

Bromley

safeguarding children board

serious case review for publication

‘Elizabeth’

Fergus Smith

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# introduction

## Trigger event & need for serious case review

### On 24.01.14, 17 year old Elizabeth was killed by a 16 year old friend ‘X’ at his home in Surrey. In October 2014 ‘X’ was found guilty of murder and given a life sentence with a minimum of 25 years.

### In August 2016 Bromley Safeguarding Children Board (BSCB) was asked by its Surrey counterpart to explain why it had not initiated a serious case review about Elizabeth whose home address was in Bromley. The BSCB independent chairperson at that time and BSCB members had not previously been aware of the case.

### In December 2016 after consideration of the information available at that time and in spite of some dissenting views, the then chairperson of its standing ‘serious case review panel’ had determined that the statutory criteria for initiating a serious case review (SCR)[[1]](#footnote-1) were *not* met (there having been no suspicion of abuse or neglect preceding Elizabeth’s death). That determination did not reflect the level of vulnerability which was subsequently identified and which is summarised in this report.

### By March 2017, a newly appointed BSCB independent chairperson, in discussion with the Board’s ‘SCR sub-group’, decided that emerging indicators of Elizabeth’s vulnerability and subsequent murder meant that exploring her experiences of services would generate useful learning and provide an opportunity for Elizabeth’s ‘voice’ to be heard. He determined therefore, that a SCR would be completed.

## Summary of known background

#### Perpetrator X

### X who lived at home with both parents and one of his 3 siblings had a history of self-harm and anxiety symptoms. Following concerns expressed by his mother to the family’s GP, X had been referred to his local ‘Child & Adolescent Mental Health Service (CAMHS) in 2012 when aged 15. X was provided with systemic psychotherapy for a year.

### In February 2013, X was diagnosed as having an ‘autistic spectrum disorder’ (ASD). Because his self-harm and anxiety-related symptoms had appeared to improve, X had been discharged from CAMHS in October 2013 and had no further contact with that service before he killed Elizabeth 3 months later.

### NHS England[[2]](#footnote-2) commissioned an independent investigation into the care and treatment of X in Surrey. In its report which was shared with SCR panel members, it formulated 10 recommendations for the current provider of CAMHS in Surrey (Surrey and Borders Partnership NHS Foundation Trust (SaBP).

#### Elizabeth

##### Routine review

### When Bromley’s Child Death Overview Panel (CDOP) undertook in 2014, its routine review of the death of a child resident in the borough, it appeared Elizabeth’s involvement had been predominantly with universal services e.g. school and GP. Further research by Bromley’s Safeguarding Children Board in late 2016 and enquiries during the course of this review indicate that this mistaken conclusion had been a consequence of:

Miscommunication with the school which (in the event that it had received such a request) could have provided relevant information

Information from the GP Practice which did not confirm Elizabeth’s previous involvement with CAMHS

The one-off involvement of a Metropolitan Police Service (MPS) ‘safer schools officer’ in late October 2010 (Elizabeth was then 14) not having been available to and in consequence not shared by, Surrey Police

### Details of the involvement of CAMHS and other agencies have been evaluated during the course of this SCR and are summarised in section 2 of this ‘publication report’. School 1 had reported that in her ‘year 11’ (2012-2013) Elizabeth had been unhappy in her tutor group and felt that her friends thought of her as ‘weird’. The school had responded by arranging for Elizabeth to register attendance in ‘Student Support’. Elizabeth, who was described by school 1 as kind and thoughtful was considered to be lacking in confidence with few friends. She was known to have a part-time job and her family was regarded as caring and supportive.

### Elizabeth had mentioned to school staff, a boyfriend she visited and with whom she indicated she was happy. Her mother was known to be aware and had raised no concerns about him. No evidence has been identified to indicate that either parents or school should have been wary of that relationship.

### Available GP records indicated nothing exceptional about Elizabeth’s use of the Practice (though pre-2011 records had been transferred to NHS England during the process of switching to electronic records).

##### Preliminary research for the serious case review

### With parental agreement, Elizabeth’s earlier medical records were accessed and revealed nothing of relevance to the SCR.

### Elizabeth’s Primary School was also contacted for this review and recalled a happy, quietly confident girl with a dry sense of humour and a small circle of friends. There had never been any safeguarding or other concerns during her 6 years there. Checks with several other agencies with which Elizabeth *might* potentially have been involved in Bromley and Surrey (hospitals, NHS 111 and Ambulance Services) revealed *no* contact with the young person.

## Conduct of the review: notifications & scope

### The BSCB chairperson notified the Department for Education (DfE), regulatory body Ofsted and central government-appointed ‘National Panel of Independent Experts’ (NPIE) of the decision to complete a SCR which was completed between July and October 2017 in accordance with terms of reference reproduced in section 3. The purpose of a SCR is to identify required improvements in service design, policy or practice amongst local or if relevant, national services. SCRs are *not* concerned with attribution of culpability (a matter for a criminal court), nor cause of death (the role of a Coroner).

