

# Merton Safeguarding Children Board

## Serious Case Review

### Child B



Merton  
Safeguarding  
Children Board

January 2017

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## Preface by the Merton Safeguarding Children Board Chair

This serious case review is important as it gives the Merton Safeguarding Children Board and its partners an opportunity to look in depth at how our local multi-agency system has been working to keep children and young people safe. It enables us to see practice, policy, protocols and procedures in use and to see how they were understood by the front-line practitioners and their line-managers.

B was seriously harmed by her Mother who had an on-going history of poor mental ill-health; at times, she was well and, at times, she deteriorated rapidly. The work shows the need to understand parental mental health, alcohol, and possible domestic violence and their impact on young people. These are not new themes in serious case reviews. This review shows that we still have work to do locally in ensuring that our practitioners recognise and understand this 'trigger' trio.

B was a young carer and although this was understood her needs were not assessed and supported well-enough. The review also raises questions about the understanding and operation of the thresholds in the Merton Well-Being Model and step up and step down from early help, child in need and child protection.

The review covers a longer period than would be usual for serious case reviews and some of the earlier practice described and evaluated is not a reflection of current practice; but to understand the work done in the review period it was necessary to look at the interventions done in the earlier period.

It is important that B herself contributed to this review. We are very grateful to her; her contribution increases our understanding of the impact on children of living with a parent who can become unwell through mental ill-health; the emotional impact on young carers; and the impact of witnessing parents arguing or fighting.

We are also grateful to the practitioners who reflected on and commented on the lessons arising from the analysis.

The review will only be important if we act on the lessons and embed them in current front-line practice, and its supervision and management, in our local mental health, social care and universal services.

Keith Makin  
Independent Chair  
Merton Safeguarding Children Board

## 1. Introduction

- 1.1 The purpose of a Serious Case Review, SCR is to seek to understand what happened and why it happened in the context of local safeguarding systems, rather than solely the actions of individuals relating to a single case. The case under review is an example of local working arrangements at the time that the work was undertaken.
- 1.2 Where possible a review should be informed by the experiences, views and perspective of the family and practitioners at the time, rather than just from agency records in the light of hindsight. Judgements and lessons should follow from what was known to practitioners at the time or which could or should have been known at the time; not using information which could not have been known.
- 1.3 The review is to ensure that agencies are held accountable for their services, systems and processes in safeguarding children and how they work together as a multi-disciplinary team. An SCR aims to enable the Local Safeguarding Children Board and its partner Agencies, through the single case, to test the wider effectiveness of local and national safeguarding children procedures, protocols and working arrangements.
- 1.4 A review should be proportionate, seek to understand, explain and evaluate what happened through a systems framework; but not to blame.
- 1.5 It was agreed that this review should cover the extended period of multi-agency involvement from 2010 to 2015 as the assessments and responses for the final two years cannot be understood without the detail of the earlier multi-agency involvement.

## 2. Background and reason for the review

- 2.1 In September 2015, B (age 16) was seriously assaulted by her Mother during the night, while B was asleep. The sustained attack resulted in significant damage, requiring surgery. B's Mother had a long history of mental illness, requiring in-patient and community based mental health services. Her mental health had previously been characterised by relapse, treatment, insight and then non-compliance with medication, lack of insight and relapse. In the twelve months preceding the assault, B's Mother had shown improvement to the point where she was assessed as no longer needing specialist mental health provision; but could be supported by medication and universal services.
- 2.2 In the five years, up to the assault, risks to B had been noted, she had been subject of a **child protection plan** for risk of emotional abuse and later she was a **child in need** and finally a **vulnerable child**, supported by universal services. She was a **young carer** throughout this period, but not always recognised as such. Where this was recognised her needs were not always assessed or met.
- 2.3 On two previous occasions B had been disturbed or assaulted by her Mother during the night; but no assessment was done about the significance of these night time intrusions. Not all staff making decisions about B or her mother were aware of these previous assaults.
- 2.4 In January 2014 B disclosed at school that she had harmed herself approximately two months previously.
- 2.5 The Independent Chair of the Merton Safeguarding Children Board sought information from the key agencies working with B and her family and agreed with their recommendation that B had experienced significant harm which should be the subject of a statutory Serious Case Review, as set out in Chapter Four of **Working Together to Safeguard Children, 2015**<sup>1</sup>.

