling depressed. She said that the family were in temporary accommodation but were about to be made homeless. The family were given advice about contacting the CAB and registering the family with a GP. The notes state that a referral was made to Bromley Y for 'B' but it could only provide a service if the school or GP were in Bromley. Social services made contact with the Health Visitor who said that she had no concerns about B's brother.
October 2003	B's mother made a second approach to Bromley Housing on grounds of her eviction. B's brother was referred to Ophthalmology because of concern that he had a squint. He was offered at least two appointments but did not attend.
November 2003	The homeless service sent a decision letter advising B's mother that she was considered to have made herself homeless intentionally due to refusal of permanent offer of accommodation. Hence Bromley owed no further rehousing duty. She was offered advice and assistance to secure privately rented accommodation and also notified of her right to request a further review in the county court.

December 2003	There was discussion in social services involving the head of service. Agreement was given for payment for 2 weeks Bed and Breakfast, subject to B's mother attending the office with documentation. Bromley Housing stated that she had refused 5 properties and not turned up for appointments.
December 2003	A Bromley Health Visitor called to see B's brother. B's sister and B's brother were seen alone. B's sister was looking after B's brother and said that her mother had 'popped out'. The health visitor left a message asking B's mother to call her as soon as possible.
January 2004	Housing made a temporary placement into bed and breakfast accommodation following eviction. This was for a period of up to 28 days. Education welfare, Housing benefits and health were advised of the placement into temporary accommodation. The address was in Sydenham. The family left this address on 14 January without prior notice or providing a forwarding address.
February 2004	B's mother presented again at Bromley social care. She described 'B' as not settled in school and not registered with a GP. B's mother wanted permanent housing. The family were seen in the office and the notes state that a referral was made to Bromley Y for 'B' and her sister, though there is no copy of the referral on the file.
May 2004	B's mother informed Bromley social services that housing benefit to a total of £1 784 had been cashed and not passed to the landlord. Social services were advised that the family would be evicted and stated that social services would provide no more support.
July 2004	After several attempts B's brother (aged 19 months) was seen by a Bromley Health Visitor. He was noted to be a quiet little boy and little speech was heard. B's mother reported that he had approximately 10 single words, was up to date with checks but overdue for his MMR. B's mother reported that the girls were happy at a Catholic school.
August 2004	B's mother made a new homelessness application. She stated that she wanted settled accommodation on medical grounds. She stated that she had back pain due

	to her pregnancy and 'B' was suffering from depression. (The GP records make no mention of B's mother being pregnant at that time). The family were now facing eviction their privately rented accommodation on grounds of rent arrears. Housing advised her that she would be found to be intentionally homeless.
September 2004	Her GP referred 'B' and B's sister to CAMHS at their mother's request. She reported that 'B' was suffering from recurrent depression and low mood. The referral noted that the parents had separated 6 years previously due to domestic violence. The GP asked for a formal assessment and any further management required. B's mother provided detailed additional information when asked. She did not keep the appointments that were offered in March and April 2005.
September 2004	Bromley Housing was advised by a Social Worker that the Head of Service had instructed that no further assistance would be provided to secure alternative accommodation. Social Services had previously assisted with a deposit for accommodation which was lost as housing benefit cheques were cashed by B's mother and not paid to the landlord.
October 2004	Housing records show that a placement was made into temporary accommodation following eviction. Education welfare, housing benefits and health were advised of the placement.
December 2004	'B' had a fight with a girl named 'M' in the graveyard next to her school. 'M' admitted the attack was premeditated. B's mother came to the school after the attack and was verbally abusive and threatening to staff. The school banned B's mother from the site. Police took no further action because 'a witness refused to provide a statement and 'B' was unwilling to substantiate the allegation'.
January 2005	Bromley Housing sent a decision letter to B's mother confirming that she was considered to be intentionally homeless as she had cashed housing benefit cheques and did not pay rent to her landlord. As such no rehousing duty was owed. Steps commenced to recover possession of current temporary accommodation. B's mother was advised of her right to seek a review and offer of assistance to secure privately rented