### The period of review was 01.09.10 (when a rising 14 year old Elizabeth began ‘year 9’) to her death. Any emerging information pre-dating September 2010 and believed to be relevant has also been considered. An independent report was commissioned and it was agreed that upon receipt of material, author Fergus Smith would:

Collate and evaluate it

Facilitate meetings with family and professionals

Draft, in consultation with the selected serious case review panel a narrative of agencies’ involvement and an evaluation of its quality, as well as conclusions and recommendations for action by Bromley’s Safeguarding Children Board, member agencies and (if relevant) other local or national agencies

#### Agencies contributing information

### The following were asked to supply a chronology and an evaluative report of respective involvement:

Bromley Healthcare (school nursing - no records traced)

Bromley Urgent Care Centre (UCC) (a one-off contact)

Metropolitan Police Service MPS (confirmation of a one-off involvement)

Relevant Bromley & Surrey Schools (education / initiation of pastoral care)

Bromley Counselling Services ‘1’ (drug and alcohol misuse) & ‘2’ (community well-being service for children and young people)

Oxleas NHS Foundation Trust (provider of local Child & Adolescent Mental Health Services CAMHS)

Bromley GP Services (routine family healthcare)

### In addition to the above sources the author sought and obtained information from the school-based ‘Counselling Service 3’ where Elizabeth undertook an introductory session some days before her death, a sexual health worker whom Elizabeth consulted in early 2011 and the lead author of the NHS England-commissioned report.

#### Serious Case Review Panel

Bromley Healthcare: Named Nurse

Bromley Healthcare: Designated Doctor

Bromley Clinical Commissioning Group (CCG): Designated Nurse

Bromley Public Health Programme Lead (Substance Misuse)

London Borough of Bromley Children’s Social Care: Head of Service, Quality Improvement

London Borough of Bromley: Head of Access & Inclusion, Education

Metropolitan Police Service: Review Officer

Addaction (previously Bypass): Contracts Manager London & South

NHS England: Head of Investigations

Oxleas NHS Foundation Trust: Head of Safeguarding Children

Oxleas NHS Foundation Trust: Associate Director CAMHS

Surrey Safeguarding Children Board: Partnership Support Manager

Surrey County Council: Schools & Learning – Education Lead for Vulnerable Learners

+ BSCB Business Manager

### Panel members provided professional challenge to an initial draft report. When agreed by Bromley’s Safeguarding Children Board, a copy of this final report will be sent to the national panel of experts (NPIE), regulator Ofsted and to the Department for Education (DfE).

#### Involvement of professionals & families

### The parents of Elizabeth and those of X had been informed by the LSCB chairperson of his decision to initiate a SCR. Despite the family’s ongoing grief, Elizabeth’s mother was able to offer clarification and comment about her experiences of services provided and feedback on the findings of this report, which were shared prior to publication. For that, the panel is very grateful. Efforts were also made to seek the views of Elizabeth’s father. Her mother had reported that he remains too distressed, sees little value in the exercise and does not wish to become involved. That observation has been confirmed by a member of the extended family (herself a senior manager in a Mental Health Trust with substantial professional experience of individuals’ responses to trauma and by the Police ‘family liaison officer’ (FLO) who supported the family at the time of the incident).

### The author is also grateful to the parents of X who agreed to meet him and contributed what information they could.

# Elizabeth’s story

## Involvement with safer schools officer & ‘Counselling Service 1’ (substance misuse)

### On 05.10.10, a Metropolitan Police ‘safer schools officer’ was alerted by ‘school 1’ to a concern that on more than one occasion Elizabeth (aged 14) had been visiting a named year 9 boy from a local boys’ school, drinking alcohol and taking ‘poppers’[[3]](#footnote-3). The boy had also reportedly taken (a by then deleted), ‘inappropriate’ image of Elizabeth (reportedly a video taken of an inebriated Elizabeth – nothing of a sexual nature was indicated). The officer was told that parents had been informed but neither they nor Elizabeth sought formal action. He agreed to speak to the boy on the next visit to his school. Mother has reported that she had not received confirmation of the outcome of those events.

### Comment: *albeit over 3 years before her death, the above incident offers the first known example of Elizabeth’s vulnerability*.

### Information from the GP Practice has revealed nothing of significance in Elizabeth’s records. A local provider of alcohol and substance misuse advice (Counselling Service 1) had been working with Elizabeth during 2010 though the GP Practice remained unaware of that. The agency’s involvement had been triggered by a referral from mother on 25.11.10, itself prompted by concerns about her daughter’s behaviours.

#### Initial assessment

### Mother and daughter were involved in an initial assessment by Counselling Service 1 where Elizabeth acknowledged past use of substances, some self-harming and suicidal thoughts. Concerns were shared with mother who felt (for reasons not captured in records), that a referral to CAMHS was not required at this time.

### Comment: *disappointingly,* *records fail to capture* Elizabeth’s own *view of CAMHS involvement; all involved staff have moved to other employment and it has proved impossible to locate them and explore memories; given the inevitability of staff turnover, it is critical that records are coherent and complete.*

### At Elizabeth’s first one to one session (she was then 14 years 3 months old) unspecified (i.e. detail not apparent) ‘unsafe sexual practice’ and a perceived pressure to engage in intercourse were discussed. Following a missed appointment, the worker consulted her manager who confirmed a need to refer to CAMHS. Contact was made next day. Meanwhile the worker initiated contact with the Sexual Health Services and an appointment was made for early 2011. Agencies’ responses to this point were cautious and appropriate, albeit with some significant inadequacies of record-keeping.

#### Referral on to CAMHS by ‘Counselling Service 1’

### Prompted by Elizabeth’s self-harming (scratching arms and burning herself with a lighter) and thoughts that life was not worth living, the Counselling Service recommended family therapy and counselling. Its later records refer to self-esteem being low and being upset by the break-up of a sexual relationship begun ‘in order to keep the [unnamed] boy happy’. Elizabeth was deemed to be vulnerable because she was easily influenced by others and keen to please (thus potentially coercible). No record has been found of liaison with school or other agencies. Though unspecified forms of ‘stress and anxiety’ were reported within her family, Elizabeth did not want information shared with her parents. The subsequent referral to CAMHS indicated that Elizabeth’s current sexual partner was of a similar age to her.