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<sup>1</sup> Working Together to Safeguard Children, 2015: Published by the Department for Education for HM Government.  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/419595/Working\\_Together\\_to\\_Safeguard\\_Children.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf)

- 2.6 The MSCB agreed the Terms of Reference for the review and its Scope – they are set out in Appendix 1.
- 2.7 During the Review the SCR Panel was advised that the Crown Prosecution Service had decided that the Mother should be charged with Grievous Bodily Harm for the assault on B. Involvement of Family in the Review Process took this into account in liaison with the Police. Publication of the Review was delayed until the completion of the legal proceedings and to give the Mother an opportunity to contribute.
- 2.8 As a result of the assault and Mother's ongoing mental ill health B became a Looked After Child.
- 2.9 Mother pleaded guilty to grievous bodily harm and was sentenced to a Hospital Treatment Order under the Mental Health Act, 1983.

### 3. Executive Summary and Key Lessons

**3.1 Case History** B was 16 when she was seriously assaulted during the night by her Mother in Autumn 2015. The assault resulted in significant injuries. B's Mother had a long history of poor mental health, including occasional hospital admissions, treatment in the community, periods of being well with medication and then repeated non-compliance and relapse. There was also a reported history of excessive alcohol consumption. B's Mother had disturbed B and shouted at or assaulted her on two previous occasions during the night when she was unwell.

B lived at home with her Mother and for part of the period under review her Father was there too. Tensions in the parental relationship, because of Mother's ill-health led to arguments between the parents, which were at times physical and seen as possible domestic abuse. B both witnessed and tried to intervene in these.

When B's Mother was seriously unwell B was cared for by her Father, in the family home or by him in a relative's home; or by Maternal Grandmother, outside the borough, although B continued to attend school in Merton. B's Mother and Father eventually separated and B's Father played less of a role in her care and protection.

In early 2010 B was made subject of a Child Protection Plan for nine months for emotional abuse; although she was also at risk of physical abuse. From September 2010 B was stepped down to a 'child in need' and later in 2013 to a 'vulnerable child' status.

From an early stage B's Primary School recognised that she was vulnerable and a young carer because of her Mother's ill-health. B was referred to the local young carers project but there was inconsistent take up and B ceased to attend; although agencies working with her believed that she was still being supported by the project. As B grew into adolescence mental health services and primary health services recognised B as a carer for her Mother but did not see the significance of her continued vulnerability as a young carer.

Prior to the assault in 2015 B had physical symptoms thought to be related to stress; and later she self-harmed.

**3.2 Multi-Agency Work to protect and support B** Section 8 below discusses in more detail the evaluation of this review. In considering the findings, it is important to note that the review was extended to cover a much longer period than usual (2009 – 2015) as the Review Team agreed that the two years up to the serious assault could not be understood and analysed without also understanding the earlier work undertaken by single agencies and in a multi-agency safeguarding context. It should not be assumed, however, that the practice described in the earlier period 2009 – 2013 remains current; evidence in the review period and in the review process suggests that improvements were already in place by the time of the assault. However, the Review has noted some areas for local agencies and the Merton Safeguarding Children Board to consider and take action to re-assure itself that multi-agency work to recognise, support and safeguard children, where a parent has significant mental health problems, is

robust.

There was good practice by the Police in responding to allegations of domestic abuse and sensitively recognising that Mother had mental ill-health and that B was vulnerable. Both of B's schools recognised her vulnerability and that she was a young carer; her secondary school worked well to support her as she developed and to respect her privacy. When Mother's risky or erratic behaviour was acute there was good recognition by practitioners across the system of the possible impact of mental ill-health, alcohol use and domestic abuse on B.