	accommodation. The children and families duty referral and assessment team was advised.
April 2005	Bromley Education sent an official warning letter about school attendance.
June 2005	Home visit attempted by EWO. B's mother refused access to the home and stated that she had appealed for places for both girls. She was adamant that girls would not return to their existing secondary school.
July 2005	'B' was discussed at the COOME panel which considers non-school attendance cases before a final decision is made to commence a prosecution. Permission to prosecute was granted and the prosecution was heard in court on 2 November.
July 2005	B's mother was said to be seeking a school place there for both girls in Bexley
August 2005	A phone call was received by Bromley Housing from SLF Housing Association which was managing temporary accommodation. It confirmed that the family had been evicted. There was no forwarding address.
August 2005	The Locum Consultant Ophthalmologist at Mayday Hospital wrote to Bromley child health stating that B's brother has failed several appointments. The letter requested that child health let the eye department know if they had any up to date details.
October 2005	B's mother made an application to Bromley Council for educational grants stating that both girls were starting at secondary school in Greenwich. Contact was made with the school which stated that at that time no place had been offered.
November 2005	Bromley Magistrates Court heard a case against B's mother for her failure to ensure that the children attended school and (in her absence) fined her £100 per pupil plus £75 costs.
January 2006	'B' had been unsuccessful with an application for a year 11 place but the family were going to consider a year 10 place.

March 2006	'B' was admitted to secondary school in Greenwich year 10 on 1.
November 2006	B's sister was seen in surgery with her mother. Records state that she had suffered an assault at school 2 days previously. A scratch to her face was seen. It was noted that B's mother was advised to tell the school.
December 2006	'B' aged 16 years and 7 months attended Mayday Accident and Emergency department. 'B' had taken 21 of her mother's contraceptive tablets at 18.00 hours the previous day as she was upset with her mother. She seemed shy / scared. Initially she did not want the doctor to contact mother but later agreed. Observations were normal. 'B' was referred for psychological assessment. Mother advised a doctor – over the phone – that 'B' had emotional problems with her father and at school. She thinks this overdose may be for attention. B's mother did not want to come to A&E. B's mother was advised to contact a duty social worker or her GP for advice / support. 'B' was referred to psychiatry department and was seen by psychiatric liaison in A&E at 15.15 hours: The same history was recorded. 'B' stated that there were relationship difficulties with her mother. A comprehensive description of B's mental health state was documented. No evidence of clinical depression or any other mental health related problem was found. She was discharged home and provided with details of "off the record" counselling. After discussion with the named nurse child protection a child in need referral was made by fax to Bromley children's social care with B's consent. In response to the referral a letter was sent to the family advising B's mother to contact a duty social worker or GP for advice and support. The Department took no further action.
December 2006	Greenwich Attendance Advisory Service wrote to B's mother to inform her that a referral had been made by the school. There was no response to this letter. A referral was made to Bromley Education Welfare to

	make a visit to the family at home to ascertain reasons for non attendance as family were not coming into school for meetings. On 26 January information was provided by Bromley Education Welfare to the referrer that 'B', although in year 11 was over compulsory school age and therefore no further legal action could be taken.
February 2007	'B' committed suicide by hanging herself.

5 OVERALL EVALUATION OF THE SERVICES PROVIDED FOR ‘B’ AND HER FAMILY

This section is written in two parts. The first provides an overview of the principal findings of the Serious Case Review in relation to the standards of practice and the services provided for ‘B’ and her family. It deals with events from the perspective of the overall co-ordination of services as a whole. The second section addresses the specific points identified in the terms of reference.

Overall evaluation of the pattern of service provision and work with ‘B’ and her family

The children in the family were the subject of concern to different groups of professionals on a number of occasions. The main concerns referred were:

- Early concerns (pre-school age) that ‘B’ and her sister were left alone
- Repeated concerns about non school attendance
- Recurrent housing problems and changes of address – as a result of repeated eviction
- Financial problems linked to the misuse of housing benefit
- A history of domestic violence in the relationship between B’s parents, though by the time the referrals were made they were believed no longer to live together.
- B’s mother reported that ‘B’ was depressed on at least three separate occasions; in one instance her sister was also said to be suffering from signs of depression
- Two months before her death ‘B’ was referred to social services by hospital A&E department having taken an overdose.
- The failure to take B’s brother to attend hospital appointments for the evaluation of his squint.