### Comment: *Counselling Service 1 was wholly dependent upon Elizabeth’s account; without the involvement of other agencies it could not be confident about the age of her sexual partner; more professional curiosity might have revealed additional useful information*.

## CAMHS involvement

### Elizabeth was discussed at a multi-professional CAMHS meeting in mid-December 2010 and a decision made to accept the referral. When the allocated clinician made initial enquiries of the referrer s/he was told of the concern that Elizabeth had some difficulty in understanding social situations and was potentially vulnerable to sexual exploitation. Previously reported thoughts of self-harm or suicidal ideation were said to have ceased in the past week.

### An initial appointment was offered and Elizabeth attended with her mother. The results of that session were later discussed in a further team meeting and in the clinician’s supervision. In discussion with the referrer it was thought that Counselling Service 1 should continue to work with Elizabeth on misuse of drugs and safe sex and that subject to her agreement, a referral to Counselling Service 2[[4]](#footnote-4) would be justified.

#### Ongoing involvement of ‘counselling service 1’

### Elizabeth continued to make good use of the service offered by the counselling service. In early January 2011 mother reported to the worker that Elizabeth had been taking (un-recorded quantities of) ‘over the counter’ medication and had 3 bottles of vodka hidden under the bed. It is uncertain whether advice on required action *if* the recommended daily dose were to be exceeded was given. At her scheduled session next day the worker discussed these concerns with Elizabeth. An email request was sent 2 days later by the worker seeking a session with ‘sexual health practitioner 1’. Following an initial meeting involving the worker, sexual health professional, mother and daughter, a one to one session for Elizabeth was provided.

### The highly experienced sexual health practitioner, though mindful of the potential risk of sexual exploitation, found no evidence to reinforce that concern. She was clear that Elizabeth was ‘Fraser competent’[[5]](#footnote-5) . Only by virtue of there being an accompanying and caring mother was the referral in any manner different from many others.

### Comment: *Greater curiosity about the number or nature of the sexual relationships as well as a more formally recorded assessment of Fraser competence would have been helpful*.

### Prompted by a report about difficulty in social situations and ‘concrete thinking’, the *possibility* of Asperger’s Syndrome[[6]](#footnote-6) was considered by CAMHS. It was though, concluded that a formal assessment would be unnecessary because Elizabeth showed significant empathy toward others in distress.

#### Reported overdose & potential safeguarding issue

### Mother accompanied her daughter to a second CAMHS appointment in mid-February. Elizabeth complained of having no privacy and reported taking 4-5 (unidentified) tablets so as to ‘feel better’, *not* to kill herself. She did *not* want her mother to be told of this action. Based upon the rationale that the risk to health was low, no stated intention of repeating the action and a need to facilitate ongoing engagement with counselling, mother was not informed.

### The need to strike a balance between the needs and rights of child and parent was clearly recognised and appropriately debated in a multi-disciplinary meeting. The reasoning for the decision to withhold was also clearly recorded. Though well-intentioned, the decision effectively denied a parent considered to be caring and committed, information of potential relevance to her ability to support her daughter.

### Comment: *the decision was not ‘unreasonable’. It was though in the author’s view, toward the end of the spectrum of what could be described as ‘reasonable’ e.g. what could not have been predicted was the extent to which Elizabeth might use the support offered by her counsellor.*

### Elizabeth also reported an incident at the family home which was later shared with and caused distress to her mother. The potential safeguarding incident was discussed at a team meeting and a consensus formed that a referral to Children’s Social Care was *not* required unless there was any recurrence. That judgment (the rationale for which was not apparent in records) was shared with mother. The known vulnerability of the family *would* have justified at this time (assuming parental consent) a referral to Children’s Social Care.

### The clinician liaised with school 1 and was told Elizabeth was a ‘vulnerable girl with good enough peer relationships but easily led’. Systemic family therapy was again recommended. In the opinion of the clinical psychologist submitting a report to the SCR (and one with which the author concurs), that offer *was* an appropriate response to a not uncommon experience of tension (especially during adolescence) within the complex relationship of a mother and daughter.

#### Ongoing support from Counselling Service 1 & case closure by camhs

### Joint clinician / sexual health practitioner sessions were provided. ‘Positive relationships’ were explored and advice about sexually transmitted diseases and contraception provided. In mid-February, Elizabeth spoke of feeling depressed but by the end of that month she reported feeling better and agreed to family therapy with her mother at CAMHS. She also reported ‘putting things on hold’ with her boyfriend, which was understood (whether accurately or not is uncertain) by practitioners to mean deferment of a further sexual relationship.

### By mid-March either Elizabeth and/or mother decided not to take up family therapy. Records do not make it clear whether that had been a joint decision though it had been articulated by mother (poor record keeping is a recurring issue). The view of the worker at Counselling Service 1 was that the counselling available from ‘Counselling Service 2’ would be more effective.

### Records indicate her parents [sic] were considered to be caring, protective and supportive. In spite of tension between them, a real warmth of relationship had been observed between mother and daughter. Whilst there is evidence to support this view of mother, it is unclear on what basis the conclusion could be reached with respect to Elizabeth’s father who remained un-involved with CAMHS or other sources of support.

