

Merton Safeguarding Children Board



**Kevin
Harrington
Associates
Limited**

CHILD A

A SERIOUS CASE REVIEW

Kevin Harrington JP, BA, MSc, CQSW

TABLE OF CONTENTS

TABLE OF CONTENTS	2
1. INTRODUCTION	4
2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW	5
3. METHODOLOGY USED TO DRAW UP THIS REPORT	7
4. CHRONOLOGY	8
4.1 Introduction.....	8
4.2 Child A's early years.....	8
4.3 2008.....	9
4.4 2009.....	10
4.5 2010.....	10
4.6 2011.....	12
4.7 2012.....	13
4.8 The death of Child A.....	14
5. THE FAMILY	15
5.1 Child A.....	15
5.2 Ms D.....	15
5.3 Child A's half-siblings.....	15
5.5 Mr E.....	16
5.6 Mr F.....	16
6. THE AGENCIES	16
6.1 Introduction.....	16
6.2 London Borough of Merton; Children, Schools and Family Directorate – Children's Social Care.....	16
6.3 London Borough of Merton; Children, Schools and Family Directorate – Education.....	19
6.4 Metropolitan Police Service.....	22
6.5 Croydon Health Services NHS Trust.....	23
6.6 NHS Sutton and Merton Community Services.....	24
6.7 Merton GP Services.....	25
6.8 Croydon GP Services.....	25
6.9 London Borough of Croydon Children's Social Care Services.....	26
6.10 London Probation Trust.....	26
6.11 The Housing Provider.....	27
6.12 Croydon Urgent Care Centre.....	27
6.13 Epsom & St. Helier NHS Hospitals Trust.....	28
6.14 London Ambulance Service NHS Trust.....	28
6.15 Other agencies.....	28
6.16 NHS Sutton and Merton - Health Overview Report.....	28
7. ISSUES IDENTIFIED IN THE TERMS OF REFERENCE FOR THIS REVIEW	29
7.1 The history of the parents and extended adult group, and any implications for the care of Child A and her half-siblings.....	29
7.2 Agency involvement with Child A from her birth to the date of discovery of her body.....	30
7.3 Whether information sharing between and within agencies was sufficiently robust.....	30
7.4 Strengths and / or weaknesses in the investigations and interventions following Child A's disappearance.....	31

7.5 The significance and relevance to Child A’s well being of her grandmother’s employment.....	33
8. ISSUES ARISING FROM AN OVERVIEW OF THE CASE	33
8.1 Substance Misuse.....	33
9. REVIEW PROCESS.....	34
10. CONCLUSIONS: KEY LEARNING POINTS AND MISSED OPPORTUNITIES	35
11. RECOMMENDATIONS MADE IN THE MANAGEMENT REVIEWS OF THE PARTICIPATING AGENCIES.....	37
11.1 Introduction	37
11.2 London Borough of Merton, Children, Schools and Family Directorate.....	37
11.3 Croydon Health Services NHS Trust	38
11.4 NHS SW London, Sutton and Merton: General Practitioners.....	38
11.5 NHS SW London, Croydon: General Practitioners	39
11.6 London Borough of Croydon, Children’s Social Care Services	39
11.7 London Probation Trust	39
11.8 Epsom & St. Helier NHS Hospitals Trust	39
11.9 NHS Sutton and Merton Community Services	40
11.10 NHS Sutton and Merton (Health Overview Report)	41
12. RECOMMENDATIONS FROM THIS OVERVIEW REPORT	42
12.1 Introduction	42
12.2 Recommendations to the Merton Safeguarding Children Board.....	42
APPENDIX A: Biographical details of Independent Chair and Overview Report Author	43
APPENDIX B: References	44

1. INTRODUCTION

1.1 Child A, a 12 year old girl, was reported missing from her maternal grandmother's house in August 2012. Her body was discovered a week later in the loft of her maternal grandmother's home. Her grandmother's partner eventually entered a plea of guilty to her murder and received a mandatory sentence of life imprisonment, with a requirement that he serve a minimum of thirty-eight years.

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 the subsequent enquiries suggested that the agencies might be able to learn lessons about the way they had worked, individually and collectively, with Child A and her family.

1.4 A meeting of the Merton Safeguarding Children Board (MSCB) Serious Case Review Sub Committee on 3rd September 2012 considered what was known about Child A, her family background and the circumstances of her death. The Committee recommended that there should be a Serious Case Review (SCR) in line with the Government's guidance, "Working Together to Safeguard Children 2010" (Working Together). The then Chair of that Board, Mr Tony Eccleston, formally confirmed this on the same day.

1.5 The details of the family composition, and the designation the individuals are given in this report, are set out below.

Relationship to subject	Designation in this report
Subject	Child A
Mother	Ms D
Father	Mr E
Mother's partner	Mr K
Half-sibling	Child B
Half-sibling	Child C
Maternal grandmother	Ms G
Ms G's Partner	Mr F

1.6 Ms D, Mr K and Mr E are all around thirty years old. Mr F is in his late thirties and Ms G in her mid-forties. The ages of the children are not disclosed. All family members are white British.

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

2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1 This section of this report summarises the formal Terms of Reference 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 produce this Overview Report, with an accompanying Executive Summary. Further details can be found at Appendix A.

2.2 The MSCB constituted a panel (the Panel) to manage and oversee the conduct of the review. Although Child A lived with her mother in the London Borough of Merton, her grandmother lived in the neighbouring London Borough of Croydon. It was therefore appropriate that agencies from both localities contributed to 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

2.3 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), in line with statutory guidance, 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 Community Services	Individual Management Review
Epsom & St. Helier NHS Hospitals Trust	Individual Management Review
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

2.4 Child A's death has also been considered by the Coroner – to establish cause of death - and by the police and Crown Prosecution Service, to consider whether a crime may have been committed. The Metropolitan Police Service representative on the SCR Panel acted as the link between this Review and coronial and criminal investigations. The final report from this Review will also be considered by the Merton Child Death Overview Panel.¹

2.5 The key issues for consideration in the review are set out below. Agencies were asked to consider all those matters detailed in Working Together, 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?

¹ The establishment of Child Death Overview Panels, reviewing the deaths of all children under 18 and reporting to the LSCB Chair, became a mandatory requirement in April 2008

- 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?

2.6 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, Child B and Child C.
- 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 on 3rd August 2012
- Any significance and relevance to Child A's well being of her grandmother's employment (as a care worker).

2.7 Agencies were further asked to review any involvement in relation to Child B and Child C from the dates of their birth until the discovery of Child A's body. This has been done and there are no matters relating to Child B or Child C which should be disclosed in this public document.

3. METHODOLOGY USED TO DRAW UP THIS REPORT

3.1 This Overview Report is based principally on the agency IMRs, background information submitted and subsequent Panel discussions and dialogue with IMR authors. Family involvement is discussed at section 7 below.

3.2 The report consists of

- A factual context and chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by of each agency, and of their IMR.
- Closer analysis of the specific issues identified in the Terms of Reference.
- An account of any further issues arising from an overview of the case.
- Conclusions and recommendations

3.3 The government has introduced arrangements for the publication² in full of Overview Reports from Serious Case Reviews, unless there are particular reasons why this would be inappropriate. Working to that requirement, it will still be appropriate that some confidential information is not disclosed³. This report is written in the anticipation that it will be published. Consequently the information it contains is limited in order to

- 1) take reasonable precautions to prevent the identification of the child concerned or other family members
- 2) protect the right to an appropriate degree of privacy of family members
- 3) avoid the possibility of heightening any risk of harm to other children.

4. CHRONOLOGY

4.1 Introduction

4.1.1 Each of the agencies involved in this review submitted a detailed chronology, in tabular form, of their involvement with the family in the period under review. Those submissions have been co-ordinated into an integrated tabular chronology. This document is some 230 pages in length. This section of this report summarises that chronology in an accessible way. It does not include every contact, or failed contact, and does not provide a detailed account of all the work carried out.

4.2 Child A's early years

4.2.1 When Child A was born her mother, Ms D, who was in her late teens, lived with Ms D's mother, Ms G. This review has seen no evidence that Child A had contact with her father, Mr E, who no longer lives in London.

4.2.2 After some early feeding problems Child A's health and development were normal. In her early years she and Ms D lived at various addresses, both in London and in the south-west of England. In 2002 Ms D referred herself on one occasion to Croydon CSC but full records of this have not been retained. It does not appear to have led to any continuing contact.

² See letter from the Parliamentary Under Secretary for State for Children & families dated 10th June 2010

³ This issue is helpfully explored and developed in Lord Carlile's review of the "Edlington case", a Serious Case Review conducted in Doncaster
[The Edlington case: A review by Lord Carlile of Berriew CBE QC : The Department for Education](#)

4.2.3 By the time Child A was three years old Ms D appears to have started her relationship with Mr K, with whom she was to have two children. Mr K was convicted of drugs offences for the first time in 2004. In 2005 Ms D moved in to the flat, in the London Borough of Merton, which was to be Child A's permanent home. Child A started school in 2005 and was found to be in good health at a school medical in January 2006.

4.3 2008

4.3.1 In March 2008, following the execution of a search warrant at her home address, Ms D & Mr K were both arrested in relation to drugs offences. Child A was present. Both Ms D and Mr K were said to be abusive to police. Police recorded that the home was untidy and dirty. Child A appeared pleasant and quiet, and did not seem alarmed by the events. She was taken to school by police officers, accompanied by her mother. Mr K was subsequently charged with drugs offences.