There were two child protection enquiries (carried out in 1993 and 1994) about the two young girls being left alone before they started school. Both of these enquiries were unsatisfactory in some respects.

After these initial concerns the family were brought to the attention of professionals on a number of occasions. The first referral (about school non attendance) was only a few months later, but no link contact was made with the agencies that had dealt with the previous concerns, so no overall assessment of their well being was formed.

From then on, each time the children were re-referred the concern identified in the initial presentation never placed the children within the highest categories of need or risk and the children never received a detailed or comprehensive assessment of their needs. It is clear that 'B' would have benefited from this so it is important to establish what prevented it taking place. There are a number of factors which contributed to this arising from:

- the practical circumstances of the family
- the approach of professionals and
- the response of B's mother.

These factors are listed here and discussed in more detail in the following paragraphs:

1. The mobility of the family
2. Failure of professionals to look at aspects of the children's needs outside of their own specific brief and the needs of other children in the family
3. Failure of professionals to take the whole history into account
4. Difficulties achieving engagement with B's mother
5. Lack of attention to domestic violence and the actual living arrangements in the family
6. Poor sharing of information and updating of colleagues

8.1 Mobility

The family moved on several occasions within Bromley and also moved between Bromley and Croydon. In four years in Croydon they had at least four addresses. ‘B’ and her sister also changed schools at least five times. Consequently the professionals involved with them changed and the sisters did not become well known to any one group of professionals.

Families who move a lot pose inherent difficulties. Unless it is a current looked after or child protection case, agencies such as social care and education welfare usually close records when their contact with a family ceases or a family moves and only pass on information if another agency seeks it. Health agencies try to ensure that records follow the child and a full history is available, but this can only happen if the professionals concerned know where a family is moving to or where the family has come from. Even if this is known there are often administrative delays in forwarding records so professionals often have to assess the family without the benefit of having all the records.

In this case, the family’s chaotic pattern of address changes and the inevitable fragmentation of records was an important part of the children’s life and should have been recognised as an additional risk factor, rather than just being a factor which made it more difficult to engage the family.

The effect of mobility was exacerbated by ‘B’ and her sister’s poor school attendance. Schools are frequently in a strong position to identify and refer vulnerable children. It is striking that in this case – even though their mother asked for GP referrals for mental health problems on three occasions – the only school referrals related to non attendance. This suggests that even their schools did not get to know them well enough to identify other problems.

8.2 Failure of professionals to look at aspects of the children's needs outside of their own specific brief and the needs of other children in the family

The agency reviews highlight a number of points at which professionals focused on only one aspect of need and failed to look at the needs of all of the children. For example:

- Social care professionals treated referrals about housing and financial problems in a very narrow way,
    - Not asking more detailed questions about the impact of the housing problems on the girls
    - Not thinking more broadly about the full range of their needs
    - Not making contact with other agencies that had been involved with the family since previous social services involvement

  This was despite that fact that their mother had indicated that the children had missed a considerable amount of schooling and were said to be suffering emotional difficulties.
- Education welfare staff focused exclusively on school attendance problems and had only limited communication with other professionals;
- The education welfare service did not make phone contact with or refer the children to social services; formal notifications were made but – in line with usual practice – social services did not attend meetings called to consider school attendance problems as the case was not allocated.
- There were single discipline assessments made of individual members of the family but no-one ever obtained a complete picture of the whole family's health needs
- There seem to have been no specific concerns about B's brother, so some of the professionals dealing with him may have made the assumption that the other children were OK.
- B's brother's health visitor in Croydon was aware that his sisters were having difficulties but did not liaise with the school nurse or other professionals

8.3 Failure of professionals to take the whole history into account

The family was referred to Bromley social services on three separate occasions and self-referred at least twice. Social services staff treated each individual presentation of the family in isolation from the previous history. In 2004 the referrals were treated as if the family was not previously known to social services – despite B's mother telling them she was. Even when the previous history was available the response provided was a minimum one, based just on the current presentation. No attempt was made to elicit information relating to the family from agencies covering their previous addresses.

The level of response should have taken into account the whole history of problems that the family had experienced and also the fact that there had never been any success in providing services.