The review suggests that there is a culture of practitioners and their managers not keeping policy, guidance and agreed local protocols central to their work and the supervision or management of that work. The work undertaken did not always adhere to expected evidence-based practice.

Risk assessments were not rigorous and did not take sufficient account of history or developing patterns and the risk of relapse, even though a pattern of relapse was noted. There was insufficient assessment of the ability of the protective members of the family to be able to safeguard B or of their optimism when they thought Mother was well again. When, later, it came to light that B had harmed herself the assessment was inadequate.

As the risk assessments were not robust the plans were not robust. Multi-agency child protection planning was weak, written agreements were poor and when they were not followed through there was no contingency plan. The risks were rightly seen as emotional abuse; but the risk of physical abuse – about which there was evidence was not assessed.

Although B was quickly recognised to be a young carer there was no thorough assessment of the significance of this role to B. Nor was there an assessment of the impact on B emotionally of her Mother's ill-health and what this might mean. B felt responsible for her Mother's care and in the latter stages mental health workers saw B as a carer, inappropriately.

In the early period the safeguarding system worked well to recognise B as at risk; but quickly there was too much optimism, based on Mother's recovery. Core Group Meetings did not work well. There was not a pattern of sharing key information with partner agencies outside meetings and if a key agency was not present they would not have the key information. In the later stages, there were far fewer agencies involved and there was no active monitoring of Mother's well-being.

At the point when Children's Social Care was planning to step down the status of the case from child in need and later was planning to close the case there was poor awareness of how to escalate concern about this by Partner Agencies, to senior managers. Similarly, when the Child in Need meetings were not working there was no escalation to senior managers, within or across agencies.

There were mixed results in seeking and obtaining B's views and her parents' views; and in weighing them up in assessments.

The case records, and the conversation with B herself, for this review, show that there was insufficient awareness of and attention to family history and dynamics, and to cultural aspects; even though one of the parents raised traditional belief systems as a possible dynamic. This raises a question of how well-equipped practitioners are to assess the importance of cultural and religious perspectives of mental ill-health.

The review sought to gain a picture of the support to front line staff through supervision or management of the case but because of the timeframe there is no clear picture. This raises questions about how such supervisory conversations with staff, and case-management guidance to staff were recorded. Agencies found it harder to evidence this; which is, in itself, a finding.

In terms of the local commissioning strategy a question arises about the operation of a multi-agency holistic 'Think Family Approach' for the provision of services where parents have mental ill-health.

**3.3 Lessons** The priority lessons are set out more fully in Section 9

The Review Panel has considered that a lot of the information and analysis for this review is historical; required to provide an understanding of how this case unfolded and was managed. It cannot be assumed that all the findings are still relevant, therefore. Some may also have been particular to this case and less generalizable across the local safeguarding system.

The Panel identified several over-arching lessons which it considered were still relevant and of higher priority.

They are:

**A holistic 'Think family' Approach has not been embedded across multi-agency children's and adults' services in Merton.**

**Young carers are not always recognised as such; and when they are their needs are not always understood or attended to by the whole multi-agency system.**