4.3.2 This incident was routinely notified to Merton CSC by way of a MERLIN⁴ report. The local authority decided that a social worker should liaise with Child A's school and any health professionals involved with the family, establish whether there were any concerns for any children of the family and visit the family. The outcome of these investigations should be reported back to a manager who would decide on the appropriate action.

4.3.3 A social work student therefore contacted the school to enquire whether there were any concerns for Child A. The student was told that someone would call back but there is no further recording by any agency in relation to this incident. It appears that a CSC manager then decided to close the case without further action

4.3.4 In April 2008 Mr K was charged with further drugs offences. He subsequently received a community punishment after pleading guilty to possession of drugs on two occasions. Mr K largely complied with the requirements of this order but was repeatedly recorded as having no motivation to cease or change his use of illegal drugs.

4.3.5 Child A was seen at hospital in June 2008, accompanied by Ms G, in relation to an injury to her foot. The hospital has recorded that they considered the possibility of any child protection issues, as they would do for all such presentations, but the matter was judged to be a straightforward minor injury.

4.3.6 In July 2008 Child A's end of year school report reflected reasonable levels of achievement – mostly B's and C's – but her attendance was only 78%.

⁴ MERLINS are the routine notifications sent to local authorities when police come into contact with children.

4.3.7 When Ms D commenced ante-natal care in respect of Child B the initial hospital recording notes that she said she used both cannabis and alcohol. The recording noted that Ms D was “referred”, in relation to her use of drugs and alcohol in pregnancy, but no further action appears to have followed from this.

4.4 2009

4.4.1 During January 2009 Ms D’s landlords were in touch with her on a number of occasions about rent arrears and failing to control dogs in communal areas. In response Ms D claimed to be in conflict with other tenants and to need dogs for her protection. There is evidence from the reports submitted to this review by the landlords that these matters persisted throughout the period of her tenancy (which has ceased following the death of Child A). These issues are not detailed further in this chronology.

4.4.2 At the end of the school year Child A’s attendance was 80.6%. She was said to be a “*lovely girl*”, described as ‘*methodical and well organised*’. Her achievement remained good, reported as “*mostly Bs*”. The report contained a note saying “*poor attendance raised*” but giving no further information.

4.4.3 Later that summer Child A was treated in hospital for a minor injury. This was caused by an accident and routine screening procedures for child protection concerns were properly followed, identifying no evidence to cause concern. Treatment was appropriately followed up and she was routinely discharged in due course.

4.4.4 During this year Mr K twice came to police attention in relation to possession of cannabis, which he did not deny. He was cautioned once and received a financial penalty on the second occasion.

4.5 2010

4.5.1 In March 2010 the Education Welfare Service (EWS) wrote to Ms D, noting that Child A’s attendance remained around 79% and requiring her in future to produce medical evidence for any absence from school caused by illness.

4.5.2 Later that year Ms D commenced ante-natal care for her third child. When first booking in she disclosed use of cannabis and was referred for assistance with this and for advice on smoking cessation, but declined these services. There are no further records of Ms D engaging with ante-natal services during this pregnancy.

4.5.3 At the end of the school year Child A’s attendance had remained around 83%, her achievement levels were still at the B / C level and she was again described as “*a joy to have in class*”.

4.5.4 In August 2010, on being released from prison, Mr F gave the prison authorities the address of Child A’s maternal grandmother, Ms G, as his home

address. He had completed a custodial sentence for possession of an offensive weapon (a machete). Mr F was compliant with the Probation Service throughout post-custodial contact. During that period he was registered under Multi Agency Public Protection Arrangements⁵ (MAPPA).

4.5.5 This is the first time in this account that there was clear evidence linking Mr F to Child A and her family. Agencies – particularly police and probation – had substantial knowledge of Mr F prior to that. He had many criminal convictions dating back nearly twenty years to when he was in his late teenage years. These included violent and drug-related offences, and he had served a number of custodial sentences. Information from police indicates that he has had a very brief relationship with Ms D.

4.5.6 Following the birth of Child C a midwife recorded that a referral, using the Common Assessment Framework⁶ (CAF), had been made to CSC because of Ms D's known substance misuse, and because *"Following discussion with a hospital social worker) it appears that client is known to social services as they possess information about her older children"*.

The referral also mentioned Ms D's lack of compliance with ante-natal care. Ms D was apparently made aware of the referral but refused to sign the form giving her consent to its being made.

4.5.7 The following day the midwives established that they had made a referral to the wrong local authority (Croydon when the family lived in Merton), and made the referral to Merton. There was a prompt response and a discussion with a social worker who asked that the midwives should see the family at home the next day, as was already planned, and that they should then call CSC to review the situation. CSC made a record that they would then conduct an Initial Assessment⁷.

4.5.8 A midwife did visit the following day and discussed her visit with a social worker. It appears they decided that there was in fact no basis for CSC to carry out an Initial Assessment. The midwife recorded that *"I had no real concerns re baby, bonded well, feeding well, they are not going to pursue ... Social Worker will contact (Ms D) to let her know"*.

⁵ Mr F was subject to MAPPA because he had been convicted of a violent offence which had attracted a custodial sentence of 12 months

⁶ The CAF was established by the former Department for Children, Schools and Families. It is described as

"a standardised approach to conducting assessments of children's additional needs and deciding how these should be met... The CAF promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development"

⁷ *The Initial Assessment is a brief assessment of each child referred to Children's Social Care Services where it is necessary to determine whether the child is in need, the nature of any services required, and whether a further, more detailed Core Assessment should be undertaken (paragraph 3.9 of the Framework for the Assessment of Children in Need and their Families (2000))*

A social worker subsequently left a telephone message for Ms D advising that they would not be following up and this was confirmed in writing to the midwives.

4.5.9 Child C had some medical / developmental problems requiring continuing treatment and oversight, and on one occasion was admitted to hospital. While he was being assessed and a history taken from Ms D, she again spoke of using cannabis.

4.6 2011

4.6.1 At a routine call by a health visitor in February 2011 Ms D spoke of various concerns, particularly her unsatisfactory housing situation. She agreed that the health visitor could make a referral to a Children's Centre which would be able to offer advice and support. The referral was made and an officer from the Early Years Service tried to contact Ms D but she did not respond and the service terminated their involvement.

4.6.2 Mr F's probation supervision ceased at the end of February. The formal assessment of risk - medium risk to public and staff and low risk to children - had remained unchanged throughout the period on licence.

4.6.3 In March Child A's school wrote to Ms D about unauthorised absence from school. The letter specified the unauthorised absences and reminded Ms D of the procedure that parents were asked to follow. Child A's school report in June was similar to those for previous years. She was congratulated for her achievement levels but again her attendance had been only around 80% with 26 unauthorised absences and 38 authorised absences. By the end of the year in July attendance had risen slightly, to 84%. All reports of achievement were at grades A or B, with behaviour and attitude both being graded A.

4.6.4 With the assistance of the health visiting service which conducted a CAF assessment, an application was made for funding for a nursery placement for Child B. In the information supplied by Ms D to inform the application she referred, apparently for the first time, to having experienced domestic violence in childhood, and again admitted regular use of cannabis. The form stated that Ms D did not like to go to Children's Centres or parks because of *"anxieties about not being accepted by other parents"*.

On this occasion Ms D did agree to sign the CAF. In due course a nursery place was arranged, to start in September.

4.6.5 On 7/8/11 Child A was seen at a Minor Injuries Unit accompanied by her maternal grandmother. She was said to have been staying with Ms G and had developed a rash. This was diagnosed and treated as a viral rash. Routine checks were carried out and confirmed that there were no known child protection concerns.

4.6.6 Later that month Ms D and Mr K came to the attention of police in East Sussex. They were arguing in the street in the presence of the three children. Police intervened and Mr K was arrested for being drunk and disorderly. This

incident was notified routinely to the local authority for the area in which the children lived, Merton. A decision was taken that there should be an Initial Assessment and a social worker visited the home.

4.6.7 Mr K was at the address – though he said that he did not live there – looking after Child C. The other family members were said to be out together. Mr K said that the incident was a disagreement which had got out of hand. The social worker made a further unsuccessful visit to the home and then did succeed in seeing Ms D at home, accompanied by Mr K and the younger children. Child A was said to be unwell and was not seen.

4.6.8 A full Initial Assessment was undertaken. All other relevant agencies (including Child A's school) were contacted and no concerns were expressed. Ms D reported that she had no concerns for Child A who was a well behaved child. Ms D signed a written notification that she understood the potentially negative impact on children of seeing their parents behaving as they had done. Overall, Ms D was said to present as loving and caring. The social worker suggested that there be a period of monitoring by the Vulnerable Children's Team.

4.6.9 Child A had now transferred from junior school. A school report in October noted that her attendance level was 67%. However, when the situation was reviewed by the Vulnerable Children's Team in November it was decided that there was no need for continuing contact with a social worker and that school / nursery should monitor the children's welfare, referring back to CSC as necessary. Because of an administrative error this request was not passed to the school.

4.6.10 Around the same time housing officers visited the home on a number of occasions. They saw Mr F there, once on his own and once in the company of Ms D, who introduced him as her father.