### On the basis of the above understanding, it was agreed that CAMHS would close the case and this was done in mid-April 2011. In the (sadly accurate) view of the allocated clinician, *Elizabeth remained vulnerable to encountering problematic peer relationships and to continuing under-age sexual activity (which might or might not be exploitative or harmful). Clinical outcomes that were recorded at the outset and end of the assessment indicated improvement and confirmed that Elizabeth was unlikely to meet any diagnostic criteria for a mental health disorder*.

### A letter to the GP confirming case closure was either not sent or perhaps not uploaded until 14.11.11. It contained no detail of any assessment or treatment from CAMHS. The term ‘vulnerable’ was included in the letter but not coded onto the Practice’s IT system where it might have informed any future consultations. Prior to the receipt of the closure letter, the GP Practice had remained unaware of Elizabeth’s involvement with CAMHS and never received confirmation of the use of either local counselling service. Record-keeping and inter-agency communication *should* have been better.

### At her penultimate Counselling Service 1 appointment in May 2011 Elizabeth reported being well and abstaining from alcohol. She said she was enjoying a youth club and was more assertive especially with boys, reported no self-harming and had not been feeling low. At what was intended to be a final appointment in June her self-report was again largely positive. Because of a delay in ‘Counselling Service 2’ offering an initial appointment, 2 more sessions were offered by and attended at Counselling Service 1. At her final session, she reported being ‘substance free’, no longer self-harming and getting on better with her mother.

## Support from ‘Counselling Service 2’ [[7]](#footnote-7)

### In the view of the clinical psychologist’s report to this review, the choice of individual counselling was a helpful one for Elizabeth who needed to better understand social situations, improve self-esteem and assertiveness. In the absence though of family therapy, it was recognised that family-related difficulties might remain unchanged. There remained little professional awareness of Elizabeth’s father or the quality of their relationship. The referral letter sent to Counselling Service 2 included many though not all identified key risks (self-harm, overdose and the potential safeguarding incident outlined in para. 2.2.8 were omitted).

### Comment: *the areas of risk omitted represented a serious failure of communication*.

### The closing notes of the Counselling Service 1 involvement reflected the records of 13 sessions attended by Elizabeth. Elizabeth reported that she had found the support useful and had ceased to self-harm. She reported an improved relationship with her mother in whom she said she felt more able to confide. No safeguarding issues were identified during the very limited period of contact with ‘Counselling Service 2’ (4 sessions were offered and 3 attended during June / July 2011). For the purpose of this review, the closed case file was reviewed and the counsellor whom Elizabeth had consulted was interviewed. Notes were described by the author of the submitted individual management review as clear and congruent with the account provided.

## Subsequent contacts with Health / Education providers

#### Health

### Elizabeth presented herself at an Urgent Care Centre (UCC) in March 2012. She reported having taken an emergency contraceptive pill supplied by a local pharmacist and was feeling sick. The identity and age of the sexual partner was not captured though mother has advised the author that he was marginally older than her then 15.5 year old daughter.

### Comment: *the pharmacy and UCC should have sought to establish the age of Elizabeth’s sexual partner. Royal Pharmaceutical Society (RPS) guidance has been updated since that time and can be sourced from* [*https://www.rpharms.com/resources/quick-reference-guides/protecting-children-and-young-people#children*](https://www.rpharms.com/resources/quick-reference-guides/protecting-children-and-young-people#children)*.*

### In January 2013 in an otherwise unremarkable presentation at an out of hours (OOH) GP service with a minor viral illness, a comment was passed to the GP Practice about ‘stress in Elizabeth’s school 1’. Aside from routine presentations for physical illnesses, in December that year, Elizabeth presented herself to the GP complaining of ‘tiredness and anxiety’. She reported that she was receiving counselling ‘at school’. Blood tests that were initiated proved to be normal. In the view of the ‘named GP’ who evaluated the service provided by Elizabeth’s GP Practice, responses were logical and proportionate.

#### Education

##### Transfer to ‘School 2’ for ‘A’ levels: general progress

### Elizabeth’s mother has confirmed that her daughter’s transfer in September 2013 to study for ‘A’ levels reflected a wish for a ‘fresh start’. Information provided by ‘school 2’ to Surrey’s LSCB and shared in late 2016 with Bromley’s Board confirmed a good attendance level of about 96% with a very few half-days of always authorised, absences. *Because* no pastoral information was received, staff remained unaware of Elizabeth’s previous use of external agencies (such information *was* reportedly transferred to a Croydon-based college which Elizabeth attended for only a day before her move to school 2 – those records were actively pursued during the course of the SCR by Bromley’s Education staff but remain untraced).

### Comment: *the loss of pastoral records represents a serious failure in information transfer and a recommendation has been made in section 4*.

### Though there exists no reason why it would or should have prompted concern, it is unclear precisely *when* teachers became aware of Elizabeth’s (believed by mother and family, as well as the parents of X and the Police to be non-sexual) relationship with her killer. *If* staff had been aware that X posed a threat to other pupils (no evidence has emerged from this or the NHS England report to suggest that they were) there would have been at least the possibility of a proactive response.

### Elizabeth had told her mother of the friendship at half-term in October 2013 and mother has informed the author that she had been planning to contact X’s mother to introduce herself, as might any parent in a similar situation. Her intention had not been prompted by any specific concern.

##### Initial counselling appointment

### About a week before her death, Elizabeth, having been referred by a member of the school’s ‘leadership team’ in mid-December 2013, was seen for an initial assessment session by a school-based counsellor[[8]](#footnote-8). That counsellor was contacted by the author and the arrangements that had been made for and the conduct of, what would be Elizabeth’s *only* session shared.