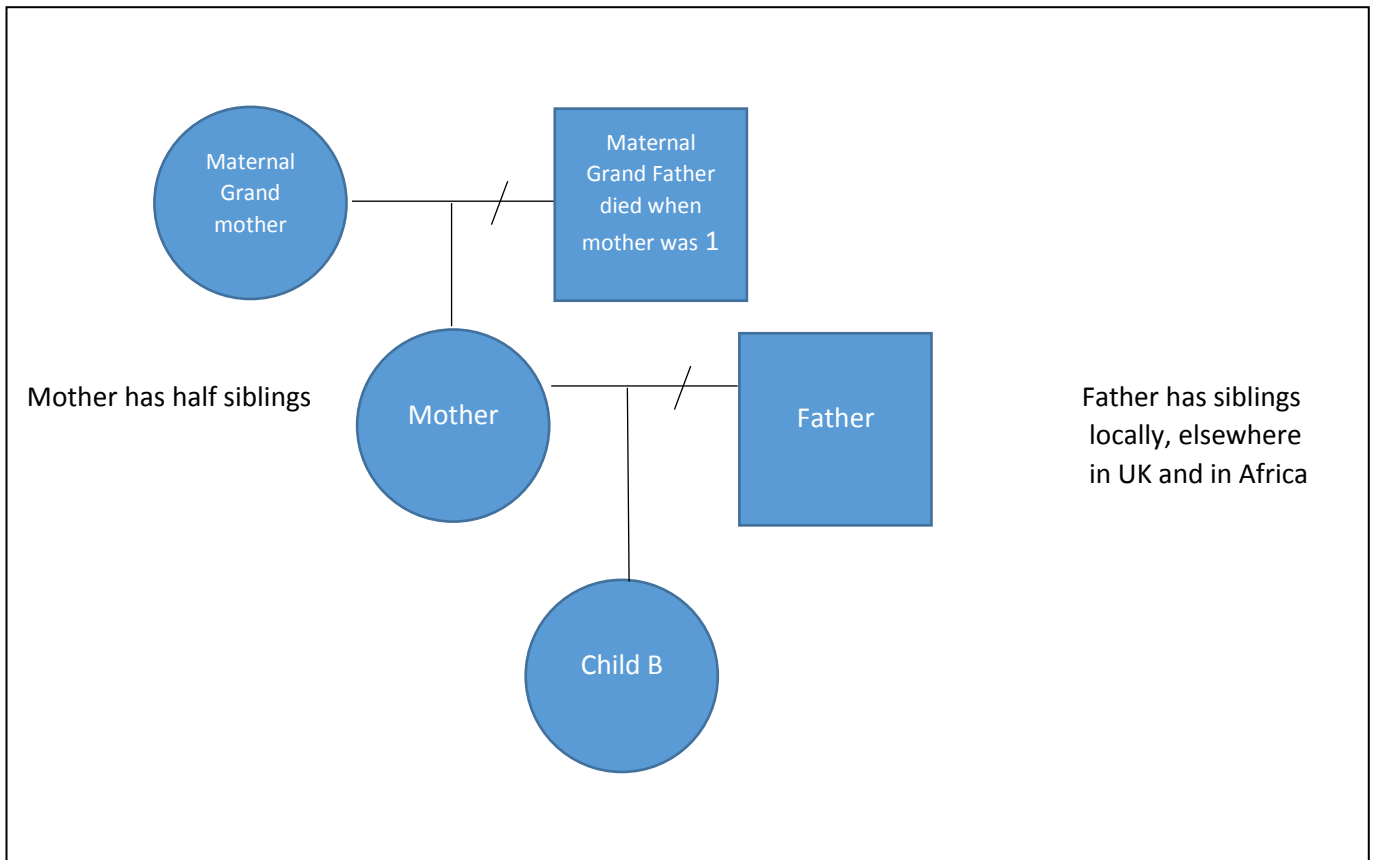
**Recognition of trends or patterns of risk, or changes in risk and when to 'step up' or 'step up' a case are not robust; and there is a lack of confidence to escalate concern.**

**Negotiating, enabling and enforcing child protection plans, child in need plans and written agreements was not effective in this case – is that a wider pattern?**

**There was insufficient leadership and quality assurance in the use of multi-agency safeguarding meetings and processes.**

## 4. B's Family

### 4.1 Genogram (Only family members who were known to be significant have been added)



### 4.2 Background

- 4.2.1 At the time of the work being undertaken on the case a background family history for Mother and Father was not taken. Decisions were taken without this key information. Mental Health Services gained the following information which became available to others as part of this review.
- 4.2.2 Mother was the youngest of four children, half-siblings. Her father died when she was one-year-old. Mother was placed in foster care briefly as a child; she was said to have been happy in foster care. It is not known if this was private foster care or local authority foster care.
- 4.2.3 Mother was well educated to degree level.
- 4.2.4 Mother had a long history of mental ill-health from late adolescence. There were several hospital admissions, poor compliance with medication and inconsistent engagement with mental health services. When in relapse she showed thought disorder, agitation and poor emotional regulation and responses; with psychotic and paranoid thoughts and difficulties in managing the stresses of everyday life.