4.6.11 Towards the end of November someone contacted Child A's school and advised that Mr F should be added to the list of people who could be contacted about her. This was not checked with Child A's mother and it is not clear if family members were aware of this.

4.7 2012

4.7.1 In February Mr K was charged with further drugs offences (possession of cannabis and cocaine) and was sentenced to a programme of Community Payback (previously known as Community Service and Community Punishment).

4.7.2 Child A's school attendance was formally reviewed by her school and Education Welfare Service (EWS) staff in February. This meeting, which also considered the situation of 46 other children, noted that there had been some improvement. However by March her attendance had fallen to 59% and Ms D was asked to come to a meeting at the school to discuss this. This was the first stage of the formal school absence procedure. She did not attend.

4.7.3 In April the school asked the EWS to follow up with the family – the second stage of the procedure. The EWS issued a “Penalty Notice Warning” and again asked Ms D to attend a meeting to discuss the situation – the third stage of the procedure. Again she did not attend. The EWS was to arrange a further informal meeting but had not done so before the next formal review in school in July. This review described Ms D as “hard to engage” but the EWS was asked to try again. Around this time the family also failed to attend a number of appointments and meetings about the other children, with health visiting and nursery staff.

4.7.4 In mid July a Financial Penalty notice was issued to Ms D because of Child A’s non-attendance. In fact this Notice was not correctly served, because of an error in the documentation, and therefore was not legally enforceable. However, apparently in response to this, Ms G contacted the school. She advised that henceforth Child A would be living with her, asked that her tutor put her on daily report and raised the issue of entitlement to free school meals.

4.7.5 Later that month Child A was seen with her mother at the Urgent Care Centre (UCC) at Croydon University Hospital. Child A had bruises and abrasions after an accident with a cyclist travelling at speed. She was triaged and her injuries were found to be minor. No analgesia was necessary. There were long waiting times and they did not stay.

4.7.6 At the end of July the Health Visitor made an opportunistic visit to the family, after they had failed a number of routine appointments for various checks and immunisations, but Ms D would not allow her into the home.

4.8 The death of Child A

4.8.1 On 3/8/12, a Friday, Child A was reported missing by her mother. It was said that she had last been seen leaving Ms G’s home at around midday. Police enquiries were initiated. The out of hours social work service was notified.

4.8.2 On Monday 6/8/12 it was clarified that Child A’s family home was in Merton, not Croydon as had originally been thought. Merton CSC initiated a range of enquiries with other local authority services and provided police with background information.

4.8.3 Merton CSC also sought to assess the situation of Child B and Child C. Police were made aware of the Local Authority’s duty to investigate and assess any possible safeguarding issues in relation to these children and in due course it was established that the children were staying with family friends. A joint visit was made by a police officer and a social work manager, who were able to satisfy themselves that the children were well and being well cared for. Ms D was also seen during this visit.

4.8.4 Later that day a body was found and recovered from the loft at Ms G's house. This was found to be the body of Child A. Mr F and Ms G were both arrested on suspicion of murder. A neighbour was also arrested on suspicion of assisting an offender. Ms G and the neighbour were bailed and Mr F was remanded in custody. Subsequently it was decided that there should be no charges preferred against Ms G. The neighbour was charged with wasting police time.

4.8.5 A few days later it came to light that Ms G was employed as a care worker in a private sector residential home for adults with learning disabilities, in the London Borough of Sutton. She was suspended from work. Enquiries were made and it was confirmed that Mr F and Child A had been seen at the home on a number of occasions. On one occasion Mr F was believed to have been drunk. There had also been concerns about Ms G's performance at work, including disciplinary action for bullying a resident. Following discussions the owners of the home made changes to staffing and management arrangements and it was agreed that there was no evidence of continuing concerns for the safety of residents.

4.8.6 Mr F eventually pleaded guilty to the murder of Child A.

5. THE FAMILY

5.1 Child A

5.1.1 The only agencies to have any substantial contact with Child A were her schools and particularly her junior school. The reports submitted from that school give a consistent picture of a pleasant, healthy child with the ability to achieve. As an intelligent child she will have been aware of the issues arising from her poor school attendance. She will have increasingly understood the ways in which misuse of drugs and alcohol were affecting her life.

5.2 Ms D

5.2.1 Ms D explicitly stated, at the early stages of the review, that she did not wish to contribute to this process. A further attempt to engage her was made later but no response was received. Then, at a late stage, she did ask to be involved, and met with the SCR Panel Chair and a female senior officer from the local authority.

5.2.2 At this meeting Ms D clarified some information about the family history. She did not feel that there were any problems in the family that the agencies involved in the Review could have helped with. The SCR Panel Chair was able to explain the process and outcomes of the review.

5.3 Child A's half-siblings

5.3.1 It is not appropriate to disclose any information about these children, in this public report other than to be clear that there are no child protection concerns for them.

5.4 Ms G

5.4.1 It was decided to await clarification of whether there would be any criminal charges against Ms G before contacting her. When it was decided that there would be no criminal charge she was contacted and invited to contribute to this review. No response was received from her.

5.5 Mr E

5.5.1 Mr E did not respond to an offer to meet him to discuss the situation. As he was believed to have played no part in his daughter's life since her birth, it seems unlikely that he would be able to contribute to this process and no further action has been taken.

5.6 Mr F

5.6.1 No contact was initially made with Mr F. This was reviewed when the criminal matters were concluded and the SCR Panel agreed that there was no indication that the learning from the review for the agencies would be enhanced by making any contact with him.

6. THE AGENCIES

6.1 Introduction

6.1.1 Each of the agencies contributing to this review has carried out an internal review (IMR), detailing and analysing their involvement with the family. This section of this report confirms the nature of that involvement and comments on the analysis contained in the IMR.

6.2 London Borough of Merton; Children, Schools and Family Directorate – Children's Social Care

6.2.1 This IMR addresses both the contact Child A had with children's social care services (CSC) and considers issues relating to her education. In Merton education and children's social care services are part of an integrated service to children and families.

6.2.2 The first contact with CSC was in 2008, when Child A was seven years old. Police raided the family home in relation to suspected drugs offences. This was routinely notified to CSC by way of a Merlin⁸ report, which referred to

- possession of Class A drugs
- a very abusive response to police from Ms D and Mr K, in the presence of Child A
- Child A appearing unaffected by these unpleasant events
- poor conditions in the home.

⁸ Merlins are the Metropolitan Police Service's notifications of children / young people coming to their attention

A CSC manager decided that checks should be made with partner agencies, to determine whether any other causes for concern had been noted, and asked a student social worker to carry out these checks.

6.2.3 The student made one call to the school and was told that a return call would be made but it does not appear that this was done. There is then no subsequent recording in relation to this incident, other than a “No Further Action” decision by a manager. As it happened some years ago, and key staff have left, it has not been possible fully to establish the reasons for this. However it is clearly a matter of concern, both as an administrative weakness and as a professional failing. The IMR notes that *“a decision to close the case without any further information to support such a decision and with no reference to a more senior manager. ... was a clear breach of guidance as set out in the London Child Protection Procedures and Merton’s Child and Young Person Wellbeing Model”*.

6.2.4 The IMR provides a detailed account of staffing and management arrangements in CSC at that time. It is clear that it was a very busy office and that there were tensions and sometimes a lack of good communication between staff and the manager who decided that the involvement of CSC should be terminated. Consequently staff – if they were not in agreement - would probably not have felt in a position to challenge the manager’s decision.

6.2.5 The IMR judges that the information passed to CSC was sufficient to warrant an investigation under section 47, Children Act, 1989 – a child protection enquiry. I do not think that threshold had necessarily been reached on the basis of the police information alone. However there was sufficient cause for concern in the content of the police notification to indicate that an Initial Assessment⁹ should have been carried out. If, as part of that assessment, contact had been made successfully with the school and followed up appropriately, the agencies would have been able to start to put together a picture of the broader problems in Child A’s life. That might have led to some continuing intervention.

6.2.6 In 2010 a second referral was made to CSC. The referral was from health services and arose from contact principally in relation to one of Child A’s half-siblings. Ms D had also spoken of her use of cannabis. A CSC social worker recommended that an Initial Assessment should be carried out but a manager, after checks with only one agency, did not accept that recommendation and terminated CSC involvement.

6.2.7 This was a premature decision. No checks were made with Child A’s school. Issues of substance misuse were not given sufficient weight. The IMR comments that *“this decision was that it was solely based upon the (sibling)... and no consideration was then given to a broader assessment of the family”*.

⁹ A brief assessment of a child referred to Children’s Social Care Services where it is necessary to determine whether the child is “In Need”, the nature of any services required, and whether a more detailed Core Assessment should be carried out.

The manager did not think about the family as a whole but based her decision on partial information about the half-sibling. It is disappointing to see this evidence of a narrow perspective particularly at a time when the “Think Family” initiative¹⁰ was being actively promoted by government. The IMR provides information about the particular circumstances of key staff involved which may explain the inconsistency and lack of thoroughness evidenced.

6.2.8 In the summer of 2011 Child A and the family were again brought to the notice of CSC, again by way of a police notification. Police in a town on the south coast had attended a public altercation between Ms D and Mr K, in the presence of the children, following which Mr K was arrested for being drunk and disorderly. This was routinely notified to children’s services in Sussex, from where it was passed on to Merton CSC. Again there was a decision to carry out an Initial Assessment.

