



**ROYAL BOROUGH OF GREENWICH  
SAFEGUARDING CHILDREN BOARD**

**SERIOUS CASE REVIEW**

**‘YOUNG PERSON X’**

**FERGUS SMITH**

10 .05.18



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# 1 INTRODUCTION

## 1.1 EVENT TRIGGERING THIS SERIOUS CASE REVIEW & IMMEDIATE BACKGROUND

- 1.1.1 On 29.05.17 'X' (a 16.5 year old male of White British ethnicity) fell from the 9<sup>th</sup> storey of a building in the Royal Borough of Greenwich.
- 1.1.2 Following chronic difficulties in his family, X had entered the care system in late 2016 and was fostered. It later became apparent that X had very significant mental health difficulties. He had been provided with voluntary and involuntary child and adolescent mental health services (community and hospital-based) in the 3 months preceding his death. At the time of his death there existed uncertainty about where and with whom X might live in the longer term.

## CONSIDERATION OF A SERIOUS CASE REVIEW

- 1.1.3 In accordance with the 'Local Safeguarding Children Board Regulations 2006' and local agreed procedures, X's death was discussed at a 'rapid response meeting' on 01.06.17. The case was subsequently discussed at the borough's 'serious case review sub-group' on 19.06.17. At that meeting, it was concluded that, insofar as there had been no suspected or known abuse or neglect, the criteria for undertaking a serious case review were not met<sup>1</sup>. This conclusion was shared with the independent chairperson of the Safeguarding Children Board. She gathered additional evidence and consequently determined that there was potential learning and that a serious case review should and would be completed.
- 1.1.4 The Department for Education, regulatory body Ofsted and the 'National Panel of Independent Experts' (NPiE) were informed of the chairperson's decision on 31.08.17.
- 1.1.5 This review was undertaken between September 2017 and February 2018 in accordance with the case-specific terms of reference reproduced in section 3.

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<sup>1</sup> 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 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

## 1.2 PURPOSE, SCOPE & CONDUCT OF THE REVIEW

### PURPOSE & SCOPE

- 1.2.1 The purpose of a serious case review (SCR) is to identify required improvements in service design, policy or practice amongst local, or if relevant, national services. It is not concerned with the cause of death which was, at the conclusion of an Inquest in March 2018, determined by the Coroner to be 'suicide'. At the request of the Coroner, a copy of a near-final draft of this overview had been supplied to the Inquest and the author was also required to appear as a witness.
- 1.2.2 The period of service delivery to be reviewed was debated by the SCR panel members who sought to establish a proportionate approach to the extensive involvement over time, with the family of many local agencies. It was determined that the review should (following substantial multi-agency work in the period 2013-16), capture the period from the evaluation of need and risk at case closure by Children's Social Care, to X's death i.e. from 01.01.16 to 29.05.17. Any agency possessing relevant material that pre-dated this period was invited to include it.

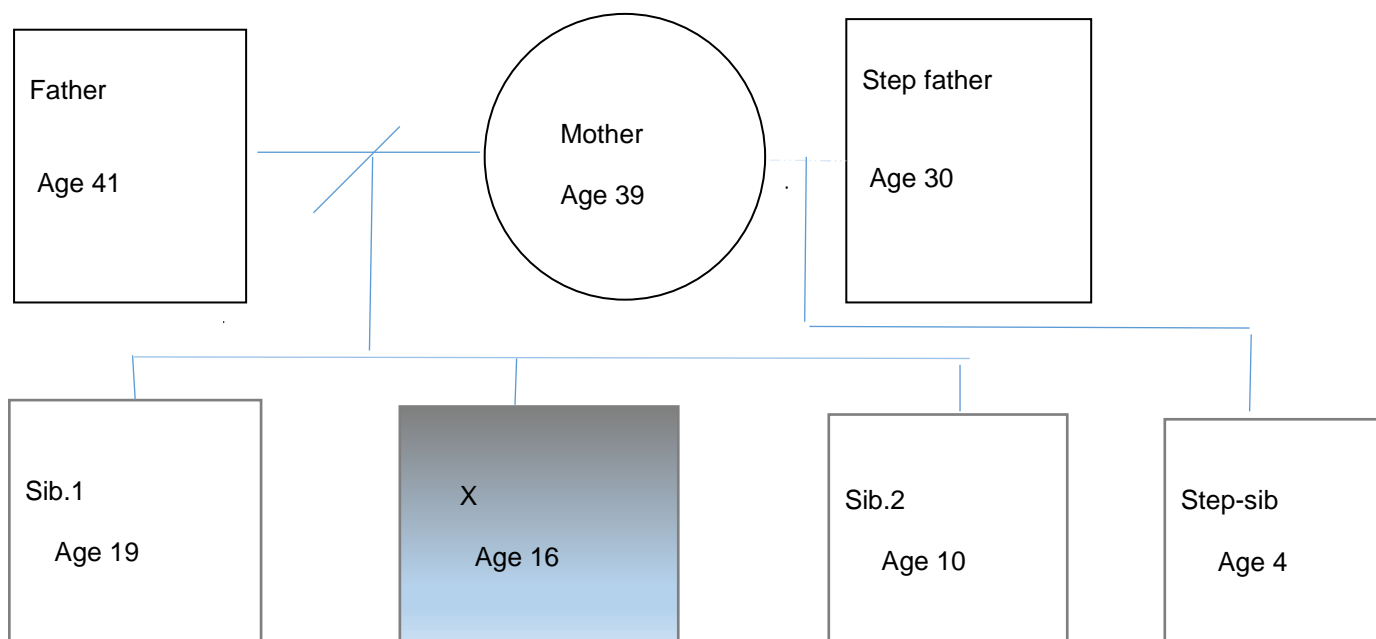
### CONDUCT

- 1.2.3 An independent report was commissioned from [www.caeuk.org](http://www.caeuk.org) and it was agreed that lead reviewer Fergus Smith would:
- Evaluate submitted reports and develop and conduct briefing / learning events with relevant professionals
  - Draft for consideration by the SCR panel, an evaluation of the quality of agencies' involvement with conclusions and recommendations for action by the Royal Borough of Greenwich Safeguarding Children Board, member agencies and (if relevant) other local or national agencies

### Family involvement & links to Coroner

- 1.2.4 Formal notification of the serious case review was sent by the LSCB to the Coroner and to X's mother who was invited to contribute. Uncertainty about his father's address required (before sending sensitive and confidential material) a preliminary attempt to obtain confirmation. No response was received and father's location remained uncertain. At the conclusion of the Inquest, X's mother indicated that she would like to share her experiences and perspectives. Mother, her own mother and the author consequently met on one occasion and this was supplemented by a further lengthy phone conversation. This final draft reflects at relevant places, the family's experiences of, and opinions about services provided.
- 1.2.5 Reports from involved agencies were also supplemented by the author's direct communication with X's foster carers and their supervising social worker who were able to confirm and offer some detail about a number of findings that emerged from the review's examination and debate about professional records.

## FAMILY STRUCTURE



## PANEL MEMBERSHIP

- Lead reviewer (chairperson)
- Senior Manager for Relevant Educational Trust
- Head of Quality Improvement Service Royal Borough of Greenwich Children's Services
- Lead Psychiatrist Lewisham CAMHS (South London & Maudsley NHS Foundation Trust)
- Designated Nurse Safeguarding Children Greenwich Clinical Commissioning Group (CCG)
- Designated Nurse for Looked after Children Greenwich CCG & Oxleas NHS Foundation Trust
- Named Nurse Safeguarding Children Lewisham & Greenwich NHS Trust
- Representative of Metropolitan Police Service
- Head of Safeguarding Children and Lead Named Nurse Oxleas NHS Foundation Trust
- Royal Borough of Greenwich Safeguarding Children Board Manager & Business Support Officer (minute-taker)

1.2.6 The main findings of the serious case review were debated with relevant practitioners before revision and formal acceptance by the SCR panel. The panel's agreed report was subsequently presented to the Royal Borough of Greenwich Safeguarding Children Board where it was accepted subject to the addition of some relevant evidence that emerged in the final stages of the Inquest.

1.2.7 A copy of this report is being sent to the national panel of independent experts (NPIE) and to the Department for Education (DfE).