### 4.3 Racial and cultural aspects

The family is Black British, with African heritage. Some members of the wider family lived in Africa and some in other parts of London and the UK. Mother was Christian. Father was Muslim.



## 5. Timeline of key events and actions to support B and her family

- 5.1** The SCR Panel was provided with chronologies by the agencies which worked with B or her family which showed significant contacts over the period under review.
- 5.2** A working timeline was created to show the key phases of family life and agency and multi-agency involvement. The timeline showed how key functions of the local safeguarding system were working, or not working, in terms of recognition, referral, information sharing, joint work, and formal meetings; as well as the direct intervention with B and her family. This was used to analyse and evaluate the work done.
- 5.3** Originally it was agreed that the review would focus on the two years up to the critical incident. However, this was extended to cover the period from 2009 when there was an incident which led to B being placed on a Child Protection Plan. To understand the two years up to the serious assault on B it is necessary to understand the work undertaken between 2009 – 2013, as this had a direct impact on the subsequent assessments and actions in the last two years. It is important to realise, also, that practice then may have been different to more recent practice following the publication of Working Together to Safeguard Children, 2013 and the revision of the Merton Child and Young Person Well Being Model<sup>2</sup>, which sets out for all agencies in Merton the threshold for access to services.
- 5.4** It is not appropriate to publish the full details of the timeline used by the SCR Panel to analyse and evaluate the work undertaken. A key summary timeline is included at Appendix 3.

(Does the SCR Panel want this heavily reduced timeline at Appendix 3 in the SCR or not at all?)

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<sup>2</sup>Merton Child and Young Person Well Being Model A multi-agency practitioner handbook which sets out agreed responses to children at various levels of need. Originally agreed in 2004 and updated and revised in 2009 and 2013, <http://www.merton.gov.uk/health-social-care/children-family-health-social-care/safeguardingchildren/lscb/lscbprof/isa/mwbm.htm>

## 6. Family Perspectives on the Services offered to them

### 6.1 B The Young Person's views in retrospect

The Lead Reviewer met with B and her current social worker. The meeting was held after the Mother's trial. B could talk about her experiences of support and services without worry of compromising the criminal process. The focus of the conversation was on B's perception of the help she, and her family, had received from Services and not on the incident where she had been seriously harmed. She was a young adult looking back at her childhood experiences.

B was confident and able to speak easily; she showed emotional intelligence and resilience; and a great deal of care and love for her Mother. She appeared to be a confident in herself and her identity as a young Muslim woman.

B felt that she had been caring for her Mother when her Mother had been unwell, since B was at primary school. 'No-one told me to look after her. But I had to look after her, even from a young age'. I was aware that I was on a child protection plan but really 'I got through every time Mother was ill on my own'. 'But what did I get? – Still going to Grandmother, **not home**, and not relief from the problem'.

When Mother was well she was a good Mother, she cooked and took her medication regularly.

B would know when her Mother was becoming unwell, when she became isolated and would not go out and would stay in her room. Mother would take her medication but it would always run out early. She would start to talk to herself, have sleepless nights and would talk about family members (but not in an aggressive way). Mother worried about the side-effects of the medicine. When Mother stopped taking her medication she would just switch, start an argument and start throwing punches.

B said that there were disagreements between her Mother and Father over Mother's illness, the medication and its possible side-effects. He questioned whether African traditional beliefs were a cause of Mother's illness, which neither Mother nor B would accept. B felt she had no-one to talk to about that.