6.2.9 On this occasion the assessment was completed, and is generally thorough except that the assessing social worker was not able to include a sufficient focus on Child A. Although the social worker visited the family on a number of occasions Child A was always said to be somewhere else. The social worker also tried to see Child A at school. She had just moved to her secondary school and was absent because of illness (which was medically confirmed). When checks were made with that school they did not know about her long history of poor school attendance and the social worker was consequently also not made aware of it.

6.2.10 There was insufficient evidence of cause for concern to justify any continuing direct involvement from CSC and the assessment was signed off as completed. Child A was never seen by the social worker, or indeed by any social worker. There is no indication that this was a consequence of deliberate attempts by the family to prevent contact. Equally there is no indication that seeing Child A would have made any difference to the subsequent events. As the IMR comments

“It is debatable what Child A may have said in any interview with the social worker but not seeing her was...an opportunity missed”.

6.2.11 Although the assessment was concluded staff felt sufficient concern that some monitoring arrangements were put in place, by way of a referral to the council’s Vulnerable Children Team¹¹ (VCT). However, the referral did not clearly explain what monitoring was required. The IMR notes,

¹⁰ A government initiative which aimed to improve the identification and support of parents or carers experiencing problems and to co-ordinate the support provided by different agencies to each family, especially those experiencing significant problems.

¹¹ The Vulnerable Children Team (VCT) is a school-based social work service which undertakes enhanced family assessments of school aged children (5 - 16yrs) to avoid escalation into statutory services or, as was the case here, as part of ‘step down’ arrangements from statutory services.

“the reason for monitoring was not explicit in relation to any of the children / parents either in the detail of what was to be checked, nor the required timescale”.

6.2.12 This lack of clarity was then compounded by administrative error within the VCT:

“(the family) name was unfortunately missed from the agenda of routine network meetings and there is no record of any discussion and decision taking place”.

The VCT had intended to ask Child A’s school to monitor her but failed to do so.

6.2.13 A service like the VCT offers an important support to the delivery of “statutory” children’s services, but its purpose and processes need to be equally clear and reliable. The IMR, which is otherwise extremely thorough in identifying areas of concern and drawing up recommendations to address them, does not evaluate the reasons for this family slipping through these arrangements for “low level” inter-agency monitoring.

6.2.14. The family should have been assessed in 2008 and 2010. This would have led to a better informed assessment in 2011. However following this CSC had no contact with the family until Child A was reported missing. The subsequent events are discussed below

6.3 London Borough of Merton; Children, Schools and Family Directorate – Education

6.3.1 The key principles which underpin the responsibilities of schools and the local authority in respect of school attendance are that:

- regular and punctual attendance at school is key to the academic and social development that will improve the life chances of children and young people;
- children and young people who attend school regularly and punctually are less likely to be at risk, both in terms of engaging in anti-social behaviour and in terms of their own health, safety and welfare;
- parents and carers have a duty to ensure that their children attend school regularly and punctually in order to get the most benefit from their schooling;

Poor school attendance is the only explicitly evidenced cause for concern for Child A. It featured from a very early point in her school career and was never adequately explored or addressed.

6.3.2 Non-attendance was already evidenced in Year 3 when the incident occurred which culminated in Child A being brought to school by police following the drug-related search of her home. The IMR is concerned that school staff did not proactively liaise with CSC after this event. This judgment may be over-informed by hindsight. There was no evidence of harm to Child A. There may have been a reason for this police involvement with the family which did not give cause for concern. Although there was already evidence of non-school attendance, this was very early in the child’s school career. I

would not necessarily expect the school proactively to have contacted CSC at this time.

6.3.3 In any event CSC had been notified routinely by police. The school's poor response when CSC raised the matter with them is of more concern. This appears to be an individual error – a member of staff said that they would make enquiries and call back but did not do so. Then, because CSC had terminated their involvement before the enquiries were completed, this was not picked up by them. The weaknesses in both organisations were at a level – team manager and deputy headteacher – at which you would not expect the need for close supervision of day to day practice. This was a missed opportunity for early exchange of information.

6.3.4 Having said that, even if the two agencies had communicated fully, the end result is likely to have been that the school would be asked and would agree to monitor the situation. Had they done so, the only evidence for continuing concern would be Child A's attendance. Otherwise she was described (at the time) as

“a child who had real potential and a really positive relationship with staff and fellow pupils”.

6.3.5 However the issue of attendance was serious, particularly in starting at such a young age, and persistent. The IMR sets out the scale of the problem: *“In the 4 years she attended (junior school) she was present less than 80% of the time for 11 of the available 40 months. Applying the more recent standards of 85% attendance she only achieved this for 25 of the 40 months total. She only achieved 100% attendance for 2 out of 40 months. In years 4, 5 and 6 her pattern of attendance started at a relatively high level early in the school year and started to deteriorate through the second and third terms... the entire pattern throughout Year 3 never met the 80% threshold and the pattern of absence at least 1 day per week was not picked up either by the school or EWS”.*

6.3.6 The legal context to the issue of responding to non-attendance at school is set out in the provisions of the Anti Social Behaviour Act 2003 and the Education Act 1996 (s444). In 2011/12, when Child A transferred to secondary school, the Persistent Absence Threshold for unauthorised absence in any half-term was raised from 80% to 85% or more – this is the level which will trigger action by the school and/or local authority.

6.3.7 It is not clear whether there was any particular pattern to the absences – whether, for example, they mostly occurred immediately before or after weekends. The IMR also does not indicate if there was an associated problem of lateness. Despite having attendance hovering around the 80% mark throughout her time at junior school, the only action taken was that in March 2010 Ms D was told that any subsequent absence from school as a result of illness had to be supported by medical confirmation. There is no evidence that Ms D complied with this requirement, nor that it was enforced.

6.3.8 There is a suggestion that the school was tolerant of Child A's absence because they thought she was assisting her mother with the care of her half-siblings. This would seem to me to be an aggravating feature of the absence rather than an acceptable explanation. In any case there was a marked attendance problem before the siblings were born.

6.3.9 At the time of the change in the Persistent Absence Threshold the Department for Education¹² noted that
"In secondary schools there has been consistent progress made to improve pupils' attendance ...However, in primary schools the picture is not so positive..... Primary schools seem to be more reluctant to challenge poor attendance than secondary schools....Evidence shows that pupils who are persistently absent in secondary schools have had poor attendance levels in primary school".

6.3.10. There does appear to have been a lack of challenge from this school and the IMR is ambiguous in its response to this, pinpointing the evidence of cause for concern but then noting that
"Since (the appointment of the current head) the school overall, and Child A's attendance in particular, showed trends of continued improvement".
As stated above attendance never reached 85% for any academic year and should have been challenged. The lack of challenge needs to be understood in the context of the school's response to non attendance by other pupils. The possibility should be explored that the reasons for the lack of challenge are to be found in the school being disarmed by the child's engaging presentation and reasonably good achievement.

6.3.11 Child A's poor attendance continued at secondary school and predictably deteriorated further. It had not been flagged up to her new school by her junior school as a cause for concern. It was identified by the new school at a relatively early stage but the response was slow and process-driven. There was no attempt to liaise with any other agencies to explore whether there might be other problems in the family. The EWS did not check whether the family were known to CSC, when they could easily have done so. Attempts to engage Ms D in discussion about the situation were not vigorous. The point of legal action was reached but that legal action then failed because of administrative error.

6.3.12 There was a missed opportunity for the EWS to try again to become involved, to support the arrangement by which Child A went to live with her grandmother. Despite the tragic outcome to this move it was the first evidence suggesting that the family accepted that non school attendance was a problem. However the fact that there had been discussions with Ms G appears to have been known only to the person who had those discussions, a form tutor. It was not shared with the EWS or Head of Year. It is not clear whether any written record was kept. As the IMR comments
"it showed yet again how the work of one part of an agency could operate without the knowledge of another".

¹² Department for Education Press Release 12th July 2011

6.3.13. The IMR puts the situation in the context of the overall pressure of work on the Education Welfare Service –

“the changing trigger criteria for Persistent Absence action meant that the referrals to the EWS had tripled from over 300 to more than 900 per year”.

Nonetheless at the end of her first year of secondary education there had been

- no exploration of the causes of the problem of non-school attendance which had been manifest for several years
- no action involving the family to assess and address the problem

6.3.14 The London Borough of Merton has issued revised guidance for schools on non-attendance while this review has been underway.

6.4 Metropolitan Police Service

6.4.1 Many of the adults in Child A’s life have come to police attention. The one with the most significant contact before Child A was born was Mr F. He had an adult criminal record dating back to his late teenage years including offences of violence, dishonesty and drug use. That record of criminal activity continued in the period under detailed review when he has again been found guilty of offences of dishonesty, violence, including racially aggravated assault, and the possession and supply of Class A drugs. He has served a number of custodial sentences.

6.4.2 From police records it is known that the use of illegal drugs features significantly in the extended family history. Child A was present in 2004, with her mother and maternal grandmother, during a house search in which drugs were found. There were two house searches at Child A’s home in March and April 2008 which led to the conviction of Mr K for drugs offences. Child A was present during one of these searches. Mr K was again convicted of drugs offences in 2008 and 2012.