### Elizabeth had sought reassurance through counselling with respect to the pressure she felt in relation to social relationships and academic demands. She made no reference to any unwelcome pressure to be sexually active and spoke positively of her boyfriend X whom she did not identify by name. Whilst acknowledging and describing (accurately) previous difficulties Elizabeth denied current misuse of substances. Her presentation and account of her history and present circumstances prompted no concern on the part of the counsellor with whom Elizabeth agreed to meet weekly. Nothing in the routine referral for counselling or response provided, justifies any recommended service improvements.

#### Agency responses following death of Elizabeth

### In addition to the questions about what might have been done better preceding Elizabeth’s death, concerns had been identified about the following responses after it:

Information from the GP for the CDOP process was incomplete and misleading

There was insufficient awareness amongst Safeguarding Children Board members about the murder of Elizabeth

The debate about the requirement for or desirability of a SCR seems to have taken place outside of a formal process, without direct involvement of all those whose role e.g. designated doctor / nurse justified them offering advice to the independent chairperson of the Board

Records within Bromley Education Service had not (at the time this SCR commenced) been updated to capture either Elizabeth’s further education provider nor untimely death

### This SCR has identified a number of ways in which, in spite of all the efforts of professionals and family, the vulnerability of a young woman such as Elizabeth might be better recognised and responded to.

# Responses to the terms of reference

## Family history

*What agencies did Elizabeth engage with, or not engage with, during her adolescence and did she have any particular vulnerabilities*?

*Were any safeguarding issues identified in respect of Elizabeth? If so, were they acted upon appropriately and in a timely way by all agencies*

### Aside from essentially unremarkable use of primary and secondary mainstream schools and GPs, Elizabeth engaged well in adolescence with targeted services focused upon substance misuse and wider mental health needs (poor record-keeping / information sharing served to constrain the benefits). No records confirming any involvement with school nursing services in either Bromley or Surrey have been traced.

### Vulnerability to social (and potentially sexual) exploitation was appropriately identified by professionals in Counselling Service 1 and CAMHS and reasonable responses initiated. Prompted by a referral from a responsible parent, ‘vulnerability’ *was* recognised with respect to:

Substance misuse (alcohol and ‘poppers’)

Sexual exploitation by individual boys

Complex relationships at home

### Staff at school 1 in close co-operation with Elizabeth’s mother also recognised and responded to perceived vulnerabilities by instigating additional support (the detail of *how* this was done remains uncertain, in consequence of the loss of pastoral records). It appears that school 2 was also sensitive to and acted upon Elizabeth’s discerned / declared needs (though had her pastoral records been available, the nature or extent of those needs could have been better evaluated).

### It remains uncertain which pastoral records were passed over to the college in Croydon at which Elizabeth was (extremely briefly) ‘on roll’. School 2 did not receive any pastoral information that might have been forwarded by either establishment. This systemic weakness has informed a recommendation in section 4.

### Recognition by Counselling Service 1 staff of Elizabeth’s acknowledged vulnerability appropriately triggered involvement and a joint approach with the Sexual Health Service and later with CAMHS.

### The comprehensive report of CAMHS work makes it clear that Elizabeth’s needs were understood and that careful and sensitive discussions were completed with the young woman and her mother. It is also clear that good use was made of the combined expertise of the members of the multi-disciplinary team, though the decision to withhold information from mother was justified by the narrowest of margins.

##### Safeguarding issue 1: reported overdose

### CAMHS records confirm that there was a very considered response to Elizabeth’s report of having ingested 4-5 tablets. In close consultation with the multi-disciplinary team and her colleague in Counselling Service 1, the following factors were considered:

Risk of harm from the overdose

Risk of repeating the behaviour

Elizabeth’s wish for privacy / reduced parental intrusion and her express wish that her mother not be informed

Need to facilitate ongoing assessment / treatment

Confidence in mother as a source of protection for Elizabeth from individuals or substances to which she might remain vulnerable

### The conclusion arrived at was that the wishes of then 14.5 year old Elizabeth should be respected (her mental capacity and ‘Gillick / Fraser competence’ - see footnote 5 - was not doubted) The rationale for that conclusion was reproduced in the CAMHS report supplied and in the view of the author was, by the narrowest of margins, justified.

##### Safeguarding issue 2: incident within the family

### Elizabeth’s report of an incident at home prompted an exploration with Elizabeth alone and then together with her mother. At a subsequent multi-disciplinary meeting, further thought was given to the implications of the reported event and whether a referral to Children’s Social Care was justified. Though most of the CAMHS records of engagement with the family are clear, they do not describe sufficient detail nor the rationale for not seeking the involvement of Children’s Social Care.

### In the view of the author, Elizabeth’s report set in the context of her other known difficulties justified it being considered a safeguarding issue and responded to accordingly.

## Assessment & decision making

*What assessments were completed, and were they timely and of adequate quality?*

*Were the decisions and actions that followed assessments appropriate?*

*Were Elizabeth’s views and wishes sought and taken into account in assessments and planning?*

*Was the level and extent of agency engagement and intervention with Elizabeth and her family appropriate*

### Elizabeth engaged well with Counselling Service 1 where it was appropriately determined that (in addition to advice on matters of sexual health) she should be referred to CAMHS.

### CAMHS completed during its relatively brief 3 month involvement (and not withstanding comment made in para. 3.1.9), a sufficiently thorough and timely assessment of need and liaised with relevant other agencies such as the referring Counselling Service 1, school 1 and later the recommended provider of counselling – Counselling Service 2. Actions taken were consistent with assessed need.