B said that she kept a lot of secrets. B would say 'Mother's fine, everything's fine' when it was not.

B self-harmed when she had 'a lot inside': 'it was a way of letting the pressure go; the pressure of keeping up the image of being fine; and being tired of being upset'. When the self-harm (cutting) was discovered B was offered counselling at school 'but it would not have helped'; 'you just have to get on with stuff'.

B went to live with her Grandmother for a year and had routine visits from a social worker which 'were fine'; 'I was used to those'. 'I was comfortable at Grandmother's but it was not home, I was a long way from friends'.

Father would take her occasionally to see Mother. B would have liked to see her Mother more; 'I wasn't allowed to see her as much as I wanted' 'No one asked me about how I wanted contact with my Mother'. B felt that by only being able to see her Mother with her Father that her relationship with her Mother was inhibited. B missed her Mother – 'but I got used to it happening – not seeing her from time to time'.

The Primary School arranged counselling for B – 'I went but it didn't help'.

B thought that too much was expected of her Father and that she was not consulted enough or asked her view, especially when there had been incidents to which the Police had been called.

'Some social workers I could talk to. But others it was harder, especially if they said negative things and threatened to take me away'; 'I was still too young for them to be so blunt'.

B felt supported by her Primary and Secondary Schools 'I could always go and talk to someone if I was crying; or they would come to me'. The School had a good balance between privacy and correctness in

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class. Key people, not everyone knew. 'I didn't find it helpful when people pushed me for counselling'. B missed school sometimes to make sure that Mother was paying bills and going to her voluntary work. 'I could have talked to the school, but I thought it was my responsibility to look after Mother'. B tried to downplay it and say that it was not a big deal. Her school attendance was up and down. The school nearly took her Mother to court.

Young Carers 'was good as the focus was not on just me'; 'I didn't feel pitied.' 'You could tell your story'. B could get away from home and the reality for a while. It was good to do things like cook and meet with other young carers. 'Young Carers understood – I didn't have to pretend' 'I could feel like rubbish'. Young Carers didn't push for counselling – they had talking sessions about a physical or mental illness which were very helpful, and didn't focus on any one person.

But B stopped going to Young Carers as she thought her Mother could not be left at home alone.

B was worried about her Mother being discharged from hospital too early. She argued the case with the mental health workers in front of her Grandmother; but doesn't think that they paid attention to her. B felt that she was 'left to get on with it'. She did not think that the mental health team pushed as hard as it could to maintain contact and only came back when things got really bad. Mental health workers stopped coming to the house – 'when they had come it had put Mother and me at ease'.

Both B's parents could get angry with each other. When the Police came they would not fully involve B, even if she was the one who had called the police; a police officer may speak to her and ask if she was okay, but would not ask B what had happened to check the versions given by her parents.

## 6.2 B's Mother

The SCR panel were advised not to pursue interviews with Child B's mother until after she had been sentenced. The view was then taken, following advice from colleagues in adult mental health, that Child B's mother was not well-enough to participate in this SCR.

## 7. Practitioners' and Managers' Perspectives

### 7.1 Lessons arising from the Practitioners' Learning Event and any other representations

As part of this Review the Practitioners who had worked with B and her family were identified and invited to a Practitioners' Learning Event, led by the Independent Author and the Designated Nurse. Not all the Practitioners were able to attend as some were no longer employed in Merton. 20 attended, one of whom had not been directly involved but represented a service which was fully involved in B's life.

Merton Safeguarding Children Board is grateful to the Practitioners and Managers who attended. Their detailed responses are in Appendix 2, key reflections are summarised here.

For some of the practitioners, their involvement was brief and several years before the review learning event. They were now able to piece together, in retrospect, the whole of B's story rather than just the parts they knew and had played. Their responses were, therefore, probably influenced by having more information and hindsight, as well as their reflections on their own involvement at the time. Some, who had been involved in the earlier phases, noted improvements over the five-year period in some of the local safeguarding systems and reduction in pressures.