6.4.3 The police IMR notes that on a number of these occasions Merlin reports were not made and passed to the local authority’s children’s services, which should be done whenever a child or young person comes to police attention. The report also notes that on the one occasion when such a report was made it did not include information about weapons found at the home. This knowledge would have been important for any agency which might be visiting the family home.

6.4.4 Non-compliance with Merlin arrangements had become a significant problem for the MPS. In many Serious Case Reviews that problem has been identified in the analysis of police performance. The IMR sets out details of a substantial package of measures to promote compliance with Merlin requirements and to improve monitoring of compliance. The Board sought further reassurance from the MPS that these measures were effective and there is consequently a recommendation from this report.

6.4.5 Despite relatively extensive involvement with adult members of the family, police had little contact with Child A and have provided no information to evidence poor direct care of any of the children. Concerns do arise from the substantial evidence of drug use across the family, and from Child A's apparent familiarity with misuse of drugs and its consequences. The report describes how, during the police raid in 2008, officers found Child A to be *"very pleasant, quiet and not shocked by (the constantly abusive behaviour of Ms D and Mr K), which led the officer to conclude that this behaviour was an everyday occurrence"*.

6.5 Croydon Health Services NHS Trust

6.5.1 This Trust was formed on 1st August 2010. It includes a large number of community and hospital based health services in the Croydon area which, in previous configurations and organisational arrangements, had contact with Child A and family members. The most significant of these, for the purposes of this review, are:

- Maternity services in respect of Child A and her siblings
- The health visiting service provided in respect of Child A
- Accident and Emergency Services to Child A and other family members

6.5.2 No matters arise from the provision of services when Child A was born and followed up. Subsequently Ms D disclosed to ante-natal services that she used alcohol and smoked cannabis throughout the pregnancy. The use of cannabis, alcohol and tobacco was discussed with her by a midwife in 2008 but no further action was taken. As the IMR comments *"The antenatal midwife identified cannabis use, smoking and alcohol use in pregnancy but there is no evidence that the amount and frequency of this use was asked, or how this may have altered Ms D's perception and mood and consequently her parenting capacity"*.

6.5.3 Child A was not identified as a child requiring a targeted school nursing service at her secondary school. There was minimum contact between school nursing and the child, which, given the information available to the team, was appropriate. It may have been helpful that the school nurses were advised of the problem of non-attendance at school.

6.5.4 During her next pregnancy Ms D was asked if she wished to be referred to services for assistance with her use of drugs and alcohol. She declined and no further action was taken ante-natally. Ms D's use of ante-natal services during this pregnancy was minimal, with only two appointments attended.

6.5.5 At birth there were some concerns about the baby's presentation and development and fears that these may have been linked to use of cannabis and poor compliance with ante-natal care. This led midwives to make a referral to CSC (discussed in section 6.2 above). The community midwife recorded that she had *"no real concerns regarding the baby, bonded well, and feeding well"*.

It was on this basis that CSC took the decision that there should be no further action. This IMR also notes that the midwives did not actively hand this information over to health visitors.

6.5.6 This IMR has been unable to comment fully on health visiting services to the family in respect of Child A. It is reported that *“Written Health Visiting records have not been located; at this time the community records management systems lacked local guidance”*. Consequently there is limited information available about Child A’s health and development in her early years.

6.5.7 Ms D had 3 attendances (two at Accident & Emergency, one at a minor injuries unit) where she had sustained injuries as a result of outbursts of anger. It is known that she was referred to a specialist service about anger management. The IMR comments *“Ms D presented in A&E with self-harm injuries related to anger management issues. This may impact on her parenting capacity. There appears to have been a lack of professional curiosity by staff to enquire if she was a parent or carer (or) ...about what makes her angry”*.

6.5.8 Overall health professionals from this agency offered little challenge to Ms D’s explicit acknowledgment of use of alcohol and illegal drugs.

6.6 NHS Sutton and Merton Community Services

6.6.1 This agency was responsible for school nursing services to the junior school which Child A attended. There was only one contact with the school nurses, when Child A was routinely screened on starting at the school. The screening consisted of a health questionnaire for parental completion, including a consent form signed for the school nurse to see the child in school. Routine height and weight screening were undertaken. Children were only offered a full health assessment if health concerns were identified by either the parents or school. The health questionnaire and consent form are not filed in the paper records so it is likely that they were not completed by Ms D. A Community Nursery Nurse documented that she had obtained verbal consent from Ms D to see Child A. Child A’s height and weight were between the 50th and 75th centile. No other health concerns were identified and no further referrals were received. Consequently Child A was not seen by the school nurse service again. The IMR notes that *“it is unusual for parents not to return child health questionnaires and parental consent forms (but) this would not have initiated further school nurse involvement as no health needs were identified in initial screening”*.

6.6.2 This IMR otherwise addresses issues relating to Child A’s half-siblings and reports that *“There was extensive health visiting contact between Miss D, Child B and Child C, however there was little analysis by the health visitor of the information available to robustly assess risk within the family”*. The extensive contact was principally a consequence of one of the children having a number of health and development problems. During this contact the

Health Visitor noted a number of social problems and difficulties in the family, which would have affected Child A. There are references to poor conditions in the home. Ms D had disclosed long-standing use of cannabis and on one visit health visiting staff could smell cannabis. The IMR notes that staff failed to challenge Ms D about this or follow it up in any way. In fact a health visitor documented the evidence of cannabis use but wrote that the *“care of the baby was not compromised”*.

6.6.3 It is not clear how the health visitor reached that conclusion. There is evidence¹³ that cannabis use damages the ability to concentrate and decreases motivation. People who smoke cannabis and those around them are exposed to the toxic chemicals in tobacco smoke. There is no evidence of immediate harm to Child A but the pattern of drug use in the family may be linked to her school attendance problems. This is discussed further below.

6.7 Merton GP Services

6.7.1 This report has been produced for the South West London Cluster of PCTs, the organisation which at the relevant time commissioned the provision of general practice in the area. It confirms the evidence from other sources about Ms D’s problematic use of alcohol and illegal drugs and comments that *“It is unclear from the records that a holistic assessment of her social situation, including any possible risk to her child was considered fully. This is most notable in 2005, when she presented with the possibility of alcohol and cannabis abuse”*.

6.7.2 However the report contains little information about Child A herself, who *“was seen on a few occasions (for) minor and self limiting illnesses”*. Overall the IMR notes that *“There are no concerns about safeguarding issues as a result of this IMR. The standards for clinical care described in Good Medical Practice have been met”*.

6.8 Croydon GP Services

6.8.1 This IMR deals with GP services provided to Child A when she was a baby and services to both Ms G and Mr F. There is minimal information relating to Child A who was last seen by these GPs when she was 16 months old. The practice has retained some electronic records which relate to immunisations only. Ms G registered at this GP surgery in 2002. Mr F was registered there in 2007. At this time, Mr F was recorded as living at Ms G’s address. In February 2012 he was de-registered by this GP practice after failing a number of appointments.

6.8.2 Mr F spoke to the GPs about his use of drugs and alcohol but was not being treated for these problems. Ms G consulted the GPs about issues relating to her emotional well-being. This consultation would not necessarily

¹³ See, for example, [The dangers of cannabis - Live Well - NHS Choices](#)

indicate a risk to a child and, in any case, at that time there is no indication that Ms G played any routine part in caring for Child A.

6.8.3 This is essentially a report which provides background information. The IMR states that

“The assessments and consultations completed met clinical needs and in the absence of any information relating to Child A’s welfare being compromised, there is no indication that practitioners missed opportunities”.

6.9 London Borough of Croydon Children’s Social Care Services

6.9.1 Croydon CSC have contributed a report to this review for information, firstly because Child A’s father, Mr E, was a member of a family which was very well known to them. However there is no record of contact with Mr E after he was eleven years old. Croydon CSC had no knowledge of the relationship between Mr E and Ms D, which appears to have ended before Child A was born. It is not known whether there were lasting links between Child A and Mr E’s family.

6.9.2 Secondly Croydon CSC have records of two instances when Ms D came to their notice, once when she was pregnant with Child A and once when Child A was 19 months old. However the agency cannot detail more precisely the nature and outcomes of those contacts, explaining that

“During the period under review, the client data system in Croydon Children’s Social Care was cumbersome and difficult to use. It was possible to record on the system in a way which did not clarify the reasons for referral or contact, or the basis of decision making. This was exacerbated by there being a mix of paper and electronic records and (by) destroying (rather than archiving) after three years, contacts and referrals which did not lead to a Child Protection Conference or a care episode”.

6.9.3 It does not appear that these two contacts led to any continuing involvement, or that they indicated any particular cause for concern about Child A at that time. It is disappointing that the agency should have had such poor systems but encouraging to learn that

“The authority is currently implementing a new electronic recording system for children’s social care cases”.

In the light of this information no recommendation is made from this report about the failure to keep important records.

6.10 London Probation Trust

6.10.1 This agency has had no involvement with Child A. They have submitted a report to this review because there has been a substantial history of contact between probation services and Mr F.

6.10.2 Probation records indicate that Mr F had a difficult childhood, spending time in care and becoming homeless at a young age. In 2003, when he received a lengthy custodial sentence for drug-related offences, he was said to be

“a poly-drug user and a registered heroin user (and was) also assessed as having an alcohol misuse problem which was compounded by being of no fixed abode at the time of sentence”.

