

Merton Safeguarding Children Board



**Kevin
Harrington
Associates
Limited**

CHILD A

A SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

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1. INTRODUCTION

1.1 Child A, a 12 year old girl, was reported missing in August 2012. Her body was discovered a week later in the loft of her maternal grandmother's home. Her grandmother's partner entered a plea of guilty to her murder.

1.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Boards to undertake reviews of serious cases. The Regulation defines a serious case as one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either –

(i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.3 A number of local agencies were known to have had contact with Child A and members of her family. The circumstances of her death and subsequent enquiries suggested that the agencies might be able to learn lessons about the way they had worked, individually and collectively, with the family. This led to the decision by the Merton Safeguarding Children Board that there should be a Serious Case Review (SCR).

1.4 That SCR was conducted between September 2012 and April 2013. Details of the SCR process and those involved are attached in the appendices to this report.

1.5 Child A's mother met with the Chair of the SCR Panel and a female senior officer from the local authority. She did not feel that there were any problems in the family that the agencies involved in the Review could have helped with.

1.6 It is right to say that, before her death, no agency was aware of any evidence of concern for Child A's safety.

2. THE FACTS

2.1 Child A lived with her mother and her half-siblings¹. All family members are white British. This review has seen no evidence that Child A had contact with her father, Mr E, who no longer lives in London. Child A's health and development were normal. She is generally described as a bright, happy child with a warm personality.

2.2 There were persistent problems with Child A's school attendance, from an early age. This problem was not tackled during her time at junior school.

¹ It is not appropriate to disclose any information about Child A's half-siblings, but it is right to clarify that there are no safeguarding concerns for these children.

Despite her poor attendance her levels of achievement at school were good and she was a popular child.

2.3 The use of illegal drugs in Child A's family was known to a number of agencies. Her mother disclosed during pregnancy that she routinely used cannabis. Other family members were known to have criminal convictions for drug-related offences. When she was pregnant Child A's mother was offered assistance in addressing her use of drugs but did not take up this offer.

2.4 The issue of drug use in the family was discussed between health and social care services on a number of occasions but this did not lead to any further actions.

2.5 Merton Children's Social Care services received a number of referrals about Child A's family. These referrals arose from general concerns and there was no direct evidence of abuse or neglect, but the earlier referrals were not followed up thoroughly. These were missed opportunities to assess and try to engage with the family.

2.6 Merton Children's Social Care services did assess the family on one occasion, after they had come to police attention. Child A was not interviewed during this assessment but all relevant agencies, including Child A's school, were contacted and no concerns were expressed. Overall, Ms D was said to present as "loving and caring" and there was no evidence to indicate a need for continuing contact with social workers.

2.7 When Child A moved to secondary school her school attendance deteriorated further. The school started taking steps to address this but her mother did not respond to any communications. The school had reached the stage of taking legal action against Child A's mother when Child A's maternal grandmother intervened. She wrote to the school stating that she had made arrangements for Child A to stay with her and her partner – Mr F - in a neighbouring London borough. Some weeks later Child A was reported missing and subsequently found to have been murdered.

3. KEY LEARNING POINTS AND MISSED OPPORTUNITIES

3.1 The only firmly evidenced cause for direct concern for Child A was her poor school attendance. At her junior school it was not robustly addressed and there was an unsatisfactory lack of challenge in the school's approach. This is in keeping with some national findings about the management of non-attendance at junior schools.

3.2 We still do not have a clear understanding of why Child A was so frequently absent from school. Child A's mother avoided all attempts to explore and tackle this issue. No professional discussed the possible reasons for poor school attendance directly with her or with Child A. It may be that staff at the junior school were disarmed by Child A's engaging presentation and reasonable levels of achievement.

3.3 Child A's secondary school did seek to tackle the attendance problem but their approach was procedurally driven, rather than based on direct contact with the family. This reflects the national pressures on schools in relation to dealing with non-attendance.

3.4 There is substantial evidence that Child A lived in a situation where the use of illegal drugs was an everyday occurrence. This is likely to have affected her and the care she received throughout her life. It was not robustly challenged by health professionals in their contact with her family and there may have been an inappropriate tolerance by some professionals of the use of cannabis.

3.5 There were some weaknesses in the local authority's "out of hours" service's immediate response to Child A's disappearance, including a failure to notify a senior officer. These matters did not affect the overall course of events. By contrast the work subsequently carried out by local authority staff when normal working hours resumed was vigorous and thorough.

3.6 There was some confusion and miscommunication between police and the local authority about their respective responsibilities while Child A was missing. Police action was focussed on Child A's disappearance, while the local authority still had to reassure themselves that there were no grounds for concern for other children of the family. Local services were under pressure because of the degree of public concern and media attention, but it is in such circumstances that the requirement for services to work collaboratively becomes most important.

3.7 Although there are lessons to be learned and areas in which services can be improved, there was no information known to any agency which would suggest that Child A's life would end as it did, or indeed that she was at any risk of physical harm.