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The Practitioners were given a summary of the timeline and a summary of the emerging lessons identified by the SCR Panel. The purpose of the Learning Event was to obtain the Practitioners' experience of the case and the operation of local systems at the time it was being managed to assist with understanding what happened and why.

The Practitioners responded in a child-focused, open, reflective and honest way, sharing their insights and experiences. They confirmed the SCR Panel's views and added some detail of the working conditions at the time that the case unfolded.

### 7.2 Practitioners noted the following:

- 7.2.1 Risk assessments and Thresholds for Intervention** There was a lack of thorough risk assessments, including alcohol use; and on the challenges for the wider family and their ability to work within the Plan. Insufficient attention was given to the possible impact on B. There was a lack of contingency and safety planning. There was confusion about the use of written agreements and how they are used by the wider multi-agency network. There was and still is confusion about the agreed thresholds for intervention.
- 7.2.2 The child's voice and experience** There was no clear understanding of what B was experiencing at home; or what level of care she was giving her Mother.
- 7.2.3 B as a young Carer** There was no Young Carer's Assessment. Some agencies did not recognise that B was a Carer. Others knew this and accepted it without thinking about whether it was appropriate. Schools and social care thought that B was receiving a service as a young carer and were unaware that she had withdrawn from it.
- 7.2.4 Information sharing** Assumptions can be made that other Agencies know what is happening when, in fact, they have not been informed of changes.
- 7.2.5 Networking and use of Multi-Agency Meetings** Thought needs to be given to the risk of arranging multi-agency meetings in the school holidays. Schools should always be invited to Children in Need Meetings and considered for Strategy Meetings. **Children in Need Meetings** should be more structured and more consistent. When should information from **Care Programme Arrangement Meetings** be shared with Partner Agencies? When is it appropriate to hold '**Professionals' Meetings**' without parents' knowledge or being invited?
- 7.2.6 Systems Issues and Dynamics** Changes of practitioners in the case increased difficulties.

Electronic recording systems are incompatible and can increase problems of sharing information and history. It was noted, however, that there had been improvements in the Social Care record system over the period of the case.

Workloads and non-clinical demands can detract from clinical and case work. Over the period of this case workloads in Children's Social Care were reported to have improved. There was pressure to close the cases which were not seen as priority.

There was a lack of understanding or faith in an escalation process by Partner Agencies to challenge social care decisions.

Reflective supervision and advice were not always available to Practitioners.

There was a lack of understanding of Belief Systems as a dynamic and no training in this for practitioners.

## 8. Discussion and Evaluation

## 8.1 Good Practice

Police responses were for the most part as good and recognised that although the presenting issues were apparently 'domestic' disputes, these were not classic domestic violence but had an underlying mental health cause. Police were seen as responsive to B and her needs (although note B's own view of this) and to the Mother.

The Primary School (not a focus of this review) recognised that B was a Young Carer and referred her to Young Carers Merton, which was appropriate. It also ensured good transition and understanding of B's situation to her new secondary school (which she appreciated).

The Secondary School was very supportive of B, advocated for her needs, and worked sensitively to respect her privacy but to ensure that additional support could be arranged.

It was right for B to be made subject of a Child Protection Plan in 2010.

There were some good examples of joint work by Mental Health practitioners and Children's Social Care social work, particularly joint home visits (although they were not consistent and not followed through when the case was stepped down).

## 8.2 Use of agreed protocols and procedures

### 8.2.1 London Child Protection Procedures

The London Child Protection Procedures are the primary multi-agency procedures for agencies working in Merton. Local Agencies may also have their own internal guidance. Merton Safeguarding Children Board also had in place additional policies, protocols and procedures during this period.

Relevant to this review were the **London Child Protection Procedures**: Edition 4 published in 2010. In particular, the procedures on **Parents with mental illness; Parents who misuse substances; Self-harming and suicidal behaviour; Young Carers, Child Protection Enquiries; Child Protection Conferences; Professional Conflict Resolution (*Escalation*);** and possibly **Spirit Possession and Witchcraft**.