6.10.3 In 2010 Mr F was sentenced to 12 months in custody for possession of an offensive weapon (a machete). He was released in August 2010 and gave the home of Child A’s maternal grandmother as the address at which he would be living. He was generally compliant with the probation service throughout his time “on licence”. Standard assessments completed by probation officers during that period consistently found that he posed a medium risk of harm to the public and members of staff, and a low risk to children. The licence period expired in February 2011.

6.10.4 The history of contact with the probation service is, for the purposes of this SCR, unremarkable. Sad though this personal history is it is, there is nothing to suggest a particular threat to children. Although the report identifies some weaknesses in recording there is no indication that assessments and provision made by the probation service missed any relevant information or were unsatisfactory in any way.

6.11 The Housing Provider

6.11.1 The social landlords for the property at which Child A and her family lived have provided a management review. This details events from April 2005 when Ms D’s tenancy commenced until October 2012 when the family was rehoused by another Housing Association after the death of Child A.

6.11.2 During the period of that tenancy the contact between the family and the housing provider related to

- Routine housing maintenance matters and rent arrears
- Complaints that the family’s dogs were not kept under control
- Problems and disputes with other residents on the estate

6.11.3 The housing provider was made aware of the drugs raid carried out by police in 2008. On two occasions when dealing with routine matters staff from the housing provider visited the home and met Mr F, who was introduced as Ms D’s father.

6.11.4 The IMR concludes that there were *“no failings in our role to provide a responsive repairs and housing management service, and that we found no safeguarding issues in our management of Ms D’s tenancy”.*

6.11.5 The report does contribute to the general picture of problems in the family but appropriately provides little information about Child A.

6.12 Croydon Urgent Care Centre

6.12.1 Croydon Urgent Care Centre (UCC) is a GP led centre, co-located with the Emergency Department within Croydon University Hospital. This agency

had one brief contact with Child A just over a week before she went missing. She was brought to UCC by her mother in the evening, after she had *“walked into the path of a bicycle, travelling fast”*.

6.12.2 She was triaged and found to have abrasions and swelling to her arms and feet. They were asked to wait but were not then called for nearly 90 minutes, by which time they had, perhaps understandably, left the premises. There were no other concerns so it was not necessary for the UCC to take any further action.

6.13 Epsom & St. Helier NHS Hospitals Trust

6.13.1 This hospital has only been involved with the family in that both Mr K and Mr F attended Accident & Emergency Services to be treated for minor injuries. On one occasion Mr F was drunk, further confirming the picture of his misuse of alcohol. The hospital had no contact with Child A or any members of her immediate family.

6.14 London Ambulance Service NHS Trust

6.14.1 The LAS have records of being called to the family home on nine occasions between 2003 and 2010. The first attendance was to Child A, aged three, who had fallen and injured her arm. There were no child protection issues arising from this, nor from any of the subsequent LAS attendances.

6.15 Other agencies

6.15.1 Home-Start Merton is a charity which aims to assist families experiencing stress or difficulties to meet the needs of their children under five. This organisation had offered support and assistance to Ms D but this was declined. The organisation had no knowledge of Child A.

6.15.2 A number of adult services agencies were involved in responding to the issue of Ms G's employment as a carer. Some factual information about the family emerged from the discussions between these agencies and was made available to the review. This is dealt with in section 7.6 below

6.15.3 NHS Direct had been contacted by various family members during the period under review. Brief details of those contacts were made available to the review but contained no significant information.

6.16 NHS Sutton and Merton - Health Overview Report

6.16.1 The purpose of the Health Overview Report is to evaluate the practice of health professionals involved in the case under review, and to serve also as the IMR for the commissioners of health services provided. The report considers the submissions made by all the NHS agencies involved in this review. It largely echoes the findings of those reports. It confirms that *“Child A was virtually ‘invisible’ to health care professionals”*.

6.16.2 The report does identify a significant gap in the arrangements for sharing information between NHS organisations. The report explains how, as a result of re-configurations of NHS services, it is now the case that midwifery records from Croydon University Hospital do not necessarily – depending on which borough a family lives in – get shared with the health visitors to whom responsibility is transferred when the midwifery service ceases. This was not a significant issue for Child A but the report appropriately identifies that it could be problematic. A recommendation is made which seeks to address the problem.

7. ISSUES IDENTIFIED IN THE TERMS OF REFERENCE FOR THIS REVIEW

7.1 The history of the parents and extended adult group, and any implications for the care of Child A and her half-siblings.

7.1.1 As detailed throughout the report there has been relatively little contact between most members of the family and the agencies involved in the review. This section of the report is consequently based on limited information.

7.1.2 Child A's father faced a number of family difficulties during his younger years but he apparently played no continuing part in his daughter's life.

7.1.3 Mr K, the father of Child A's half-siblings, has a criminal record for a number of offences related to drug misuse. No other significant information about him has emerged in the course of this review.

7.1.4 Mr F is known to have had a difficult and disrupted childhood. His adult life is marked by persistent and sometimes serious criminality, for which he has served a number of custodial sentences. He has been said to be addicted to Class A drugs although no firm evidence of this has emerged in the course of this review.

7.1.5 Mr F is believed to have been known to both Ms D and her mother. Shortly after Child A moved to secondary school someone contacted the new school and advised that Mr F should be added to the list of people who had parental responsibility for her – the significance of this remains unclear. There are accounts of Mr F being drunk on one occasion at the workplace of Ms G, while Child A was also present. No other information has come to light about the relationship between him and Child A.

7.1.6 This review has received little information about Child A's maternal grandmother, Ms G, apart from matters relating to her most recent employment detailed below. She has no criminal record. She appears to have played a significant part in her granddaughter's life but little is known about their relationship.

7.1.7 Ms D has occasionally spoken to health professionals about difficulties she experienced as a child, including domestic abuse in her family. There is a

deep and enduring link between domestic abuse and the safeguarding of children. The London Child Protection Procedures stress that *“All the five key outcomes for children identified in Every Child Matters¹⁴ can be adversely affected for a child living with domestic violence and abuse – the impact is usually on every aspect of a child’s life”*.

Local guidance on the MSCB website confirms that *“Long term effects often include poor educational attainment, anti-social behaviour, youth offending, high levels of teenage pregnancy, and alcohol and drug misuse. As children become adults, they are more prone to becoming victims or perpetrators themselves”*.

7.1.8 There are some indications that Ms D continued to be troubled by her childhood experience. She disclosed the abuse. She spoke of having problems with anger management, which is evidenced, and sought assistance with this. She is known to have used cannabis regularly and some people use drugs as a way of escaping emotional stress. The issue of substance misuse is discussed at section 8 below.

7.2 Agency involvement with Child A from her birth to the date of discovery of her body.

7.2.1 This has been covered above, in the sections relating to each agency. Child A was a healthy girl and had minimal contact with any health services. She came to police attention as a result only of their investigations into drug use by adults in her family.

7.2.2 The agencies with the most significant contact are her school and the local authority’s children’s services. The key issues are

- Child A’s non-attendance at school and the agencies’ response to that.
- missed opportunities to carry out fuller assessments of the family situation

7.3 Whether information sharing between and within agencies was sufficiently robust

7.3.1

“A key factor in many serious case reviews has been a failure to record information, to share it, to understand the significance of the information shared, and to take appropriate action in relation to known or suspected abuse or neglect. Often it is only when information from a number of sources has been shared that it becomes clear that a child is at risk of, or is suffering, harm”¹⁵.

As this quotation from the London Child Protection Procedures reminds us, information sharing is fundamental to good safeguarding practice, and it has sometimes only been in the process of a Serious Case Review that information has been fully shared.

¹⁴ Every Child Matters was a Green Paper published by government in 2003. It was a significant and far reaching policy initiative. [\[ARCHIVED CONTENT\] Every Child Matters](#)

¹⁵ London Child Protection Procedures (3.1.1)

7.3.2 There were weaknesses in information sharing in this case. Any attempt to respond to Child A's poor school attendance could have been enhanced by a broader understanding of the difficulties the family faced. A more proactive response from Child A's school to their knowledge of a police raid on the family home would have included sharing information effectively with CSC. In the period after Child A's disappearance police did not promptly identify the need to share information to support CSC in meeting their responsibilities. The knowledge held by some health agencies of Ms D's admitted use of cannabis might have thrown light on any inter-agency consideration of Child A's school attendance (although there was no instance where a health agency specifically failed to share information).

7.3.3 At the same time there was no reason why, prior to Child A's death, some information should have been shared between agencies. Child A's presenting problem was her poor school attendance. There is no reason why any of the agencies involved in responding to that should have been aware at the time of her death of, for example, Mr F's criminal record.

7.3.4 It is always possible to improve information sharing and the other arrangements which provide the foundations for effective safeguarding. Fuller sharing of information here could have led to a better informed multi-agency offer of services to the family. However this review has not produced evidence that weaknesses in information sharing played any part in the events leading to the death of Child A.