## SOURCES OF INFORMATION

1.2.8 The following agencies supplied information to the SCR panel:

- X's school (provision of education and support)
- Metropolitan Police Service (responding to offences and the SCR trigger event)
- Royal Borough of Greenwich Clinical Commissioning Group (GP care of X)
- Royal Borough of Greenwich Children's Social Care (family support, provision of placement and care planning)
- Lewisham and Greenwich NHS Trust / Queen Elizabeth Hospital (A&E and paediatric services)
- South London & Maudsley NHS Foundation Trust (SLAM) (provision of psychiatric in-patient care at Bethlem Royal Hospital)
- Oxleas NHS Foundation Trust (Greenwich Community CAMHS)

1.2.9 In addition, the author was allowed access to selected witness statements and submissions drafted for consideration by the Coroner at the Inquest.

## TIMETABLE FOR CASE REVIEW

Event	Target date
Decision to initiate case review	31.07.17
DfE, Ofsted & NPIE informed	31.08.17
Author commissioned	25.08.17
<b>Panel meeting 1:</b> planning conduct SCR (methodology / scope)	18.09.17
Agency chronologies / reports requested	By 23.10.17 & 05.11.17 respectively
<b>Panel meeting 2:</b> appraisal of reports 1-5 received	07.12.17
Briefing event for involved professionals	15.12.17
<b>Panel meeting 3:</b> debating remaining 3 IMRs 6,7&8	18.01.18
'Preliminary' overview report submitted for consideration by panel members	22.01.18
Learning event for involved professionals	31.01.18
Submission of 'draft 1' overview to <i>panel members</i>	05.02.18 7pm
<b>Panel meeting 4:</b> discussion of 'draft 1' & agreement of any amendments	Postponed from 05.02.18 to 20.02.18 because of Ofsted inspection
Submission of 'draft 2'	3pm 23.02.18 for responses please by 2pm 26.02.18
Submission of draft for 'governance group' on 01.03.18 [postponed because of severe weather] & with negotiated amendments 'final draft' to the Coroner)	26.02.18 6pm & 05.03.18 10am
Local Safeguarding Children Board debate of 'final draft', meeting with family & consequent amendments	26.04.18 / 09.05.18 / 10.05.18
Re- submission to LSCB & agreed report to NPIE, Ofsted	To be confirmed

## 2 SIGNIFICANT EVENTS

### 2.1 PRE-REVIEW PERIOD

- 2.1.1 In 2009, following extensive and serious domestic abuse and maternal mental health difficulties, X's parents separated. X (aged 9) subsequently lived with his mother and older and younger brothers (sib.1 and sib.2) though is thought to have moved between his parents' homes at an unknown frequency in response to further conflict.
- 2.1.2 From November 2011 to January 2013 Children's Social Care was much involved with X's family as a consequence of mother's depression. In early 2013 the case was 'stepped down' to a 'team around the child' status. Concerns about X and older brother sib.1 included a fear they could be a risk to sib.2 (who was then aged 7 and had special needs) as well as to a new-born half-sibling. In response to ongoing tension and episodic violence, X spent time with his father in 2014 and continued to move between the homes of his parents.
- 2.1.3 With the aim of a 'fresh start' X had transferred in 2014 (his year 8) from a secondary school where he had experienced difficulties (some associated with the behaviours of elder sib.1) to a local alternative. Initial attendance rates and achievement levels were good. In November 2014, having assaulted his step-father and threatened to stab his mother, X's older brother (sib.1) was accommodated under s.20 Children Act 1989. A similar event later triggered X's admission to care and is described in section 2.3
- 2.1.4 During year 9 (September 2014-July 2015) there were increasing incidents of X's poor behaviour (including an assault on a fellow pupil) and slightly reduced attendance. By year 10, additional needs had prompted the allocation of a learning mentor. Attendance improved to 94%. X was evaluated as above average academically.
- 2.1.5 Examination of the records of the pre-review period revealed two child protection investigations, one centred around father and a second around mother. X's then 2 year old step-sibling was injured on one occasion when X's father and step-father fought and fell on him.
- 2.1.6 A retrospective evaluation of the 2 years preceding case closure suggests that the impact of familial violence was considerable and that all the children (victim and perpetrators) were at times at 'risk of significant harm'. Mother's mental health difficulties were recognised but she consistently failed to engage with help offered.
- 2.1.7 The remainder of section 2 overleaf describes and evaluates services offered to X and his family during the period under formal review.

## 2.2 RENEWED SUPPORT: SCHOOL & CHILDREN'S SOCIAL CARE

- 2.2.1 By early 2016, after 2 years of intensive 'child in need' support and provision of services *intended* to address X's emotional well-being and violent behaviours, case closure was being contemplated though was much-postponed as a result of various crises. On 28.01.16 a consensus was formed amongst involved agencies that a 'team around the child' (TAC) was no longer required and X no longer regarded as a child in need. His 'child in need' case was subsequently closed on 16.02.16.

*Comment: the decision to close the case has been evaluated as 'reasonable'. There had been no reports of violence for 6 months and X was progressing well at his then school (indeed in August 2016 he obtained good results in 2 GCSEs). Without regard to the family therapy that at some point in the past had been offered, the acknowledged history of exposure to domestic abuse, sib.1's attempted suicide (by hanging) when 13, and (less certainly) X's self-report of previous 'self-cutting', a CAMHS referral could have been justified.*

- 2.2.2 During the first half of 2016 X's mother was offered support from the Adult Mental Health Services 'Social Inclusion Team'. Psychological intervention was recommended but after a number of unsuccessful attempts to engage her, she was discharged in May 2016. The impact of mother's condition on her children was apparently not considered. From January to March 2016 a health visitor made several attempts to contact mother with respect to her youngest child. These services did not initiate contact with Children's Social Care.

## 2.3 EVENTS LEADING TO S.20 ACCOMMODATION

### ALTERCATION AT HOME

- 2.3.1 On 20.09.16 X was arrested at home for an assault on his mother. His father who had attended the home at his ex-partner's request, reported that X had tried to 'climb out of' the 3<sup>rd</sup> floor window. Father considered and described this as an attempt to escape rather than self-harm. X himself later reported that he had *thought* of jumping and later still, (whilst an in-patient in 2017) that it *had* been attempted self-harm in response to conflict with a girlfriend. X gave Police a 'no comment' interview. In the absence of evidence from mother, he was, after 'multi-agency safeguarding hub' (MASH) checks had revealed no concerns, released with no charge.
- 2.3.2 The report submitted by the Metropolitan Police (MPS) provides confirmation that in general, appropriate procedures (including an examination by a mental health nurse) were followed by involved officers. A comment made by X to that nurse, of having had some thoughts of jumping from the 3<sup>rd</sup> floor as well as previous self-harming ideation were not passed on to the officer in the case. In consequence they were omitted from the Merlin notification transmitted to Children's Social Care.

*Comment: the relevant individuals in the MPS have been reminded to include such updating details in any future comparable situations.*



## **X's REQUEST TO BE ACCOMMODATED**

### **First recorded threat of self-harm**

- 2.3.3 In the early evening of 22.09.16 X presented himself at Children's Social Care, said he no longer wished to live with either parent and wanted to be accommodated. Father was contacted and confirmed a willingness to continue caring for his son who was subsequently advised to return there. By 20.00 when he had not returned home, his father reported X as 'missing'. Police evaluated X as being at 'medium risk' i.e. *'risk posed is likely to place the subject in danger or they are a threat to themselves or others'*.
- 2.3.4 While X's whereabouts remained unknown, mother reported a phone call from her son indicating thoughts of self-harm and suicide. X was re-evaluated as 'high risk' and all relevant internal procedures followed. X actually returned to his father's home soon after midnight.
- 2.3.5 The report submitted to this review by Children's Social Care acknowledges that the initial decision of a duty manager not to accommodate X was under-informed (about father's violent history and mother's mental ill-health) and diminished the impact of prolonged *emotional* abuse by both parents (focusing instead on the lesser risk of physical harm) The case was though, allocated to a social worker for a Child & Family Assessment of his needs and the risk of family breakdown, with a view to informing longer term planning.
- 2.3.6 X's account to school staff of his home life convinced them that he needed to be accommodated. This view (apparently more comprehensively informed by accounts of the boy's developmental history than the records available to, or perhaps considered by social workers) seems to have significantly influenced the decision by Children's Social Care to accept father's agreement on 23.09.16 that his son could be accommodated.

### **ACCOMMODATION UNDER S.20 CHILDREN ACT 1989**

- 2.3.7 At a 'missing child' follow up visit to his father's address next day, police officers were told that X had been placed with foster carers. Officers later attended the carers' home to be told by X that he was happy with the move. A 'safe and well check' was completed and all relevant information e.g. X's fear of being beaten up by his older brother, communicated to Children's Social Care.