8.4 Difficulties achieving engagement with B's mother

The general pattern was that B's mother appears to have:

- complied with contacts when they were seen as helpful or non threatening (for example health visitors)
- sought contact when she felt that it might be of benefit (self referral to social services and housing)
- ignored contact when she felt it threatened or challenged her approach (education welfare, social services, follow up of police contact when 'B' was assaulted)

The major exception to this pattern was that on three occasions she made a considerable initial effort to get 'B' help for what she thought was her daughter's depression, but then did not take up appointments. In each instance the CAMHS service asked B's mother to engage in a process of gathering additional information resulting in some delay in providing an appointment. It is not clear if

B's mother believed that 'B' was 'better' by the time appointments were offered by CAMHS or whether there was another reason why appointments were not taken up.

On several occasions B's mother refused to engage with services, or found it difficult to know how to engage constructively. For example:

- she very rarely came to meetings about school attendance problems
- she refused access to the house to education welfare staff
- on one occasion when she did intervene forcefully at a school she appears to have dealt with the situation in such a way that the outcome was that she herself was banned (even though it appears that it was 'B' who had been the victim of the initial incident)

It would not be fair to say that she did not engage with social services as in reality very little was asked of her.

8.5 Lack of attention to domestic violence and the actual living arrangements in the family

There are a number of references in the records to domestic violence. Typically the family were said to have 'fled' or 'be fleeing' domestic violence. However at no time did any of the professionals involved:

- accurately establish what had happened and when or who had been involved
- make any assessment of the effect the history of domestic violence had had on the children or
- establish if there was any current risk.

There is no evidence that anyone considered whether there was still contact between the girls and their father and whether these arrangements were safe. It is not clear from the records who the father of B's brother is. At the time of B's death, her sister B's sister was living with her father. The reasons for this cannot be established from the records.

On a number of occasions domestic violence was cited as the reason for the family's frequent moves, though in fact the only documented evidence in the case records of the reasons for moves was that B's mother repeatedly ran up rent arrears.

8.6 Poor sharing of information and updating of colleagues

The standard of information sharing between services and between colleagues in closely related services is inconsistent.

There were examples of good communication within the health service in some incidences – for example CAMHS to GP and A&E to GP. However there were also examples of the failure to communicate. The Croydon PCT review cites a number of examples, including the following:

- There was no liaison between health visiting service and school health service at point of initial contact with the family and following contact by the Educational Welfare Service where it was identified that 'B' and B's sister were not attending school
- There is no evidence of liaison between the Educational Welfare Service and School Health Service.

The Bromley PCT report had comparable findings. Overall some health colleagues seemed to be operating without the benefit of update from other agencies. There was no evidence of any information being given to the GP or school nursing service by any agency outside the health service.

The school health service and school nurses appear to operate in a degree of isolation from other health services and other agencies. There was no evidence of effective communication from any professional to a Bromley school nurse, e.g. health visitor, GP or A&E. The school nursing service did not appear to know that 'B' and B's sister had returned to a Bromley school.

The school health service relies on the child's school to share information regarding children entering or leaving the school. At times the information held was very out of date and the agency report states that some schools do not inform school health of pupil movement or might only do so annually. On top of that there seem to have been considerable administrative difficulties in the operation of the school nursing administrative arrangements.

Cross borough protocols for dealing with attendance cases were not complied with robustly and little information was available from neighbouring Education Welfare Services regarding their involvement.

Specific questions to address from the Terms of Reference of the SCR

1) **The family have been known to agencies in Croydon, Bromley and Greenwich. Was adequate information passed between agencies and boroughs to ensure that any vulnerability the family had were identified and addressed?**

The narrative and the evaluation in the previous section of this document show that there were several occasions when there should have been better sharing of information between agencies in Croydon, Bromley and Greenwich. There were two types of circumstances: firstly, occasions when staff should have been more proactive about seeking information; secondly occasions when staff should have given more consideration to the potential value of information that they possessed to others who would be dealing with the family in the future.