7.4 Strengths and / or weaknesses in the investigations and interventions following Child A's disappearance

7.4.1 Child A's body was found in her grandmother's home some days after her disappearance. On the face of it, this apparent avoidable delay must be a matter of concern for police. However it is not the function of this review to evaluate the quality of a police "missing person" investigation. The police IMR appropriately advises that:

"This SCR is not an investigative review and no detailed analysis around the conduct, strategy or tactics of the missing person investigation is included in this report. There have been a number of separate reviews of this investigation and learning has been identified around the conduct of searches, initial reporting, ownership for the investigation and the investigation itself. These issues and other pan-London organisational learning in respect of missing person investigations have been raised on the Serious Crime and Operations (SC&O) and Territorial Policing (TP) Risk Register. There is currently a working group to take forward the internal issues identified around searching for missing persons. At the present time the MPS are reviewing Missing Person Standard Operation Procedures (SOPS) which will be published in due course and will incorporate the learning and recommendations mentioned above."

However there are issues which arise from the way in which agencies operated after Child A's disappearance which do require comment from this report.

7.4.2 The disappearance was notified to police on a Friday so that their investigations began outside “normal office hours”. As part of those investigations police contacted the Children’s Emergency Duty Team (CEDT) social worker early on the following day. The CEDT is a commissioned service hosted and managed by the London Borough of Sutton and covering four south west London authorities, including Merton. The CSC management report from Merton acknowledges that there are technological difficulties for “out of hours” staff conducting checks of records. However it does not appear that the officer on duty made every effort to carry out those checks.

7.4.3 The officer dealing did liaise with MASCOT, a “Telecare” monitoring system principally working with elderly people and vulnerable adults. This service initially searched records and advised that Child A was not known to any services in Merton. That (incorrect) information was passed by the CEDT officer to police. MASCOT staff continued to interrogate records and found that Child A was in fact known to the local authority, for the reasons set out in the narrative section of this report, but that information was not then fed back to the CEDT. Consequently police remained unaware of this. Finally, despite the very serious nature of the situation, the CEDT staff did not make any manager in Merton aware of the events.

7.4.4 Local authorities do not set out to provide the same level of children’s social care service “out of hours” as they do during the normal working week, especially with one team covering four authorities. As the team’s name indicates, what is provided is an “emergency duty” service. Being able reliably to provide information to the “999” services, and being alert to situations which require notification to managers, should be basic expectations of those services.

7.4.5 After the weekend, while the search for Child A continued, Merton CSC shared what information they had with police, and began to follow up other aspects of the situation. They rightly decided that they had responsibilities both to offer support to Child A’s family and to assess whether what was known of the circumstances of her disappearance might give rise to any concern for the other children of the family.

7.4.6 Merton CSC therefore set up a Strategy Meeting on 8/8/12, inviting the relevant statutory agencies to meet and agree a way forward. Police involved in the current operational investigation were invited but did not attend. However no direct invitation was sent to the Child Abuse Investigation Team, the section of the MPS which routinely carries out child protection investigations jointly with local authorities. Consequently police were not represented at this meeting.

7.4.7 The following day officers from Merton CSC were able to meet with police officers involved in the investigation and explain the position of the local authority in respect of the other children of the family. Police facilitated a meeting with family members and the local authority was able to carry out an assessment, concluding that no child protection action was necessary.

However there was some further confusion between the agencies when, on the day that Child A's body was found, police convened a Gold¹⁶ meeting but did not allow senior officers from Merton CSC access to the meeting. This confusion between CSC and police may reflect the stress both organisations were under as they sought to manage this complex situation.

7.4.8 Overall though there were a number of strengths in the agencies' response to this difficult situation, from the Monday after Child A's disappearance on Friday. Merton CSC promptly made resources available to deal with the situation, carried out checks with a range of other agencies and shared information freely with police. Agencies responded promptly and thoroughly to the potential safeguarding implications arising from Ms G's employment, which is discussed below.

7.5 The significance and relevance to Child A's well being of her grandmother's employment

7.5.1 Child A's maternal grandmother - Ms G – was employed at the time of Child A's disappearance and death as a senior care assistant in a residential home for adults with learning disabilities. When Child A's body was found she was suspended from work by her employers. Enquiries established that Child A and Mr F had been seen at the home with Ms G and that on one occasion Mr F had appeared to be drunk. There were also allegations of Ms G behaving in a way that caused concern about her relationships with residents and colleagues. However, after an independent investigation, it was confirmed that there was no evidence that abuse of any vulnerable adults had occurred.

7.5.2 The nature of Ms G's employment was identified as a possible cause for concern when this review was initiated. However, as investigations have continued, no association has emerged between Child A's well-being and the nature of her grandmother's employment.

8. ISSUES ARISING FROM AN OVERVIEW OF THE CASE

8.1 Substance Misuse

8.1.1 There is evidence of widespread misuse of illegal drugs by various members of the extended family, across at least two generations, in the reports submitted to this review. Even where there is not concrete evidence in the form of criminal conviction there is some evidence of association with illegal drugs for all of the adults considered in this report. Ms D openly spoke to professionals about her drug use.

8.1.2 Substance misuse can negatively affect parenting capacity¹⁷. A parent who is under the influence of drugs or alcohol, or who is addicted, will be

¹⁶ A Gold-Silver-Bronze command structure is commonly used by the MPS to co-ordinate multi-agency responses to serious incidents. The Gold meeting will determine the strategic approach to the situation.

¹⁷ See, for example, the relevant research briefing from the Social Care Institute for Excellence. [SCIE Research briefing 6: Parenting capacity and substance misuse](#)

unable to parent as effectively and reliably as might otherwise be the case. Children growing up with parents who use illegal drugs are more vulnerable to physical and sexual abuse, and exposure to contact with unsuitable or dangerous adults, criminality and a physically harmful environment.

8.1.3 There is evidence that girls are more vulnerable than boys – NSPCC Childline reports three times more calls from girls than boys about parental substance misuse. There is also research evidence¹⁸ that “role reversal” is often found in families affected by substance misuse, as children often feel that they should assume some responsibility for their parents or siblings.

8.1.4 In their biennial analysis¹⁹ of serious case reviews between 2003 and 2005, researchers found evidence of substance misuse in 57 per cent of the families for which detailed information was available.

8.1.5 Disruption to education is a common consequence of parental substance misuse. It is very likely to be a causative factor in Child A’s poor school attendance. While the review has not identified any firm evidence of child abuse or neglect arising directly from the misuse of drugs in this family, it is important to mark

- the association between substance misuse and the vulnerability of children to neglect and abuse
- the evidence of the harmful effects of substance misuse on the health and functioning of both those misusing drugs and alcohol and on those around them

9. REVIEW PROCESS

9.1 It is right that a Serious Case Review should seek to evidence and evaluate facts about the background of the family at the centre of the review, and their contact with the participating agencies. Part of the task is to look for problems which may not have been adequately addressed by the agencies. By the same token it is right to acknowledge that a family may find themselves at the centre of a review when there has appropriately been relatively little contact with the agencies. Many of the agencies contributing to this review have had little or no relevant contact with the family in respect of Child A. In those circumstances the agencies’ opportunities for learning from the review are limited.

¹⁸ (Parental problem drinking and its impact on children, Tunnard, 2002).

¹⁹ (Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005 Brandon et al, 2008).

10. CONCLUSIONS: KEY LEARNING POINTS AND MISSED OPPORTUNITIES

10.1 The only firmly evidenced cause for direct concern for Child A was her poor school attendance. This persisted at a serious level throughout her time at school. At her junior school it was not 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.

10.2. Child A's mother avoided all attempts to explore this issue and assist the family in addressing it. No professional ever discussed the reasons for her poor attendance directly 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. We still do not have a clear understanding of why Child A was so frequently absent from school.

10.3 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 is in part a consequence of the national pressures on schools in relation to dealing with non-attendance, but may also reflect a change in the nature of education social work services. There was a minor weakness in information sharing within the school so that her Head of Year and those dealing with her non-attendance were not aware, at the end of term, that she had gone to live with her grandmother some two weeks previously, although her tutor had known this.

10.4 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 professionals in their contact with Child A's family and there may have been an inappropriate tolerance by some professionals of the use of cannabis.

10.5 Children's Social Care services in Merton did not respond thoroughly to two early referrals about Child A's family. These referrals arose from general concerns and there was no direct evidence of abuse or neglect, but they were missed opportunities to assess and try to engage with the family.

10.6 An assessment was carried out by Children's Social Care in 2011, again following indirect concerns. Child A was not seen during this assessment, but overall there was no evidence to suggest a need for continuing contact with social workers. Arrangements for continuing monitoring through the council's "step down" service were not implemented because of an administrative error.

10.7 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.

10.8 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.

10.9 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.

11. RECOMMENDATIONS MADE IN THE MANAGEMENT REVIEWS OF THE PARTICIPATING AGENCIES

11.1 Introduction

11.1.1 As indicated above a number of the agencies which have contributed to this review had no significant contact with Child A or relevant members of her family. Consequently only some of the agencies have found it necessary to make recommendations. Some have made recommendations which are solely relevant to other members of this family and these are not detailed here.

11.1.2 The Panel, and the author of this report, have accepted that the recommendations set out below are appropriate.

11.2 London Borough of Merton, Children, Schools and Family Directorate

1. Staff understanding of the child's experience living with parents/carers with drug misuse needs strengthening through multi-agency training awareness.
2. Education Welfare Service database needs to flag attendance concerns for both single acute episodes and longer term chronic patterns of absence.
3. In all singular transition cases, receiving schools should ask for information of concern and sending schools should review any vulnerability and this needs to be weighted in information provided to the secondary school.
4. Junior School to ask for CareFirst check on children Year 6 transitioning on a singular basis.
5. The current review of CareFirst children's database needs to incorporate EWS case recording capacity and be able to link in real time to school's attendance data.
6. Where absence concerns lead to the initiation of legal Penalty Notices such cases should require a meeting of the relevant school's EWO, class teacher and Attendance/Designated Officer to ensure no unilateral action is undertaken without the full knowledge of those responsible for progressing the notice.
7. Any decision to not proceed with an Initial Assessment must be signed off by the Team Manager, and be shown to take due account of historical as well as presenting concerns.
8. There should always be liaison back with the referrer where any Initial Assessment is abandoned including the rationale for the decision.