*Comment: Police responses to the circumstances were sensitive and efficient.*

- 2.3.8 Children's Social Care records capture the school view that X's response to being accommodated was that *'...a load had been lifted from him'*. A record of an internal exchange of emails at school in mid-October noted that his National Youth Advocacy Service (NYAS) advocate had reported that X was happy being accommodated and would run away again if sent back to father. Mother's view is that there was insufficiently explored scope at this time for X to live with her.

## Initial Care Planning

- 2.3.9 A search of GP records has revealed no concerns about X's mental health or self-harming, indicating that any such issues or episodes had not been shared with the relevant Practice.
- 2.3.10 An initial health assessment was completed and confirmed that X was in good physical health. It did not address emotional well-being. It is thought the examining doctor had not been made aware (via GP records or a verbal briefing) of any mental health concerns, self-harming, or wider family history. The assessment including a completed standard measure of mental health (SDQ)<sup>2</sup>, the results of which did not indicate any concern and were appropriately supplied to the GP Practice with which X was registered after placement with his foster carers.

*Comment: the potential value of an initial health assessment is compromised if all relevant information is not made available; whilst significant improvements have been reported in the capture and processing of all relevant information, a precautionary recommendation has been included in section 4.*

## Statutory Case Review 1: 18.10.16

- 2.3.11 The extent to which there existed a choice of placements and how the carers were selected is not apparent from the material supplied, though they seem to have provided a very positive source of support. Both birth parents attended X's initial review which was convened within the 20 working days required by regulations<sup>3</sup>. The event pre-dated completion of the social work assessment of the family's needs. The report submitted to the SCR observes that the then 'Care Plan' (the intended outcomes of X becoming 'looked after') was clearly written and initially focused on exploring the potential for reunification. Records indicate there was 'no-one' in the extended family to look after him.

*Comment: there was scope for further exploration of extended family e.g. by means of a family group conference (FGC) and (beyond a reference to past 'cutting') there was no reference to mental health difficulties in the referral form submitted; the potential issues associated with a trans-racial / cultural placement might also usefully have been included in discussions and might have served to reduce the tension that appears to have later developed between carers and mother.*

## Completion of child and family assessment

- 2.3.12 The comprehensive assessment completed later in October by SW3 captured many key events but omitted others that might have reflected the full extent of the violence and instability within the family and the underpinning drivers of familial behaviour patterns e.g. the parents' own experiences of childhood and mother's mental ill-health.

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<sup>2</sup> A Strengths & Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3-16 year olds.

<sup>3</sup> The Care Planning, Placement and Case Review (England) Regulations 2010 as amended.

- 2.3.13 The recommendation of the completed assessment i.e. to consider counselling and mediation for X and use of CAMHS to address 'emotional difficulties and anger', overlooked the extensive history of programmes and approaches tried with limited success.

*Comment: 'start again syndrome' describes practitioners sometimes optimistic desire to 'view the case with fresh eyes' and can result in poor analysis of past history and parenting capacity. Interventions may be tried repeatedly, without critical reflection as to whether outcomes are actually changing for the child<sup>4</sup>.*

- 2.3.14 Setting aside the relevance of the recommendations in the assessment, no referrals for counselling, mediation or CAMHS were actually initiated. Mother cannot recall any steps taken by Children's Social Care to facilitate a working relationship between birth parents and foster carers.

### **X's ASSAULT OF A MEMBER OF STAFF AT SCHOOL**

- 2.3.15 On 07.11.16 X was sent home from school and told to return to the 'Internal Referral Centre' following violence toward a member of staff. A duty social worker SW4 was informed. X mentioned at school on 14.12.16 that he was feeling stressed because his mother was planning to move out of London, things were not so good with his carers and he had not been told the name of a new social worker. His complaint of no contact from Children's Social Care since 11.11.16 was relayed to a SW5. X also claimed he had been 'talked down to' by SW4.

*Comment: the accuracy of his allegations or the response to them remains unconfirmed; school staff were consistently attentive and often advocated for X.*

- 2.3.16 Next day X's case was transferred from 'Assessment & Support' to the 'Young People' team where 'SW6' became and remained case accountable. The transfer was prompted by the agreement reached at the review in October that X would need to remain accommodated. Enquiries during this review have confirmed that X stayed with family members over the Christmas period.
- 2.3.17 In early January 2017 learning co-ordinator LT1 passed on X's account of being 'uncomfortable' in placement, 'struggling to settle in' and a resentment about imposed boundaries. He said he was upset by SW5's report. Arrangements were made for him to work in the library. 2 days after contact with Children's Social Care, SW6 is reported by the school to have visited X. No case notes have been found though a report supplied after the practitioners' event in January 2018, confirms that meeting at which X's confusion was acknowledged.
- 2.3.18 The school report submitted to this review refers to a discussion between LT2 and SW6 and a mistaken understanding at school that SW6 *had* initiated a CAMHS referral, an action which (it reports) it had advocated in 2014 and had been deferred because of X's opposition.

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<sup>4</sup> Brandon M., Belderson P., Warren C., Howe D., Gardner R., Dodsworth J., Black J.(2008) 'Analysing child deaths and serious injury through abuse and neglect: What can we learn? A biennial analysis of Serious Case Reviews 2003–2005'. Nottingham, Department of Children, Schools and Families

2.3.19 During the course of this review, an email dated 19.01.17 from SW6 to LT3 was located and indicates 'I will be referring him to CAMHS for anger management which he has agreed to, but CAMHS will need to know what support is already in place'.

Comment: *no CAMHS referral was made prior to X's self-harming in March.*

## **STATUTORY REVIEW 2: & SUBSEQUENT PATHWAY PLAN**

2.3.20 SW6 met X on the day of his 2<sup>nd</sup> statutory review on 17.01.17 when he expressed a wish to work toward independent living. His need for a sense of permanence was addressed by means of a decision that he would be 'long-term fostered'. X stated his preference to remain with his current carers. For un-recorded reasons, his mother left before the meeting began and a stated intention by the independent reviewing officer (IRO) to consult her within a month was not followed through. Thus, this significant planning forum was weakened by the:

- Absence of parental opinion
- Insufficient (recorded) exploration of what 'gran' or other still un-identified members of the extended family might be able to offer by way of direct care or support
- Absence of input from the school (albeit a need to minimise the number of professionals at such sensitive events is a point made often by young people)
- An apparent absence of a *revised and updated* Care Plan (the objective) and Placement Plan (day to day arrangements including explicit delegated authority arrangements, in particular about family contacts<sup>5</sup>)

2.3.21 When asked by the author to recall the above occasion, mother reported that she had received no preparatory explanation as to its purpose, membership or anticipated conduct, and to being hurt by some abrupt comments made by the female foster carer who mother recalls was reluctant to terminate a phone call. Mother acknowledged that she had been insufficiently clear about her lawful rights and recalled feeling resentful (though not confident enough to challenge) a decision apparently made by the foster carers to re-register X with a new GP.

2.3.22 Children's Social Care has confirmed completion of a recent review of how statutory reviews are recorded (about which positive comments were made by regulator Ofsted at its last inspection in 2015/16) and this case is considered atypical. The referral to CAMHS anyway remained outstanding. X's view was that he wished to remain accommodated, finish his education and move to semi-independence.

2.3.23 The extent to which carers were a suitable 'match' was unexplored (though enquiries during the SCR have confirmed that their terms of approval did allow for long-term use).

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<sup>5</sup> In accordance with, respectively, Regs. 5&6, Reg.9 & Sch.2 & Volume 2 revised paras. 3.139-146 & Volume 4 3.9-3.24 Care Planning, Placement & Case Review (England) Regulations 2010 as amended & Statutory Guidance.

2.3.24 In addition, no record of 'statutory visits' required by the Care Planning Regulations 6 (within 1 week of placement and thereafter at a minimum 6 weekly) were located though SW6 reports their completion. Absence of Fostering Service representation may have reduced the likelihood of issues such as 'matching' or regulatory compliance being recognised.

*Comment: good practice required representation of the Fostering Service and consideration of outstanding tasks such as the CAMHS referral. A check during this review of comparable circumstances, has provided reassurances that this was an atypical situation and no recommendation has been made.*

2.3.25 The IRO recommended that a 'Pathway Plan' be completed within a month though neither progress toward that, nor other specified objectives was monitored. Mother has no recollection of receiving a copy of any Care or Pathway Plan as is required by the Care Planning Regulations referred to above (regulation 6).