Through the chronology the panel has identified instances when:

- more background information should have been sought to enable a fuller assessment to be made (e.g. in social services assessments)
- information should have been passed on to colleagues or services taking over the case (e.g. between health colleagues and between colleagues in different boroughs)
- staff involved should have contacted colleagues who might have information about other members of the family which would have provided a fuller picture

There is no evidence to suggest that there was any direct link between these failings and the death of ‘B’, but it is clear that better information sharing might have meant that ‘B’ and the rest of her family received a better service at an earlier stage and risks to her and her siblings might have been reduced.

2) **The family presented with housing difficulties in Bromley. Did Bromley children's social care and housing departments work together effectively to address this issue?**

The Bromley Housing management review found that the housing service discharged its duties under housing legislation appropriately and shared information with all of the relevant partner agencies including social services. The social care review found that social services discharged its duties in too narrow a way, paying too much attention to the family's housing problems and insufficient attention to the well being of the children in the family.

Ironically, social service's overly narrow focus on housing problems probably did not resulted in a different outcome as far as the family's housing difficulties was concerned. The family would still have been made offers of accommodation and would have been given support to find private sector accommodation. However social services could have had a much better assessment of the needs of the children.

3) **Did Bromley Social Care's assessment of the family in July 2003 adequately address the needs of the children?**

The agency management review found that it did not and the SCR panel supports this finding, having considered the information available from all the agencies. It appears that too much emphasis was placed on whether or not the family were eligible for housing and not enough on the needs of the children. It is not clear why previous records – which would have highlighted concerns – were not located and checked, even though B's mother brought the previous contact to the social worker's attention. No attempt was made to interview the children independently of their mother and too much reliance was placed on the views of the health visitor. Insufficient attention was paid to non school attendance as a risk factor.

It is even more concerning that many of these errors were repeated when the family presented again six months later.

4) Was Bromley Education Welfare Service's response to the family adequate?

Overall the response of the Education Welfare Service was too narrow in its focus and failed to take account of other risk factors which in combination with non-school attendance might have caused the children to be very vulnerable. It appears that the attendance problems were dealt with in an almost 'administrative' fashion, rather than focusing on them as an indication of need and a wider social exclusion of the girls.

It appears that this approach also characterised the work of the Education Welfare Service in Croydon. Although the family were known to be difficult to engage and very mobile, the service ceased its involvement with the case once 'B' had returned to school and once her younger sister had been accepted on the school waiting list.

The EWS in Bromley was not well supported in its work by other agencies and the chronology cites instances of this, for example:

- Schools not keeping detailed information or responding to poor attendance
- Other authorities not making early referrals so that preventative action could be taken
- Social services not recognising the significance of non attendance in its overall assessment.

Although the SCR panel lacks a full picture of all the circumstances, it appears from the records that for most of her school career, 'B' did not settle in a way that would have allowed her to make anything of her educational opportunities. It is a concern that a child such as this should have been allowed to drift through her education, without anyone making a concerted effort to help her at any point.

5) Was there sufficient follow up by Mayday hospital of B's overdose on 12.12.06 and was the response from Children's Social Care adequate.

'B' was referred to Bromley children's social care on 11 December. This followed her attendance at the A&E department at the Mayday Hospital where she was seen by staff in the department and then a duty psychiatrist. The judgement was that 'B' showed no signs of suffering from a clinical depression, but had responded to 'social stressors'. She consented to a referral being made to Bromley. The referral indicated that the staff in A&E had been concerned about B's mother's 'lack of emotional response'. The referral preceded the involvement of the psychiatrist so did not contain the details of the findings of the psychiatric assessment. The response of the duty service was to write to B's mother to advise her to seek follow up from either a GP or a duty social worker if she wanted.

In the circumstances this was an inadequate response for a number of reasons:

Firstly, no contact was made with the referrer or the psychiatrist to establish more details of the circumstances of B's admission or their assessments. These would have shown that there was conflict within the family and that B's mother had been unwilling to attend at A&E.

Secondly, no proper checks were made before the action was taken:

- a check of the social services records would have shown that B's mother had mentioned her daughter's 'depression' in a previous contact with the department
- basic checks with other agencies would have shown that B's mother had sought help for her with her depressed mood and behaviour on three occasions from CAMHS, though she had not followed through with the appointments;

- a detailed check with housing records would have shown that the same problem was mentioned at least twice to housing
- GP checks could have given a good overview of the previous medical history and a school check might have shown that there were continuing problems about B's attendance and possibly bullying.