### Elizabeth’s views and feelings were clearly centre-stage during her involvement with Counselling Service 1 (to the extent that her mother felt somewhat excluded and remained un-informed of her daughter’s overdose). Elizabeth’s views were also sought by the CAMHS clinician though on some occasions, her explicit opinion e.g. with respect to agreeing to family therapy are not distinguishable from those of her mother. This may reflect incomplete record keeping rather than any failure to heed Elizabeth’s views and the decision taken to maintain confidentiality with respect to the overdose offers evidence that her wishes *were* awarded a real importance (though her capacity to make decisions that were truly in her interest, could be challenged).

### Observations by CAMHS and by school 1 staff of the mother- daughter relationship noted it to be warm and caring, albeit strained as Elizabeth went through adolescence and sought to address some individual developmental challenges.

### The motivation of both mother and daughter to address their reported difficulties is evidenced by their positive use of counselling and school-based support.Even in hindsight, thelevel and extent of targeted agency involvement appears to have been proportionate to the apparent need and consistent with the wishes of mother and daughter, albeit diminished by inadequate recording. The wishes and feelings of Elizabeth’s father remained unknown and should have prompted greater professional curiosity.

## Vulnerability to sexual exploitation, mental health / substance misuse issues

*Was information known by any agency about ‘child sexual exploitation’ (CSE), mental health issues or substance misuse? If so, was appropriate consideration given to how these impacted on Elizabeth*?

*What information was shared with Elizabeth’s family? Was Elizabeth deemed Fraser competent*?

### Counselling Service 1 discerned and responded sensitively when Elizabeth acknowledged that she was sexually active and referred to succumbing to pressure to be so, by her then boyfriend. Neither the counsellor at that agency nor the subsequent CAMHS clinician categorised her reports of sexual activity as ‘exploitative’ and did not therefore initiate a referral to Children’s Social Care. Had they done so, it might have prompted a more holistic appreciation of influential factors and individuals.

### Awareness of and sensitivity toward the phenomenon of exploitation has risen significantly since 2010/11 and the current government definition for application by professionals is that CSE[[9]](#footnote-9) is:

‘A form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology’.

### Elizabeth appears to have been open about her circumstances and made good use of counselling opportunities provided. Her accounts across time and agencies were only of a small number of serial rather than any contemporaneous relationships and she reassured at least one counsellor about having developed the confidence to cease a reported sexual relationship. Whilst doubt must remain, there is insufficient evidence to conclude that Elizabeth was a victim of CSE (though the risk of it was greater than the average female of her age).

### As alluded to above, Elizabeth’s ‘Gillick or Fraser competence’ was never doubted by involved professionals, though might usefully have been spelled out formally and explicitly in their records.

#### Did agencies communicate effectively & work together to safeguard & promote the child’s welfare?

*Were there any cross border issues, and if so, how were they addressed*?

*Was race, religion, language, culture, socio economic class, ethnicity or disability a factor in this case and was it considered fully and acted upon*?

### There was a close and helpful liaison initiated by CAMHS with Counselling Service 1 and school 1.

### If the GP Practice had been made aware at an earlier stage of the involvement of other sources of support (Counselling Service 1), its clinicians would potentially have been able to contextualise better, any future consultations by Elizabeth.

### The records completed whilst Elizabeth was at school 1 were all reportedly transferred to the Croydon-based college but were *not* in turn passed over (or anyway were not received by) school 2 in Surrey**.**

### The ethnic origin of the mother and daughter (neither disabled) was captured. It remains uncertain to what extent any Faith or class-related issues were contemplated or debated. The absence of any direct involvement of father or Elizabeth’s sibling precluded the development of an appreciation of how the family as a whole, functioned.

## Organisational or resource factors

*Were appropriate management / clinical oversight (supervision) arrangements in place for professionals making judgments in this case*?

### It is clear from the records maintained by Counselling Service 1 that the involved worker appropriately sought and was provided with significant management advice that shaped her responses to the family.

### Records of Bromley CAMHS also confirm that its judgements were mediated by means of debate in multi-disciplinary teams as well as by individual supervision. The extent of recorded involvement with Counselling Service 2 was too limited to enable any comment beyond noting that the independent evaluation of it offered no criticism of the level of management or clinical oversight.

### There was a significant amount of multi-disciplinary debate within CAMHS and a helpful link made by Counselling Service 1 with the Sexual Health Service. Whilst the feedback to the GP Practice by CAMHS was inadequate, there has emerged no evidence of a lack of supervision or any reluctance to share relevant information across agencies. The decision to withhold some information from mother has been evaluated elsewhere.

## Domestic violence in Elizabeth’s relationships ?

*What was the nature of the relationship with the perpetrator who killed Elizabeth*?

*Where was Elizabeth living at the time of her death? Was this information known to the key support services*?

### Mother’s account of her daughter’s previous intimate relationships suggests that Elizabeth had to a degree, experienced ‘coercive control’ from 2 Bromley-based boyfriends (one thought to have been a non-sexual relationship). No explicit evidence exists and mother reported none with respect to a 3rd from East Sussex. That relationship reportedly ended after the incident that triggered emergency contraceptive treatment.

### The (understood to be non-sexual) relationship with the individual who murdered Elizabeth was relatively new and had been made known to her mother *only* at the half-term (October 2013). Mother was aware of some unusual features e.g. that the young man was sitting exams at home rather than at school and that a claim that his parents owned the property in which the family lived, was false. She had *no* grounds on which to suspect any physical risk to her daughter and had been planning to make contact with the boyfriend’s mother when the tragic event occurred.