2.3.26 Though the carers themselves have expressed no concern about it and used their best judgement in seeking advance clearance and direct agreement with X, the report submitted by Children's Social Care commented upon the absence of an updated 'Placement Plan'<sup>7</sup> with sufficiently detailed 'delegated authority'<sup>8</sup> about overnight or more extended stays with family members. Of even greater significance was that X (already concerned about mother's planned move from London) may have been anxious about where he might in future live.

2.3.27 Neither then or later was there written confirmation about proportions of time that the multi-agency network considered would be in X's best interest to spend at the foster carers' home or with respective parents or grandmother/s. X's *grandfathers* whose involvement emerged during this review, are virtually invisible in agencies' records.

2.3.28 Planning for older teenagers looked after under s.20 is challenging insofar as parents retain and the local authority does not obtain parental responsibility. Thus all arrangements are predicated on parental consent or (in relevant cases of a 16/17 year olds) on the young person's decision to remain accommodated in spite of a parent's expressed wish (s.20(11) Children Act 1989)<sup>9</sup>. Responsibility for determining these arrangements seems, by default not intent, to have been left with X and represented a significant (arguably excessive) level of responsibility. The challenges typified by this case offer potential learning and a recommendation has been made in section 4.

*Comment: the author's conversation with the carers enabled the maternal and paternal grandmothers to be distinguished; professional records though did not adequately define and distinguish 'nan'; 'gran', 'grandmother' etc.*

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<sup>6</sup> Reg.23 Care Planning, Placement & Case Review (England) Regulations 2010

<sup>7</sup> Reg. 9 Care Planning, Placement & case Review (England) Regulations 2010

<sup>8</sup> As required by volume 2 revised paras.3.139-3.146 and volume 4 revised paras. 3.9-3.24

<sup>9</sup> In consequence of s.20(11) Children Act 1989 AB could agree in his own right to remain accommodated even if either or both parents sought to resume care, but his knowledge of that right in law, and even more relevant, his capacity to manage his ambivalence remains uncertain.

## **FURTHER VIOLENCE AT & FIRST TEMPORARY SUSPENSION FROM SCHOOL**

2.3.29 On 18.01.17 the GP Practice was informed by letter of X having been suspended from school for a 3 weeks.

*Comment: it is unusual to see a GP Practice included in the agencies notified of suspensions; during the serious case review details of the incident of aggression toward a female teacher were supplied.*

2.3.30 LT2 of the school leadership team liaised with the virtual head about alternative arrangements for X's education whilst suspended (and on 06.02.17, in place of a 'personal education plan' (PEP) review, a crisis meeting agreed to plan reintegration).

### **CHILDREN'S SOCIAL CARE 'PATHWAY PLAN'**

2.3.31 An updated 'Pathway Plan' of 31.01.17 has been located. It contains no parental views and omits reference to domestic abuse or self-harming. The foster home was noted to be suitable though a potentially significant reference to X 'isolating' himself remained unexplored. The document did refer to the maternal grandparents but the 'needs assessment' omitted reference to X's declared fear of his elder brother and father. The conclusions are that the placement should be 'supported' by stays with his maternal grandmother and contact with his mother limited 'because it served to undermine the placement'. The rationale for these conclusions is unclear.

*Comment: it is not obvious how the desired arrangements were to be actioned or reconciled with the apparent acceptance at the second review that contact with family would be at X's discretion; no work was undertaken to facilitate communication and collaboration between birth and substitute family.*

2.3.32 The Children's Social Care report provided to the review describes the 'Pathway Plan' as a snapshot in time rather than a dynamic document and notes that it was provided *only* to the foster carers.

### **DIFFICULTIES IN PLACEMENT**

2.3.33 The report supplied by Children's Social Care refers to a positive bond between X who was interested in becoming and his male carer who is an accountant. X also valued the carers watching him play soccer at which he was very skilled, and shared enjoyment of the carers' grandchildren and social events. Although the carers reliably supplied monthly reports for their 'supervising social worker' (SSW), these were not passed on to SW6, thus failing to make use of valuable first-hand observations of X's stated wishes and observed and reported feelings. This has been confirmed as an individual oversight and does not therefore require a recommendation for systemic change.

2.3.34 At her meeting following the conclusion of the Inquest mother reported her view that the initially positive relationship X enjoyed with carers deteriorated and that she never felt accepted or respected by them.

- 2.3.35 X had told school staff on 28.02.17 that his placement had 'broken down' and he had spent 2 nights at his nan's. A subsequent meeting (no Children's Social Care record of it has been traced) involving SW6, LT1, LT2 and X produced an agreement that he would return to his carers when his nan travelled to Spain for a pre-arranged holiday. Information supplied to the serious case review following the practitioners' event in January 2018 indicate that SW6 met X on the same day, heard his anger with the school decision to suspend him and encouraged him to access the school counselling service. The carers' account of this period differs and indicates that this had been a planned and agreed stay with the paternal grandmother.
- 2.3.36 Though no record of this intention was located, the panel has belatedly been informed that SW6 had intended to convene a 'placement stability meeting' on 09.03.17. His plan was subverted by X's hospitalisation described. The perceived need for such a response does suggest an instability of placement which does not emerge from records, though is consistent with mother's recently expressed views.

## **2.4 1<sup>ST</sup> A&E PRESENTATION: ADMISSION TO BETHLEM ROYAL ADOLESCENT UNIT FOLLOWING SELF-HARM**

- 2.4.1 Apparently triggered by a row with his girlfriend (the relationship with whom had remained largely unknown to the professional network or carers), X was brought to hospital by ambulance on 08.03.17 having attempted to hang himself with his belt. The relationship, according to the young woman's witness statement for the Inquest, had begun in May 2016 and clearly continued to be of great significance to X.
- 2.4.2 A joint assessment was subsequently completed by CAMHS 1 and SW6. Whilst CAMHS was reportedly not made aware of X's or his older brother's history of self-harm, the former fact was elicited by the assessing junior doctor completing an initial assessment at A&E. X later attributed a worsening of mood in the previous year to his efforts to move into foster care and from there to independence.

### **Informal hospitalisation**

- 2.4.3 Accounts of X's response to the possibility of his girlfriend visiting the hospital suggest a very anxious young man. X remained in hospital overnight and next day, after some confrontation involving sib.1 (whose partner was coincidentally in the hospital's Labour ward) and the female foster carer, a transfer as an informal patient to a CAMHS in-patient unit at the Bethlem Royal Hospital was completed.
- 2.4.4 Mother has reported to the author that she found out about the self-harm only because her son phoned her i.e. neither hospital or Children's Social Care staff had notified her on the day of the incident.

*Comment: mother (and father) retained their lawful parental responsibility and should have been notified promptly.*

## Subsequent sectioning of X & arrest of father

- 2.4.5 On 14.03.17 an in-patient clinician (a junior doctor) contacted CAMHS to report an incident. On the understanding that he was to meet a male friend, X had been granted 'unescorted' leave from the ward. In fact the planned meeting had been with his girlfriend, who failed to appear. An upset X subsequently called his mother and reported that he was at a train line and contemplating ending his life. Police were called and X was sectioned under s.2 Mental Health Act 1983.<sup>10</sup>
- 2.4.6 A reference to SW6 speaking to a LAC nurse about 'pictures and messages sent by X' has been explained as his threats to self-harm if his girlfriend did not respond to communications. It also emerged that the carers discovered that X had been carrying a knife for many months.
- 2.4.7 Whether there is any connection is unknown, but also on 14.03.17 X's father was arrested and admitted to threatening to kill his current partner. He attributed this to stress, in part about X's hospitalisation.

### 'Welcome meeting'<sup>11</sup>: 16.03.17

- 2.4.8 X asked for his foster carers *not* parents to attend this meeting (suggesting he trusted them). It was attended by the ward manager, senior house officer, ward social worker, female foster carer and SW6. There was no community CAMHS representation. X was noted to be suffering from 'severe depression'. He was initially withdrawn and not keen to join in activities. By day 4 staff had developed plans relevant to his depression and anger and X said he was willing to consider 'psychologically minded talking therapies' and medication.
- 2.4.9 The LAC Health Service and School Nursing were duly notified of the A&E presentation and admission to the Royal Bethlem respectively.
- 2.4.10 Arrangements were negotiated with X for a trial weekend leave (24.03.17- 26.03.17) with his mother, to include contact with girlfriend, grandparents (maternal or paternal is unspecified) and father. A subsequent email exchange with SW6 makes it clear that the social worker was frustrated by not having been party to these negotiations.