Thirdly, it seems that no specific consideration was given to B's right to be approached independently of her mother. At the time of the incident she was 16½ but the letter was addressed only to her mother, who it was known had been very inconsistent about engaging with services.

Overall the response of children's social services to this referral was inadequate. If either 'B' or her family had been prepared to co-operate it would have provided an opportunity to make a detailed assessment of B's needs less than two months before her death. There is a possibility that a more concerted attempt to offer assistance at that point would have affected the outcome. Because we know very little about the actual lead up to B's death and her state of mind at the time, it is impossible for the panel to know whether or not her death could have been prevented.

6) What lessons can be learnt to improve the way agencies work together in Bromley to safeguard vulnerable families?

The family were sporadically in contact with many services, but on each occasion the contact failed to result in a full assessment being carried out. This was in part due to the fact that the presenting problem was never judged to be in itself serious enough to require a full assessment. In some instances this was clearly not the case (for example the drug overdose in late 2006 merited a proper social care assessment); in other instances this may have been justified by the initial presentation, but a basic check of background information from other agencies could have lead to the recognition that a fuller assessment was required. As it was, no one ever sought or obtained a good overview of the needs of the children

and as a result they were never found to have reached the threshold required for any concerted intervention.

It would be wrong to lay responsibility for this solely at the door of professional agencies, either individually or collectively. We do not know why it was the case but B's mother was (at best) very ambivalent about involvement with social services, avoided contacts with the education welfare service and did not take up a number of opportunities to attend CAMHS. The family also moved on numerous occasions making it very difficult for professionals in any of the universal services to develop a long term view about the children's needs.

However mobility and lack of parental co-operation are common factors and need to be recognised as a risk factor that should heighten concern rather than simply being a reason why children don't receive a service over many years. In order for this to happen, more effort is needed, precisely because the family is mobile. The behaviours identified as flaws in practice in this case need to be reversed. For example professionals need to:

- be alert about aspects of the children's needs which may not be being met outside of their own specific brief
- be more aware of the needs of other children in the family and make relevant referrals and seek relevant information
- take steps to establish relevant history, find out if similar incidents have occurred previously, locate and read records and then take all the relevant history into account
- pay attention to domestic violence and other specific known indicators of risk and establish the facts about them
- be alive to the potential relevance of information that they have and proactive about seeking information from and providing information to other colleagues.

In other words, professionals have to go a step further where they know a family is highly mobile. To a degree good practice consistent with this approach can be integrated into policies and procedures and prompted by recording systems, but there is a limit to which procedures can cover everything and to a degree

achieving good practice will always rely on a high level of professionalism on the part of staff and on managers and supervisors systematically checking to see if these considerations have informed the work.

One of the specific justifications for the ‘Contact Point’ system (formerly known as the ‘Child Index’) is that it will specifically assist in working with children of families who are very mobile and difficult to engage. Its aim is to enable practitioners very easily to check the details of children and the agencies and professionals who are involved with them. This case is one where it is easy to see how the Contact Point system should make a difference. However it can only make a difference if it holds all of the relevant information about which professionals have been involved and if professionals see the value of using it. Once they have information available to them about other professionals who are involved, professionals still need to understand the importance of contacting and involving other professionals who may have had dealings with the family.

Many of the same considerations apply to the Common Assessment Framework. In this case there might have been a great deal of value in any one of a number of professionals completing a CAF in order to get a better picture of the young person ‘in the round’. However this will only happen if professionals are prepared to step a little outside of their specific professional remit.

Potentially the material in this case review provides a good yardstick against which to measure the effectiveness of these innovative integrated processes. If they are to be of any use they need to be able to help provide better services to a young person such as ‘B’.

We would recommend that the findings of this Serious Case Review are brought to the attention of the teams implementing these initiatives to establish how they might in reality support better practice in a case such as this. In addition this SCR might provide useful training material as an example of the sort of case where Contact Point and CAF might make a difference.