9. All closure / abandonment decisions must be communicated formally in writing before a case is closed.
10. All 'step down' decisions following assessment and closure by a social work team should be clear about the specific purpose of 'monitoring' and the required timeframe.
11. All CSC professionals should be supported and reminded to escalate matters to senior officers if they have concerns about their ability to safeguard children in the face of less than effective partnership working by partner agencies.
12. All CEDT (out of hours) social work staff, permanent and sessional, to be set up for full system access to Carefirst and to receive refresher training on access to ensure they can locate all permanent information.
13. All CEDT staff to review and refresh awareness of the responsibilities to notify senior managers of any incident likely to attract media/press attention.
14. All workers to sign receipt of log in and relevant hardware (eg, fobs) and LB Merton and CEDT Manager to maintain a central register of this activity, including dates of training attended.
15. All MASCOT staff to receive refresher training on children's Carefirst and record all CEDT requests for contingency access if they are unable to log on.
16. All relevant discussions and agreed activity should be set out in the closure / transfer record in CareFirst and then shared with the relevant agencies, for inclusion in subsequent school based network meetings.
17. The allocation and support of an effective lead professional is key in supporting families to accept and engage with services in the right way at the right time for them.
18. All staff to be supported through guidance and procedure to note and record all matters of concern that are raised between staff and with parents/carers, consistent with the agency recording policy.

11.3 Croydon Health Services NHS Trust

1. Increase staff awareness of the need to develop professional curiosity when working with adults who may be parents or carers.
2. Review of risk assessment processes at antenatal booking to include expanded information when there is disclosure of drug use, alcohol consumption, or smoking in pregnancy.

11.4 NHS SW London, Sutton and Merton: General Practitioners

1. The GPs should review it system and procedures for managing did not attend letters to ensure that any clinical risk is effectively minimised.
2. The GPs should develop a policy and procedure for providing clinical care to children under 16 who are unaccompanied by a parent or responsible adult.
4. The GPs should consider if the current practice around collecting demographic information should include details for children about schools attended, family links, cultural factors and parental responsibility

11.5 NHS SW London, Croydon: General Practitioners

1. The issues raised in this case should be made available to all independent contractor services so they can reflect on current practice and improve practice. This will include the think family agenda.
2. The need to maintain comprehensive and accurate records to be included in training and supervision processes.
3. Individual health professionals involved in this review to be debriefed

11.6 London Borough of Croydon, Children's Social Care Services

1. The findings of this IMR be shared with those who will be designing and implementing Children's Social Care's new recording system
2. Specific action is taken to ensure that the use of categories in the new system is clear and that the use of mandatory fields helps ensure that the data collected is meaningful
3. The findings of this IMR to be shared with the project group currently reviewing the Children's Social Care procedures to ensure that this learning informs the review of the data retention policy.

11.7 London Probation Trust

1. The Assistant Chief Officer for Croydon should ensure that all staff are adhering to the London Probation Trust recording conventions and that case discussions from supervisions are reflected in the Delius case management system under 'management consultation'.
2. The Assistant Chief Officer for Croydon should also ensure that Court staff record in Delius any referral or notification to Social Care according to London Probation Trust's Children's Safeguarding Policy.

11.8 Epsom & St. Helier NHS Hospitals Trust

1. Men who present with alcohol or substance misuse should routinely be asked about dependants and information should be routinely shared with health and social care partners as appropriate.

11.9 NHS Sutton and Merton Community Services

1. The lead health visitor for this family requires competency assessment, with a focus on the ability to understand, assess and analyse risk factors in vulnerable children and their parents/carers.

2. SMCS to commission Level 3 child protection training – Assessing Risk factors in vulnerable families for all health visitors and school nurses. This will include the use and development of tools based on the Framework for Assessment of Need.

3. Communication between professionals needs to be strengthened. This includes:

a) Liaison between the health visiting and school nursing. The culture of health visitors and school nurses working in “silos” needs to be changed to adopt an ethos of joint working. This is currently being addressed through the strengthening of SMCS safeguarding team. Historically safeguarding supervision was only provided within disciplines. The safeguarding specialist nurses are currently being developed to provide safeguarding supervision across all health disciplines, including “team around the child” supervision. The service is now managed by a universal service manager which brings together the teams for health visiting and school nursing in each borough under one manager.

b) Communication between health visitors and community midwives. A system for effective handover from the community midwives to the health visitor needs to be established for vulnerable families.

c) Communication between health visitors and GP's. Review of the role of link health visitor in GP practices to ensure appropriate and timely communication regarding clients with safeguarding concerns. This needs to include systems are in place to ensure health visitors are notified in the antenatal period of women with identified vulnerabilities, especially when they are booked for antenatal care out of area. Regular communication and liaison needs to be established between GP surgeries and health visitors to ensure information sharing of vulnerable families.

4. A referral system needs to be developed for health visitors to refer families for CAF assessments when it is identified that 2 year nursery placements are required. This should not be reliant on the RIO monthly team planner, but ensure the community nursery nurse is aware of why a CAF is required, including reason for CAF and previously identified risk factors and vulnerabilities. Health visitors are the accountable practitioner and need to ensure they receive timely feedback on a completed CAF. Health visitors must document on RIO that they have reviewed the CAF, including future plans.

5. A protocol to be developed for health visitors/school nurses to compile chronologies using the “notable events” field on RIO. This will include what significant events need to be included in the chronologies.

11.10 NHS Sutton and Merton (Health Overview Report)

1. NHS Sutton and Merton Safeguarding Children Executive Group, are to monitor the Action plans and also through the MLSCB.

2. NHS Sutton and Merton should formally hand over this Health Overview Report and its findings to Merton Clinical Commissioning Group by 31st March 2013, to ensure organisational memory and that responsibility for monitoring commissioning and provider recommendations and action plans occur. The CCG accountability and assurance framework should make sure the learning from this case is embedded and sustained across the health economy.

3. Royal Marsden Hospital Sutton and Merton Community Health Services should review/consider the type and quality of support, monitoring and supervision given to Nursery Nurses when tasks which concern families/children that are vulnerable or at risk are delegated by health visitors or school nurses.

4. During future SCRs or Commissioning-led IMRs when women who live in Sutton or Merton borough have used Midwifery Units outside of the borough the Epsom and St Helier Hospital's Named Midwife for Safeguarding Children should arrange to have sight of their community midwives' documentation within the out of borough hospital's midwifery records (which are returned to the hospital the mother gave birth in) so that midwifery care can be scrutinised and safeguarding practice improved where appropriate.

12. RECOMMENDATIONS FROM THIS OVERVIEW REPORT

12.1 Introduction

12.1.1 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 (**provisional**). Where they are particularly significant they may overlap with the recommendations, set out above, made by individual agencies. They are in line with the Government's guidance²⁰ that

“Recommendations should usually be few in number, focused and specific, and capable of being implemented”.

12.2 Recommendations to the Merton Safeguarding Children Board

12.2.1 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.

12.2.2 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.

12.2.3 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.

12.2.4 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,

12.2.5 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.

12.2.6 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.

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

²⁰ “Working Together” (2010 Paragraph 8.40)

APPENDIX A: 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.

APPENDIX B: References

Footnotes have been used to indicate specific quotations from or references to research, practice guidance and other documentation. This Overview Report has been generally informed by the following publications

- Working Together to Safeguard Children,(HM Government 2010)
- The Victoria Climbié Inquiry (Lord Laming 2003)
- The Protection of Children in England: A Progress Report (Lord Laming 2009)
- The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2007/08
- Safeguarding London's Children: Review of London Serious Case Reviews First Annual Report (London SCB 2007)
- Joint Area Review, Haringey Children's Services Authority Area Review of services for children and young people, with particular reference to safeguarding (2008)
- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn – A biennial analysis of serious case reviews 2003-2005
- Understanding Serious Case Reviews and their Impact - a Biennial Analysis of Serious Case Reviews 2005-07 DCSF 2009
- Developing an effective response to neglect & emotional harm, Gardner 2008
- Child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect (Cawson, Wattam, Brooker, Kelly November 2000)
- Review of the involvement and action taken by Health Bodies in relation to the case of Baby P (Care Quality Commission (2009).
- Learning together to safeguard children: developing a multiagency systems approach for case reviews. (SCIE 2009)
- The Munro Review of Child Protection: Final Report (HMSO May 2011)
- The Munro Review of Child Protection: Interim Report (HMSO February 2011)
- Publication of Serious Case Review Overview Reports: Letter from Parliamentary Under Secretary of State for Children and Families 10th June 2010
- Early intervention and prevention in the context of integrated services: evidence from C4EO and Narrowing the Gap reviews: (C4EO August 2010)
- Early Intervention: The Next Steps - An Independent Report to Her Majesty's Government Graham Allen MP (January 2011)