*Comment: this event and the later discharge described below suggest some scope for increased sensitivity to the social circumstances into which a patient is being discharged and for drawing on the experience and views of involved agencies such as school and Children's Social Care to evaluate them.*

- 2.4.11 In the event, X returned and reported that the weekend had been enjoyable. Over the following week, he was both more engaged with staff as well as challenging and at times aggressive, toward peers. He also showed himself capable of reflection.

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<sup>10</sup> S.2 Mental Health Act 1983 allows a patient's detention for purposes of an assessment for up to 28 days.

<sup>11</sup> A 'Welcome Meeting' is a standard 'tier 4' in-patient practice used to review the antecedents and context of an admission and clarify and plan treatment whilst on the ward.



- 2.4.12 X was reviewed by the ward consultant before further leave for the weekend prior to the discharge described below. This weekend was also noted to have gone well. On return X was assessed by the ward as 'mentally well overall, though reactive to interpersonal rejection'.

#### **Discharge / Care Planning Arrangements (CPA) Meeting 1: 04.04.17**

- 2.4.13 In addition to hospital staff, this meeting was attended by the male foster carer, birth mother and SW6. Care co-ordinator CAMHS1 contributed by means of a conference call. Because the meeting was held during Easter holidays, no school representative was available, though it had supplied information for those attending.
- 2.4.14 It was concluded that X was no longer in crisis and could return, initially to his grandmother's home and then on to his foster carers on 07.04.17. An appointment to meet with CAMHS1 was agreed for 11.04.17. The GP Practice was kept informed of progress and received a discharge summary on 07.04.17. The school was not though, forewarned of X's return at the beginning of the Summer term.

*Comment: if CAMHS been present or submitted views in writing, it might have been more successful in promoting its view that X's discharge was premature.*

#### **2.5 PROVISION OF A COMMUNITY-BASED 'CHILD AND ADOLESCENT MENTAL HEALTH SERVICE' (CAMHS)**

After a successful day of unescorted leave on 06.04.17, and in accordance with the agreed plan, X was discharged to his maternal grandmother. The Unit understood that X was to return to his carers at the end of Easter holidays so as to prepare for exams. In a subsequent exchange between CAMHS1 and SW6, it was agreed that grandmother would bring X to his appointment on 11.04.17. X did not attend and on 'follow up', denied risks, self-harm or suicidal ideation. He attended an appointment on 12.04.17 when he appeared low in mood. A further appointment was made.

- 2.5.1 CAMHS received from SLAM1 an outline plan for liaison about school timetabling prior to exams. CAMHS was informed of a delay in mother's plan to move to another area so as to develop her relationship with X, though it was understood that a return home was *not* being planned by him (an example of differing expectations of the end result of the care episode).

#### **Unplanned return to school**

- 2.5.2 On 17.04.17 X arrived unaccompanied for the new term. Because staff had not been briefed by CAMHS or Children's Social Care this left them and X with raised anxiety. Arrangements were though put in place to facilitate re-integration. Attendance rates later dropped in consequence of illness, CAMHS appointments and at times, X's choice.

*Comment: X's return should have been an element of a multi-agency plan.*

- 2.5.3 On 18.04.17 his case was discussed at a CAMHS team meeting where it was agreed that responsibility would be transferred from the 'Adolescent' to the 'LAC' Team. CAMHS7 provided a prescription for 20mg of Fluoxetine daily (a small dose). At an appointment later that day with CAMHS1, X reported fluctuating moods and feelings of loneliness. He spoke of returning to hospital where he felt safe and cared for. A 'safety plan' was agreed and further appointments made.
- 2.5.4 X was again discussed at a team meeting on 19.04.17 and a need for psychotherapy from the LAC team and a psychiatric review agreed. The operational manager CAMHS8 challenged the proposed transfer and determined that X's need for stability meant that his case should remain with the Adolescent Team (which it did).

*Comment: there was considerable debate amongst involved mental health professionals and the manager's intervention offers evidence of patient-centred oversight.*

- 2.5.5 In a planned phone contact on 21.04.17 X revealed suicidal ideation the night before. A safety plan was agreed. CAMHS made contact with the foster carers. They both reported an increase in level of concern about X's mental state since 19.04.17. They agreed to provide 1:1 supervision, seek to ensure that X was not left alone and to encourage him to attend A&E. In a later phone conversation X's preference to resume his in-patient experience was shared and CAMHS1 informed her/his manager of developments.
- 2.5.6 On 24.04.17 CAMHS1 contacted the carers and was told that X had enjoyed a trouble-free weekend though was now refusing to attend school. X was reportedly due to meet SW6 that day who was alerted by CAMHS1 to the raised risk (arising 3 days earlier) in relation to self-harm / suicide.
- 2.5.7 SW6 agreed to re-assess the risk and to take X to A&E if necessary. He was denied that opportunity because X went instead to his mother. 2 days later CAMHS1 and X held a further phone conversation, agreed a 'safety contract' and agreed that they would meet next day.
- 2.5.8 By 27.04.17 CAMHS7 noted the need for a psychiatric review. On the same day X attended an appointment with CAMHS1 accompanied by one of his foster carers. He reported a slight improvement in mood since returning to school though still displayed symptoms of moderate depression. Aside from an attempt to agree more structured time for X, an urgent medication review was scheduled for 02.05.17 and a follow-up with CAMHS1 on 05.05.17. CAMHS made a further call on 28.04.17 and informed X that his medication review had been postponed until the same day at their next session. At an agreed follow-up on 02.05.17 X reported a problem-free weekend.

## 2.6 2<sup>ND</sup> A&E PRESENTATION & ADMISSION

- 2.6.1 On 04.05.17 X's carers accompanied him to A&E at Queen Elizabeth Hospital where he was assessed by CAMHS10 (a duty clinician) and admitted to the paediatric ward. X referred to suicidal feeling the day before which he attributed to exam-related stress. He challenged the efficacy of medication and denied current suicidal ideation.
- 2.6.2 X returned to the care of his foster carers and was seen again next day by CAMHS1 and CAMHS9 when he evaluated his mood as being 4/10. No evidence of current helplessness, suicidal ideation or intention was observed. Letters outlining the results of the assessment were sent out to the foster carers and to SW6. The GP Practice was also appropriately informed of the events. The school liaised with the virtual school staff and continued their efforts to support X.

### Further violence at school

- 2.6.3 On 09.05.17 an aggressive outburst left the vice principal concerned for the safety of staff. Following her phone conversation with the carer, X went home. From this date, X was considered to be on 'study leave'. Liaison between school and local authority 'virtual school', enabled provision of a home tutor, collection of work, revision and arrangements for sitting relevant examinations.

### CPA review meeting: 12.05.17

- 2.6.4 At a meeting involving X and CAMHS1 and CAMHS9 he reported 'fleeting suicidal ideation'. A plan for weekly psychiatric input from CAMHS9 and seeing CAMHS1 the following week was agreed. His risk level was assessed as 'low'. A gradual transfer to the LAC Team was agreed and (though the features suggesting that possibility are not apparent) an 'Autistic Spectrum Disorder' (ASD) assessment was to be initiated. On 12.05.17 CAMHS1 contacted the school by email to inform staff of X's frustration at not being allowed to attend. CAMHS1 emphasised that education was both a personal priority and a protective factor for X. In response the school referred to 3 incidents of aggressive conduct and emphasised availability of a virtual portal and acceptance to sit scheduled exams.

*Comment: both professional perspectives were legitimate, one highlighting the priority to be awarded a vulnerable patient, and the other the balance a school necessarily has to strike between an individual pupil with additional needs and the needs / rights of the larger number to safety and undisturbed education.*

- 2.6.5 SW6 spoke with CAMHS1 on 16.05.17 and fed back the results of an (unrecorded by Children's Social Care) meeting at the school. X would receive extra support at home with his revision. SW6 reminded staff of a 3<sup>rd</sup> statutory review due on 06.06.17.