### Mother’s account confirms information that emerged during the murder inquiry about where Elizabeth was living i.e. that although a grandmother lived in a nearby village, Elizabeth was living at home and attending school 2 daily. Aside from school staff and mother, it remains unknown whether any other parties were aware of the relationship. Even if they had, it is by no means clear that the relationship (given no communicated suggestion of X posing a risk to others) would have prompted any response.

## Organisational responses following death of Elizabeth

*What information was shared following Elizabeth’s death and why was a Serious Case Review not considered at that time*?

*What information was shared between Surrey and Bromley LSCBs*?

*Did Bromley’s child death, rapid response and case review processes work? What were the barriers? Were the parallel processes (coroner and police investigation) clear? Have these now been resolved*?

#### Framework in place at time of Elizabeth’s death

### Until 2016 the Bromley Safeguarding Children Board ‘serious case review sub-group’ met *only* when an SCR was being undertaken for a specific case. No formal means existed for unexpected child deaths to be reported to the LSCB on a case by case basis. This means that there are no formal minutes of any meeting where Elizabeth might potentially have been discussed and a formal recommendation made to the independent chairperson.

### An email trail between the then ‘designated doctor’ for child deaths, chair of CDOP and ‘head of quality assurance’ indicates differing opinions about the need even for a ‘rapid response meeting’. Documents traced during this SCR confirm that the case had been debated at a February 2014 meeting of Surrey’s SCR Sub-group at which members were clear about Elizabeth’s ‘ordinary residence’. The then respective independent LSCB chairs were considering some form of ‘peer review’ but for reasons that neither Bromley nor Surrey’s LSCBs have been able to confirm, this idea was not progressed.

### Elizabeth *was* discussed at CDOP meetings in March, June, September and December 2014 but the absence of formal links to a SCR sub-group or the Board (as well as non-receipt of information sought from school 2) meant that her case was not referred beyond that forum.

##### Initial decision

### The formal decision *not* to hold a ‘rapid response meeting’ (which remained unknown to most of the Board) was made by the then ‘designated doctor for child deaths’ and was apparently based upon:

A (mis)-understanding of Police advice that the rapid response process could not be carried out alongside homicide enquiries

Acknowledgment that statutory guidance provided by *Working Together to Safeguard Children* 2013 emphasises that any responses ‘must not prejudice criminal proceedings’

An *apparent* absence of safeguarding issues and

Reassurances that the family’s support needs were being addressed by Police and others

### What emerges from the NHS England report is that the needs of the victim’s family were unintentionally overlooked, so that the assumption indicated by the latter bullet point was mistaken.

### The additional impact of not holding a rapid response meeting was that there was no further scrutiny of Elizabeth’s vulnerabilities or any safeguarding issues. Following the established process would have established at an earlier stage that she was known to CAMHS and drug and alcohol-related services.

##### Challenge from Surrey LSCB & current arrangements

### Prompted by a response from the NPIE about the NHS England-commissioned report regarding the young man X, Surrey’s LSCB contacted Bromley LSCB in August 2016 asking why no SCR had been undertaken. The absence of minuted formal meetings meant that the business manager (in post only for a year) was unable to provide an explanation / rationale. Further enquiries established that Elizabeth *had* been known to Oxleas NHS Trust and to Counselling Service 1. This prompted further scrutiny of the case.

### Enquiries completed by the chairperson of CDOP confirmed that rapid response meetings *should* still be initiated when there is a homicide enquiry and is now embedded practice for unexpected deaths. In addition, the business manager now attends the CDOP and all rapid responses and presents all unexpected child deaths to the quarterly Serious Case Sub-Group. Extra-ordinary SCR meetings are also held *if* there is a complex case with information gaps and possible safeguarding issues. For these reasons, no recommendation for system improvement is necessary.

# Conclusions & Recommendations

## Conclusions

### Some aspects of Elizabeth’s experiences and agencies’ responses to them indicated a heightened level of vulnerability and some potential advantage might have been gained had there been more information exchange and multi-agency communication.

### This SCR was focused upon Elizabeth’s experiences of service delivery (as opposed to those of her killer). *Nothing* has been found to indicate an acute physical risk to Elizabeth from another person and no alternative responses by any of the agencies with which she (or her family) were involved could have served to predict or prevent her murder.

### Opportunities for improvements in the way services recognise and respond to vulnerability (in particular record keeping and its communication) have been identified and inform the recommendations below.

## Recommendations

#### Bromley gEneral practitioners

### With the aim of increasing the proportion of children coded ‘vulnerable’ on GP electronic records and number of GPs using safeguarding risk assessment tools:

The named GP should circulate to Practices the new ‘Vulnerable Adolescents Strategy’ and associated protocols produced by Bromley’s Safeguarding Children Board

Training at the GP academic half-day in January 2018 should include the challenge of professional curiosity and safeguarding risk assessment when young people present with anxiety, importance of transferring information about vulnerability from received letters to codes on the internal system, importance of completing ‘feedback forms (currently labelled ‘form B’s) following the death of a child

#### Bromley healthcare

### Bromley Healthcare should check and provide the Safeguarding Children Board with an assurance that the record-keeping of school nurses is of an acceptable standard.

#### Oxleas NHS Foundation Trust (CAMHS)

### The Trust should reinforce by means of learning events, current expectations that where there are safeguarding concerns consideration should be given to consultation with the Trust’s Safeguarding Team or Children’s Social Care and the rationale for decision-making and actions recorded on clinical records.

### An audit should be completed on the quality of information sharing within and between partner agencies (in particular identification of risk).

### Guidance on patient confidentiality and the guidance on information sharing and the duty to do so when significant risks are identified, should be circulated to all clinicians.