6 RECOMMENDATIONS

The agency management reviews made recommendations for action in relation to the following areas:

Bromley Children's Social Care Services

- how and where children are assessed when the presenting problem is impending homelessness.
- the need for better liaison with the education welfare service
- the need to obtain agreement to contact those services in other boroughs for information
- the need for an initial assessment when a young person has taken an overdose or attempted suicide.

Bromley Council Education Welfare Service (EWS)

- the need for social services to recognise poor school attendance as a sign of vulnerability
- the need for schools should ensure that all documents are passed from school to school to ensure a full case history is available
- the need for the local authority to be more robust in ensuring that schools comply with the legal requirements regarding a pupil's removal from the school and with speed of admissions procedures.

Bromley Primary Care Trust (PCT) and other Bromley health services

- Arrangements for the assessment of families moving into Bromley by health services and the review of old records on those families
- Communication with school nurses from health visitors, GPs and A&E departments
- Recording of contacts and plans following contact with social services
- Administrative audit of school nursing records

- GP follow up of CAMHS tier 3 non attendance
- GP responses to incidents of self harm
- The need to be alert to the mobility of some families, especially where there has been domestic violence
- Training of staff over domestic violence and abuse
- Follow up of children and young people who have failed to attend at CAMHS appointments.

Croydon Primary Care Trust

- exploring the feasibility of producing a standard where the Health Visiting and School Nursing services are informed of frequent changes of addresses for children who are not “open episodes” of care to these services.
- trust generic record keeping audits for PCT Children and Family Services should meet requirements for current Safeguarding responsibilities.
- review of PCT Child Protection Standards.

Bromley Council Homeless Persons Unit

The report recommendations that further consideration should be given to whether limited access to children’s services records would assist in identifying where other agencies are involved with families and may be able to assist with assessments.

Mayday Hospital NHS Trust

The report identifies that – following contact with local agencies – it was decided in error not to send a notification to B’s school nurse. The decision was made because as she was above the age of compulsory schooling it was assumed that she would no longer be at school. The report recognises that had the referral been made or copied to the named nurse for safeguarding in the relevant PCT, this would have been rectified and the information would have been available to the

relevant school nurse. The report recommends that this should be the standard practice in future.

South London and the Maudsley (SLAM)

The report identifies the following areas of concern which relate to the general service offered by the trust in this setting, and not to the specific service provided in this case. It finds that:

- the arrangement with Croydon whereby adult psychiatric liaison services see 16-18 year olds (rather than the local CAMHS service) presents an additional challenge to this liaison team for specialist knowledge.
- there is no specific requirement for team members to have any training in this area
- there is a very limited structure currently in place between the CAMHS and the liaison teams for information sharing and working together to meet the needs of this group
- there is limited recourse to immediate support for liaison staff in clinical decision making for adolescents from non SLAM boroughs.

The report makes recommendations in relation to all of these issues.

The following agency reports made no recommendations.

- Croydon social care and Education Welfare Service
- Greenwich school attendance advisory service
- Lewisham NHS Trust
- Metropolitan Police Service

The Serious Cases Review Panel also made additional recommendations in the following areas:

- The implementation of the Contact Point system in Bromley
- The implementation of the Common Assessment Framework in Bromley
- To ensure that there is a clear protocol is agreed between social care and the education welfare service setting out the criteria that should be used for referrals to social care, thresholds for each agency's response and arrangements for problem resolution in cases where there is disagreement.
- To improve the working of the panel for children who are out of school
- To ask the Director of Children's Services to write to all local schools setting out the issues which have been highlighted in this case in relation to the safeguarding duties of schools, specifically the need for schools to:
    1. adhere to relevant guidance regarding the removal of children from school rolls and the admission of children where a school has places.
    2. make full use of the School 2 School (S2S) service in all relevant cases
    3. ensure that when a child transfers from one school to another all relevant records on the child are transferred with the child.

- To ensure that when – as in this case - records refer to a history of domestic violence or domestic abuse and there is reason to believe that it may have had an impact on children, professionals should attempt to establish and confirm basic information about the incidents that have occurred so as to be able to establish:
    1. what has happened
    2. the potential impact on children of past events
    3. whether there is any current risk to children.

- To receive an up to date report on the welfare of the two younger siblings of 'B' identifying if there are any continuing safeguarding concerns.