## UNPLANNED RETURN TO MATERNAL CARE / REPORTED MISSING / FURTHER SELF-HARM

2.6.6 On 19.05.17 CAMHS1 contacted the foster carers and was told that X had moved out of his placement and returned to his mother 3 days earlier. They reported that they had informed SW6 and did not raise concerns about X's safety. A further call by CAMHS1 to X's mother revealed her assertion that her son had [her description] 'run away' on 16.05.17 because, she claimed being at the carers' home was making him 'even more depressed'. Mother indicated that her son had ceased taking his medication. She also reported that on 17.05.17 X had called her and was about to jump into the Thames and that he had spent the night of 18<sup>th</sup> with his father. SW6 was on annual leave at this time though the duty service overseen by its team leader responded on 19.05.17 to an email alert from CAMHS.

*Comment: it remains unclear what the school knew or was told on this significant occasion.*

2.6.7 Police records provide confirmation that mother had reported X as 'missing', having received a text indicating he was going to kill himself. He returned very soon afterwards though refused to speak with police or ambulance officers, saying he was too tired.

2.6.8 X wished to remain overnight to be present for the birthday next day of his 4 year old step-sib. Police officers were reassured that mother had consulted Oxleas NHS Trust 24 hours Service (where she relayed the information that X had ceased taking his medication) and undertook to contact involved CAMHS staff and her son's GP next morning.

2.6.9 An incomplete record kept by an 'Adult Mental Health Service' duty nurse indicates only that mother did call that service on 17.05.17. The information captured was limited to ....'telephone from mother of X, informed me that....'[sic]

*Comment: records provided to this review do not provide confirmation that mother actually contacted her son's foster carers or GP.*

2.6.10 Later on 19.05.17 CAMHS1 spoke with X by phone. He reported that he was at his foster carers' home collecting belongings and planned to stay with his 'nan' [assumed to be the same person as the 'gran' previously referred to]. He complained of a lack of contact by his currently allocated social worker and acknowledged having had suicidal feelings on 16/17.05.17. A 'renewed 'safety plan' was agreed and CAMHS1 undertook to see him again on 23.05.17.

## Request for new foster carers & liaison between Children's Social Care & CAMHS

2.6.11 On 19.05.17 CAMHS1 emailed SW6, outlining events of the last few days and asserting it was of 'paramount importance X be provided with a new foster placement today'. The mental health practitioner also tried (un-successfully) to contact SW6. She called X's mother who reported that X was settled and out with his girlfriend. She denied any risks; a safety plan was agreed and emergency numbers provided.

*Comment: it remains uncertain whether the worker (who has since left and is therefore unable to provide clarification) was concerned that X's carers were a poor 'match' or that he needed not to be home with mother.*

2.6.12 On 22.05.17 SW6 indicated to CAMHS1 that he remained unaware of X 'running away' (as it had been described by mother) from his foster carers. He agreed to organise a professionals' meeting next day and reminded CAMHS of the scheduled review of 06.06.17.

*Comment: SW6 had been on annual leave which explains why 3 days had elapsed (without him being aware) since X had left his foster carers' home.*

2.6.13 No record of the proposed meeting has been provided though it is reported that there was a CAMHS team discussion on 22.05.17. Next day, X failed to attend an appointment with CAMHS1 and when contacted by phone denied risks. He agreed to call next day and meet CAMHS9 on 25.05.17. It was understood he was living with his 'gran' at this point.

2.6.14 At a meeting later on 23.05.17 between CAMHS1 and SW6, the latter reported that X was refusing to speak with him and had sought a new social worker and different placement. The social worker planned to refer X's mother to a source of family support said to be available from a Housing Association and said he would schedule a 'conference' (possibly a reference to the still outstanding professionals' meeting) as soon as possible. This account is derived from Oxleas Trust records because the meeting was not recorded by SW6.

2.6.15 X attended a scheduled appointment with CAMHS9 on 25.05.17. His medication was reviewed and left unchanged. X confirmed he was now living with his 'gran', but was lonely and struggling with negative thoughts and suicidal ideation. He reported he and his girlfriend had split up again and that he was not really leaving the house. X also discussed suicide as a means of revenge though denied any intention to kill himself. CAMHS9 contacted the social work manager to express a serious concern about X being at his 'gran's' home.

*Comment: agencies' records do not sufficiently distinguish between nan / gran or whether this individual was a maternal or paternal relative. A witness statement provided by X's girlfriend for the Inquest reports that the person with whom X was staying on this occasion, was his father's mother.*

2.6.16 Though not reflected in records accessed by the author of the Children's Social Care report for the serious case review panel, a response generated by the 'practitioner learning event' held in late January 2018 has reported that the psychiatrist's concern was about 'under-stimulation' and that a meeting (un-recorded at the time of X's death) had been convened next day (Friday 26.05.18).

## 2.7 3<sup>RD</sup> A&E PRESENTATION: ASSESSMENT OF RISK

### Alert by mother

2.7.1 X's mother alerted the CAMHS duty clinician (CAMHS11) on 26.05.17 to the fact that X had failed to sit an exam following an argument with his girlfriend and had stated that he 'no longer cared about the future'.

### Alert from school

2.7.2 On arrival at school on 26.05.17 X described an attempt to kill himself the night before whilst at his 'nan's'. Staff determined that he needed to be assessed at A&E and he was transported there. A senior staff member later joined X and those who had accompanied him. Discussions with X and with medical staff about arrangements for how he might attend a revision session on 30.05.17 (half-term) were held. A contemporaneous record by deputy safeguarding lead (LT2) described the practical arrangements and reported an (unsuccessful) attempt to contact SW6 and Children's Social Care duty line.

*Comment: this account offers clear evidence of the high level of care and commitment that existed amongst school staff.*

2.7.3 On presentation at A&E, X reported attempted self-strangulation and months of feeling suicidal, though denied ongoing suicidal thoughts. A full body map was completed in accordance with best practice. On this, as on the previous 2 presentations, the doctor completed the safeguarding questionnaire on the 'i-care system and initiated notification of School Nursing and GP. However the questions 'do you have any safeguarding concerns?' and 'has the child/young person presented with self-harm' were answered in the negative.

*Comment: though they had no adverse impact on clinical responses, these questions are misleading and require revision.*

2.7.4 X was referred on to the CAMHS duty clinician CAMHS12 who led and co-ordinated an assessment of what would be in X's best interests. Records of what is now known to have been a very comprehensive and thoughtful approach emerged during the course of the Inquest. CAMHS12 had accessed available records, consulted a consultant colleague CAMHS7 and involved SW6. Her account confirms that she considered all potential responses (X becoming an in-patient, sourcing a new foster placement, sectioning or, as emerged from completed discussions, a return home over the weekend). The assessment process was lengthy (an estimated 2 to 3 hours in total) and fully involved SW6, X and his mother.

- 2.7.5 In that assessment meeting X's mother was able to demonstrate insight into her son's emotional needs to feel loved and cared for. Her responses to X were warm, sensitive and appropriate. The decision to have X stay with his mother was agreed by all to be the environment that X would feel safest in and offer the greatest level of emotional support to him.
- 2.7.6 X was very open with the psychiatrist and his mother about how and when anxiety and thoughts of self-harm occurred. Observations of mother and of mother-son interactions provided reassurance that they were both committed to making the weekend focus exclusively on X's needs e.g. it was understood that his siblings would not be present. The conversations did not include any reference to the girlfriend with whom X seems to have had an on / off relationship.
- 2.7.7 Mother's responses were considered to be caring and measured; she appeared attuned to X's feelings and she was expressing a strong wish that X come back to her. A safety plan that included how X might indicate to his mother any thoughts of self-harm was agreed and an emergency phone number provided.
- 2.7.8 CAMHS12 was clear that she was seeking to maximise X's 'emotional containment' over the weekend. SW6 accepted the proposed weekend arrangements on an understanding of a meeting on 30.05.17 to discuss a further 'Placement Plan'.
- 2.7.9 An email was sent to CAMHS by SW6 informing them of the action taken by the school. The email also indicated that the social worker had informed his manager and supervising social worker who were going to contact the foster carers. SW6's team leader had advised of the need for a monitoring and safety plan to be put in place (in consultation with health professionals) in the event that X was not hospitalised.
- 2.7.10 SW6 sent an email to the school later that day to explain that X had been discharged from the hospital into his mother's care (this was not regarded as a formal discharge from s.20 accommodation). Interviews conducted for the purposes of completing the school report for this review reinforced the high level of concern felt by staff. They confirmed that whilst X said he did not want to be admitted or sectioned, their expectation was that he would be and (if consulted) they would have challenged his discharge to maternal care.