### The roll out of the ‘Sexual Health Risk Assessment Tool’ should be completed by means of a presentation at a ‘level 3’ training day with follow-up information at team meetings and other appropriate forums.

#### Bromley & Surrey Councils

### Taking account of the current statutory guidance in ‘*Keeping Children Safe in Education*’, and (from 25.05.18) the European General Data Protection Regulation (GDPR), both Councils should:

Review the lawfulness, reliability and effectiveness of the arrangements by which any pastoral / child protection-related records maintained by schools are / will be transmitted (and duplicates maintained) to further education providers

* Take any necessary action to ensure that potential reviews do not slip between geographic boundaries and that associated decision-making is independent of agency-sensitivities and subject to an effective methodology and decision-making process

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#### Glossary / abbreviations

|  |  |
| --- | --- |
| **Abbreviation** | **Meaning** |
| ASD | Autistic Spectrum Disorder |
| BSCB | Bromley Safeguarding Children Board |
| CAMHS | Child & Adolescent Mental Health Service |
| CCG | Clinical Commissioning Group |
| CDOP | Child Death Overview Panel |
| CSE | Child Sexual Exploitation |
| EMIS | A patient database accessible to many primary care practitioners |
| GDPR | (European) General Data Protection Regulation |
| IMR | Individual management review |
| LSCB | Local Safeguarding Children Board |
| NPIE | National Panel of Independent Experts |
| OOH | Out of Hours |
| RPS | Royal Pharmaceutical Society |
| SaBP | Surrey and Borders Partnership NHS Foundation Trust |
| SCR | Serious Case Review |

1. Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Children Boards (LSCBs) to undertake reviews of ‘serious cases’ in accordance with procedures in Working Together to Safeguard Children HM Government 2015. A ‘serious case’ is one in which, with respect to a child in its area, ‘abuse or neglect is known or suspected and the child has died [as in this case] or been seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard her/him’. [↑](#footnote-ref-1)
2. NHS England leads the National Health Service in England, sets the priorities and direction of the NHS and encourages and informs the national debate to improve health and care. [↑](#footnote-ref-2)
3. ‘Poppers’ is a slang term given broadly to the chemical class called alkyl nitrites, that are inhaled for recreational drug purposes, typically for the ‘high’ or ‘rush’ that the drug can create as a consequence of vaso- dilation; possession of alkyl nitrites is not illegal though their supply can be an offence. [↑](#footnote-ref-3)
4. ‘Counselling Service 2’ is a long-established local charity offering free, confidential counselling to young people and families (and would currently be described as a ‘community well-being’ service). [↑](#footnote-ref-4)
5. Nearly 30 years ago, a Mrs Victoria Gillick challenged Department of Health guidance which enabled doctors to provide contraceptive advice and treatment to girls under 16 without their parents knowing. In 1983 the judgement from this case laid out criteria for establishing whether a child under has the capacity to provide consent to treatment; the so-called ‘Gillick test’. It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. If a child passes the Gillick test, he or she is considered ‘Gillick competent’ to consent to that medical treatment or intervention. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity to consent to some treatments but not others. The understanding required for different interventions will vary, and capacity can also fluctuate such as in certain mental health conditions. Therefore each individual decision requires assessment of Gillick competence. If a child does not pass the Gillick test, then the consent of a person with parental responsibility (or sometimes the courts) is needed in order to proceed with treatment.

   The ‘Fraser guidelines’ specifically relate only to contraception and sexual health. They are named after one of the Lords responsible for the Gillick judgement but who went on to address the specific issue of giving contraceptive advice and treatment to those under 16 without parental consent. The House of Lords concluded that advice can be given in this situation as long as:

   He/she has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment

   He/she cannot be persuaded to tell her parents or to allow the doctor to tell them

   He/she is very likely to begin or continue having sexual intercourse with or without contraceptive treatment

   His/her physical or mental health is likely to suffer unless he/she received the advice or treatment

   Advice or treatment is in the young person’s best interests.

   Health professionals should still encourage the young person to inform his or her parent/s or get permission to do so on their behalf, but if this permission is not given they can still give the child advice and treatment. If the conditions are not all met, however, or there is reason to believe that the child is under pressure to give consent or is being exploited, there would be grounds to break confidentiality (Fraser guidelines originally just related to contraceptive advice and treatment but, following a case in 2006, they now apply to decisions about treatment for sexually transmitted infections and termination of pregnancy) <http://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-8-gillick-comptency-fraser-guidelines> [↑](#footnote-ref-5)
6. Asperger’s Syndrome is defined by the World Health Organisation (WHO) defines Asperger Syndrome (AS) as one of the autism spectrum disorders (ASD) or pervasive developmental disorders (PDD), which are a spectrum of psychological conditions characterised by abnormalities of social interaction and communication. [↑](#footnote-ref-6)
7. Counselling Service 2 is a third sector organisation delivering a single point of access for children and young people with emotional and mental health difficulties that impact upon their well-being; when Elizabeth was seen, the agency was much smaller and offered counselling to 11-23 year olds. [↑](#footnote-ref-7)
8. The school-based service was a well-established ‘not for profit’ youth counselling service which engaged self-employed accredited (British Association for Counselling and Psychotherapy) counsellors; it provided a confidential school-based counselling service in Surrey and other local authority areas. [↑](#footnote-ref-8)
9. The relevant professional guidance in 2010/11 was the non-statutory ‘Safeguarding Children and Young People from Sexual Exploitation 2009. [↑](#footnote-ref-9)