4. RECOMMENDATIONS FROM THIS OVERVIEW REPORT

4.1 Introduction

4.1.1 These recommendations arise from this Overview Report which reflects the views of the SCR Panel and the independent Overview Report author. They have been endorsed by the MSCB. They are in line with the Government's guidance² that *"Recommendations should usually be few in number, focused and specific, and capable of being implemented"*.

4.2. Recommendations to the Merton Safeguarding Children Board

4.2.1 The Board should, by dissemination of the key messages arising from this review, ensure that schools are reminded of the links between non-attendance at school and the safeguarding of children.

4.2.2 The Board should ensure that agencies provide guidance to inform and assist staff in responding to parental misuse of alcohol and illegal drugs. This should include support to staff in challenging parents who are complacent about the use of cannabis.

4.2.3 The Board should work with partner agencies, and the Child Death Overview Panel, to deliver a clear public message about the harmful medical and social effects of cannabis use, and its potential for damaging family life.

4.2.4 The Board should review and strengthen as necessary arrangements for recognising the enduring consequences of domestic abuse and providing assistance to families which may be affected by this,

4.2.5 The Board should promote an emphasis on ensuring that the "voice of the child" is heard across all partner agencies and that this is demonstrated in working practices and service developments.

4.2.6 The Board should ensure that there are clear arrangements for working with hostile or resistant families and that front line staff are appropriately supported in this work.

4.2.7 The Board should ask the Metropolitan Police Service to demonstrate that measures to improve compliance with the completion of MERLINS have been effective.

² "Working Together" (2010 Paragraph 8.40)

APPENDIX A: ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

During September 2012 arrangements were made to appoint the independent people who are required to contribute to the conduct of SCRs. Mr Keith Makin was appointed to lead the review and Mr Kevin Harrington was appointed to write the reports from the Review. Further details are at Appendix B.

The MSCB constituted a panel (the Panel) to manage and oversee the conduct of the review. The membership of the Panel is set out below.

Name / Designation	Organisation	Role
Mr Keith Makin	Independent	Independent Chair
Interim Head of Children's Social Care and Youth Inclusion	London Borough of Merton	Panel Member
Designated Doctor for Safeguarding Children	NHS Sutton & Merton	Panel Member
Designated Nurse for Safeguarding Children	NHS Sutton & Merton	Panel Member
Detective Chief Inspector	Metropolitan Police Child Abuse Team	Panel Member
Assistant Chief Officer	Merton & Sutton Probation Trust	Panel Member
Head of Safeguarding & Quality Assurance	London Borough of Croydon	Panel Member
Voluntary Organisation Representative	Merton Voluntary Services Council	Panel Member
Mr Kevin Harrington	Independent Overview Report author	In attendance

It was determined that the following agencies should contribute to the review. Those agencies with substantial and / or recent contact were required to submit full Individual Management Reviews (IMR) whereas agencies with less or less recent involvement should provide reports for background information. (In fact, when the reports were analysed, most of the agencies had little direct knowledge of Child A).

AGENCY	NATURE OF CONTRIBUTION
London Borough of Merton Children Schools and Family Directorate	Individual Management Review
Housing provider	Individual Management Review
London Borough of Croydon Children's Services	Individual Management Review
London Probation Trust	Individual Management Review
Metropolitan Police Service	Individual Management Review
Croydon Health Services NHS Trust	Individual Management Review
NHS Sutton and Merton	Individual Management Review
Epsom & St. Helier NHS Hospitals	Individual Management Review

Trust	
General Practitioners (Merton)	Individual Management Review
General Practitioners (Croydon)	Individual Management Review
London Borough of Merton Housing Services	Individual Management Review
London Ambulance Service	Information report
NHS Direct	Information report
Housing provider	Information report
HomeStart	Information report

Agencies were asked to consider all those matters detailed in the government's guidance, Working Together to Safeguard Children (2010), namely:

- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child's welfare?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made in the light of assessments?
- Were there any issues, in communication or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services. Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family and how was this explored and recorded?
Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case? Was there evidence of good practice?

Agencies were then asked specifically to consider issues which appeared to be particularly relevant in this case, namely:

- The history of the parents and extended adult group, with a focus on how that history may have affected the care provided to Child A and her half-siblings.
- Agency involvement with Child A from her birth to the date of discovery of her body.
- Whether information sharing between and within agencies was sufficiently robust
- Any gaps and or strengths in the investigations and interventions following Child A's disappearance
- Any significance and relevance to Child A's well being of her grandmother's employment (as a care worker).

APPENDIX B: Biographical details of Independent Chair and Overview Report Author

Independent Chair: Mr Keith Makin

Keith Makin has a social care background. He is a qualified social worker and has held management positions in social care services for over 30 years, including Director of Social Services, Director of a Government improvement agency and Chief Executive of an independent child care organisation. He has a degree in economics and post graduate qualifications in social administration and management. He is a Fellow of the Chartered Management Institute and a Fellow of the Royal Society of Arts.

Independent Author of Overview Report; Mr Kevin Harrington

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has a particular interest in Serious Case Reviews, in respect of children and vulnerable adults, and has worked on more than 35 such reviews. Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council. He has served as a magistrate in the criminal courts in East London for 15 years.