*Comment: had there previously been developed a clear multi-agency plan about which location would be in his best interests it, (even if unenforceable) might have reduced the level of X's conflicted loyalties and feelings. At her meeting with the author mother spoke positively of the approach CAMHS12 had adopted and had felt respected and involved.*

- 2.7.11 On 29.05.17 Police were called by attending London Ambulance Service (LAS) crew to a 'in cardiac arrest' thought to have jumped from a 9<sup>th</sup> floor of the block of flats. The male was later confirmed by his uncle (until then unknown to the local network) to be X.

## 3 EVALUATION OF SERVICES & FINDINGS

### 3.1 INTRODUCTION

- 3.1.1 Section 3.2 offers a response to the review's terms of reference reproduced in italics. Section 3.3 provides overall findings and section 4 provides recommended improvements for the specified services.
- 3.1.2 Reconciling the records of key agencies (Children's Social Care, school and mental health service providers) was rendered more difficult and time-consuming by:
- A notable insufficiency of SW6's case records within Children's Social Care material
  - Differing levels of anonymisation and attribution of pseudonyms / abbreviations / roles by agencies submitting reports

### 3.2 RESPONSE TO TERMS OF REFERENCE

#### *EVALUATION OF SUPPORT PRIOR TO X's ACCOMMODATION*

- *Frequency and focus of contact by agencies during 2016 ?*
  - *School-based (pastoral) & GP support ?*
  - *Recognition of and response to mental health needs prior to X's accommodation ?*
  - *Involvement of father and wider family ?*
- 3.2.1 Records of GP contacts so far identified indicate that after X was accommodated in September 2016 his foster carers (for unrecorded reason/s) brought and later (February 2017) registered him, as a patient with the Practice at which they had been registered for some time. X's parents were not consulted about that decision.
- 3.2.2 No GP records reflect any consultations related to mental health. Most are routine requests for information or notifications from Children's Social Care or health provider agencies.
- 3.2.3 Reports supplied indicate that after case closure by Children's Social Care in January 2016 the only contact by services contributing to this review were Adult Mental Health Services. Their potential value to mother (and indirectly her children) were never realised because she chose not to make use of them. The impact of mother's own difficulties on X inevitably continued after he was accommodated.



- 3.2.4 Before he was accommodated and after it, X received and clearly valued greatly, a high level of support from his school. Aside from the intrinsically valuable learning and associated sense of achievement school provided, the staff group represented a place of safety and consistency. Whilst this positive role was recognised by other agencies, it inevitably risked at times, a degree of inter-agency tension e.g. school articulating X's perceived grievances to Children's Social Care. The school was also obliged in responding to pressure from CAMHS to accept X back after incidents of violence, to balance the needs of the individual against the legitimate expectations of other pupils and staff.
- 3.2.5 As reported elsewhere, no evidence has been found to confirm an historical recognition within the school of the need for a CAMHS referral. The first record of that option was January 2017 in an exchange with the newly allocated SW6 and captured (only) by school. What was believed to be an agreed action was not (in spite of a later independently conducted s.26 review) progressed. The belated trigger for CAMHS involvement was X's self-harming in early March 2017.
- 3.2.6 X had during 2016 (as far as is known), been living predominantly with his mother. The absence of targeted service involvement renders it difficult to be certain about the impact on X. Case history would suggest the estranged parents were likely to have continued their chronically conflictual relationship with its inevitably damaging impact on all dependent children. The fact that mother called for assistance from X's father during her assault in September 2016 reinforces that supposition.
- 3.2.7 Neither of X's parents were consistently involved in the care planning evaluated below. This *might* have reflected their ambivalence or unreliability but in the author's view was primarily a weakness of the service provided. It is clear that there was untapped potential to explore and involve X's extended family. An approach such as a family group conference (FGC) could have identified relatives such as his uncle whose existence and interest remained unknown until X's death.

### **EVALUATION OF CARE PLANNING**

- *Decision to accommodate under s.20 Children Act 1989 ?*
  - *Clarity of 'Care Plan' ?*
  - *Choice & support of foster carers ?*
  - *'Placement Plan' ?*
  - *Independent monitoring & review ?*
- 3.2.8 As acknowledged in the report on Children's Social Care service delivery, its initial decision not to accept X's request to become 'looked after' in was insufficiently informed. The care system cannot always resolve chronic familial difficulties and one would not expect an immediate acceptance of the request. A considered appraisal of the known history (including sib.1's experiences and patterns of behaviour) coupled with consulting those such as the school who knew X's circumstances well, was desirable and likely to have justified (subject to parental agreement) acceptance of X's request.

- 3.2.9 The events that instead played out (X going missing and later speaking of contemplating self-harm) reinforce the author's opinion that the decision on 23.09.16 to offer substitute care was the right one.
- 3.2.10 The serious case review group has been informed that the initial 'Care Plan' was clear and had as its primary objective, return to the care of his father. Whilst that would be the starting position for the majority entering the care system, what was known about the chronic nature of parental difficulties, appears (with the advantage of hindsight) to suggest that the objective was a little optimistic.
- 3.2.11 Details of the process by which X's 'in-house' / Greenwich-approved foster carers were not included in the material submitted but it has become clear that the choice was about proximity (thus enabling fulfilment of X's wish for continuity of education). The issue of them being of Black African ethnicity and X and his family being White British appears to have been marginalised. It generated no reported difficulties though the author's meeting with X's mother suggested that there had been significant cultural differences (e.g. expectations of teenagers) that should have been debated and resolved.
- 3.2.12 X's tangible relief at becoming 'looked after' (notwithstanding later complaints about carer-imposed boundaries) and his positive relationship with the carers as well as their contribution to the professional network reinforce the contention that the couple represented an appropriate short-term placement.
- 3.2.13 Records do not explain *why* at his second formal review in January 2017 (at which neither parent was present) the plan to return to family was set aside in favour of 'permanency'; nor on what basis the carers were formally matched as appropriate for permanent care.

#### ***EVALUATION OF INTER-AGENCY COMMUNICATION & COLLABORATION***

- *Efficiency of information exchange inc. Merlins ?*
- *Effectiveness of joint or multi-agency working ?*
- *Management of 'missing' episodes ?*

- 3.2.14 To the very limited extent to which its officers were involved the MPS shared and were in turn provided with all relevant information. Omitting in a *Merlin* on 20.09.16, the update provided by the mental health nurse was an individual oversight and does not require a recommendation. On the other hand, officers did pass on X's fear of being beaten up by his older brother. A need to ensure that its Criminal Justice Liaison team member has the expertise to recognise individuals who do not satisfy the threshold for a referral to Adult Mental Health Services but may require a CAMHS referral, has been recognised by Oxleas Trust and is being actioned.

- 3.2.15 Insofar as there is a clear insufficiency of Children's Social Care records, it is difficult to evaluate the extent to which all relevant information was shared with appropriate other agencies. It is clear that the school worked hard to share and promote its views of need and risk. To a lesser extent, there was also some inadequacy in community CAMHS records which did not capture what interviews for this review revealed viz: that there had been a view that X's discharge from the Adolescent Unit was premature.
- 3.2.16 Though both mental health service providers (community and in-patient respectively) responded in a considered manner to the observed needs and discerned risks, there was some scope for more liaison and exchange of views with one another and Children's Social Care as well as with X's school where staff had developed over time, a solid and trusting rapport.
- 3.2.17 The 'missing' episode that triggered X's accommodation was handled well by MPS and (subsequently) Children's Social Care. An insufficiency of records and an absence of an agreed multi-agency plan render it uncertain about where / with whom X was either *supposed* to be or actually staying on any given day from December 2016 onwards.
- 3.2.18 The only other formal report (made to Police) of X as 'missing' was on 16.05.17, a fortnight before his death. On that occasion, officers responded to mother's alert that her son had texted her to indicate that he was heading toward the Thames with a view to killing himself. In the event, he returned home but then refused to speak with attending police officers, nor after the London Ambulance Service (LAS) was called, with its officers.
- 3.2.19 It is noteworthy that it was mostly X's mother who was alerted by X and who in turn alerted relevant agencies. That fact reinforces a sense of untapped potential for their future relationship.

## **MENTAL HEALTH**

- *Recognition of needs / medication*
- *Assessment of risks*
- *Community and in-patient responses (home leave etc)*
- *Management of self-harming*
- *Care Planning Approach*

3.2.20 To the extent that records provided offer an accurate account of potential or actual self-harm preceding X's death, the following emerge:

- Latterly, X's self-reported accounts of self-harming from the age of 11 (though these are not reflected in GP or any other contemporary records provided to this review)
- Comments made to the nurse whilst in custody in September 2016 (which conflict with father's interpretation of exiting via a window as a means of escape)
- A phone call reported by mother and linked to the above episode, in which X threatened self-harm and referred to suicidal thoughts
- A more substantive episode of attempted self-strangulation with a belt in March 2017
- Self-reported (to CAMHS) suicidal ideation on 21.04.17
- A foster carer-supported presentation to A&E on 04.05.17 when X reported feeling suicidal
- The report from his mother that X had called her on 17.05.17 and said he was about to jump into the Thames
- X's report at school on 26.05.17 that he had tried to kill himself the night before

3.2.21 In terms of risk assessment, the interface between A&E and mental health services generally worked well. On the first occasion though, there was a very unhelpful delay of 21 hours before a registered mental nurse could be sourced to support X's transfer to the paediatric ward.

3.2.22 The response to X's reported lowered mood state, including choice of medication at the Adolescent Unit, was unremarkable. Because X was staying for uncertain periods of time with various family members (an unhelpful continuation of his experience prior to entering care) it is not possible to be certain about compliance with prescribed medication.

3.2.23 There existed some scope for enhanced information sharing to better determine risk of aggression or self-harm e.g. sib.1's suicide attempt was unknown to CAMHS. Records do not confirm precisely what additional response and alerts were prompted by the heightened risk of self-harm noted on 21.04.17 and 25.05.17. Evidence that emerged at the Inquest does provide reassurance that considerable thought (informed by case history, clinical observations and an awareness of the alternatives) had gone into the assessment of need and risk at X's final A&E presentation.

### 3.3 FINDINGS & CONCLUSIONS

- 3.3.1 X's extensive experience of violent relationships, associated emotional abuse and an ongoing fear of assault by father or sib.1 seriously undermined his sense of self-worth and rendered him insufficiently resilient to cope with the demands of personal relationships.
- 3.3.2 The original hopes of both X and the local authority in early Autumn 2016 were that, away from the anxiety-provoking impact of his family's long-established behaviour patterns, he might be able to relax, relinquish his own episodic and impulsive use of violence, and exploit positively, his considerable academic abilities and positive career plans. X's *initial* response to his removal of the ongoing family tensions was (in his view and that of the professional network), very positive.
- 3.3.3 School and its staff represented a significant source of support for X and within the constraints that exist for an institution balancing the needs of the majority with the additional needs of a few (and which in addition, is available only during term times) it supported X well.
- 3.3.4 The potential value of the skill and commitment of X's foster carers and the scope for moving toward a form of independence from his birth parents was largely lost by a combination of family or X-driven conduct, underpinned by significant weaknesses in Children's Social Care's planning and monitoring of X's use of the care system.
- 3.3.5 Psychiatric services provided to X responded efficiently to his symptoms but could not in the time available, facilitate sufficient internal development to enable him to cope with an unchanged personal context following his discharge to the community.
- 3.3.6 By the time of his discharge from Bethlem Royal Hospital, records suggest that there was little more clarity and confidence (crucially in X's mind) about where he was to live and for how long, than when his father had agreed to the use of s.20 accommodation in 2016.
- 3.3.7 In consequence of the above context and in spite of the efforts of professionals, X's ability to cope with the challenge of a relationship and an argument with a girlfriend (whose significance had remained largely unknown to professionals) was compromised. Her witness statement offers a coherent and sensitive account of their difficulties.
- 3.3.8 In the light of previous episodes, the probability of future self-harm was clearly raised well above the average. However, no specific indicators were identifiable at the time arrangements for X's last weekend were accepted by the involved professionals, following lengthy and sensitive discussions with X and his caring mother (who still retained parental responsibility).
- 3.3.9 One cannot reasonably conclude that the fatal event itself was predictable or preventable by any specific action/s that should have been taken by involved professionals at the time.

## 4 RECOMMENDATIONS

### 4.1 INTRODUCTION

- 4.1.1 Some agencies have specified required improvements in their internal processes or individual practice and begun to introduce required changes. This report limits its recommendations to those of the most strategic significance, with the aim of strengthening the effectiveness of future service delivery in comparable circumstances.

#### **SAFEGUARDING CHILDREN BOARD**

- 4.1.2 The Board should use this case to consider collectively whether existing arrangements across the borough for a multi-agency approach are sufficient when:
- The circumstances of especially vulnerable young people are changing frequently
  - Professionals are seeking to formulate a response to a young person known to Children's Social Care and CAMHS who has been excluded from school for a fixed term

#### **CHILDREN'S SOCIAL CARE**

- 4.1.3 In the light of issues emerging from this case about recording, care planning (and notwithstanding reassurances that many improvements have been introduced before or during the course of this serious case review and are working well), senior managers should consider what further action may be required so as to optimise :
- 'Placement Plans' including arrangements for 'delegated authority'
  - Quality of initial health assessments (in particular ensuring adequate input information so as to facilitate an appreciation of mental as well as physical well-being)
  - Conduct of the s.26 review process (including monitoring of task completion and the right / responsibility to offer challenge)
  - Timeliness and completeness of social work case notes of contact with a looked after child and relevant agencies

- 4.1.4 Senior managers should also address and determine the extent to which there is a need for further action to ensure that formal assessments of need sufficiently:
- Recognise and giving due consideration to the likely impact on a child of extensive exposure to domestic abuse
  - Ensure that information generated about one family member and of relevance to another, is factored into assessment and records
  - (In particular when working with adolescents) capture the existence and explore the influence of, peers (girlfriends / boyfriends / when relevant gang associates etc
  - Recognise which responses have been previously tried and with what level of effectiveness
- 4.1.5 In the light of the significant proportion of older looked after children in s.20 accommodation and the challenges illustrated by this case of balancing care and control, senior managers should review the agency's policies and systems insofar they relate to 's.20 responses for adolescents'.

#### **OXLEAS NHS FOUNDATION TRUST (COMMUNITY CAMHS)**

- 4.1.6 Staff should ensure 'in-reach' (liaison / information exchange) during any period of in-patient assessment / treatment.
- 4.1.7 The existing 'escalation policy' should be re-circulated to relevant staff.
- 4.1.8 For a 'looked after' child / young person a clear and precise summary of circumstances and reasons for entering care should be maintained.

#### **SCHOOL**

- 4.1.9 The role and responsibilities of the 'designated safeguarding lead' should be made explicit within the school safeguarding policy.
- 4.1.10 Safeguarding training should be reviewed to ensure that all key safeguarding staff are aware of the threshold for a CAMHS referral and the existing safeguarding protocol, so that all staff understand how to, and are confident in initiating, a referral.
- 4.1.11 The school should clarify required procedures for a self-harming student if being transported to a hospital.
- 4.1.12 The safeguarding team should convene monthly minuted single agenda meeting with all key safeguarding staff to complement weekly briefings and informal information sharing.
- 4.1.13 Counselling should be made available to school staff in cases of unexpected child deaths.

## **LEWISHAM & GREENWICH NHS TRUST (QEH)**

- 4.1.14 The Emergency Department 'Child Protection Assessment Questionnaire' needs to be amended so as to make clear that self-harm or a suicide attempt *is* to be regarded as a safeguarding issue.
- 4.1.15 Emergency Department and Paediatric staff should be reminded of the 'Self-harm Flow Chart' and that completion of a body map is a requirement of the existing safeguarding policy.
- 4.1.16 All unwell children and those about whom there are safeguarding concerns admitted to the ward, should be reviewed by a Consultant Paediatrician.

### **GP PRACTICE**

- 4.1.17 GPs should include details of any adult accompanying a child / young person to a consultation in the child's record.
- 4.1.18 GPs should escalate safeguarding concerns if they do not receive a timely and reassuring response to a referral / notification made to another agency.



## 5 GLOSSARY: ABBREVIATIONS

Abbreviations	Meaning
A&E	Accident and Emergency Department
AMH	Adult Mental Health Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CJL	Criminal Justice Liaison Team
CPA	Care Planning Approach
IRO	Independent Reviewing Officer
LSCB	Local Safeguarding Children Board
MPS	Metropolitan Police Service
NPIE	National Panel of Independent Experts
QEH	Queen Elizabeth Hospital
QIS	Quality Improvement Service
SCR	Serious Case Review
SSW	Supervising Social Worker