The view formed from this SCR is that practitioners were either not familiar with the guidance or chose not to follow it, as the practice seen did not show understanding of the agreed guidance or give good reason why the guidance was not being followed.

### 8.2.2 Joint Protocol for Safeguarding Children and Families with Mental Health and/or Drug and Alcohol needs.

The Protocol is a bi-lateral protocol between Merton Council Children, Schools and Families Department and the Adult Community Health, Drug and Alcohol Services and Child and Adolescent Mental Health Services (CAMHS) rather than a full multi-agency protocol. Version one was issued in January 2007, version 2 in July 2010 and version 3 was amended in September 2013, signed off in July 2014. The original version carries the Merton Safeguarding Children Board (MSCB) logo. The third version carried the logo for the MSCB and the logo for the Merton Partnership, but was not endorsed by the MSCB. When the revised version was presented to the MSCB Policy Sub Group in December 2014 partner agencies noted that it was not a full multi-agency protocol and that it needed to cover other partners especially GP and Community Health services. The Protocol states that it underpinned by the principles of the Merton Child and Young Person Well Being Model 2013, namely:

- earlier and more holistic identification of needs
- earlier and more effective intervention
- improved information sharing and co-ordination across agencies

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- better service experience for children and families
- reduction in bureaucracy; and
- safeguarding and well-being of children.
- Specifically, the purpose of the Protocol is for the two services to work together to ensure:
- the needs of the whole family are considered using the principles set out in **Think Family**<sup>3</sup>
- the on-going well-being of children where their carer may have a mental health need is considered, as well as the on-going mental health care of any parents/carers of these children
- Young Carers are recognised and supported in their caring role, ensuring it is appropriate and does not conflict with their own needs being met .....

The protocol, awareness about it and its use by practitioners and their supervisors/managers are a test of the local multi-agency safeguarding system and are important in the thinking about and management of this case. The Protocol is important in that it is in the context of greater understanding from research and case reviews into the impact of mental illness on children's safeguarding and concurrent guidance in the London Child Protection Guidelines – several editions which cover this period. It must be seen in the national and service context of lessons from mental health and safeguarding young people.

See also 8.6 below in relation to the Joint Protocol and its expectations on young carers.

Little evidence was found in the review of adherence to the principles of the Joint Protocol.

### 8.2.3 Merton Child and Young Person Well-Being Model<sup>4</sup>

The Model was originally launched in 2004 as the **Merton Child and Young Person Concern Model (CCM)**. In 2009 the Model was revised and re-launched in a multi-agency practitioner handbook and again in 2013 in line with restructure of Merton Children's Social Care Services.

It sets out and maps the agreed thresholds for recognition of need, assessment and intervention at the various levels of need and applies to all agencies working in Merton. The Merton Children's Partnership has regularly delivered multi-agency training several times a year on the model and its use in association with the Merton Safeguarding Children Board.

The work in this case suggests that some agencies and practitioners were not fully aware of the processes, and step-up and step-down processes, as the family moved up and down the hierarchy of need; especially when the case was not clearly in the child protection arena.

Greater awareness of the Model would have enabled better challenge (escalation) between agencies when there were disagreements about thresholds.

- 8.2.4** The SCR Panel questioned whether this lack of awareness of key guidance and procedure, or lack of its use is a local professional cultural phenomenon. It was noted that it was probably the case in the period 2012 – 14 but the case gives less information about current practice. It raises the question of how practitioners learn and value processes and use guidance and how they are supported in this by their managers and agencies. It also raises the question about how agencies ensure that front line staff are aware of and use the agreed policies and guidance.

## 8.3 Trigger Trio<sup>5</sup> – Parental Mental Health, Alcohol Use and Domestic Violence – recognition,

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<sup>3</sup> Think Family SCIE, 2009

<sup>4</sup> <http://www.merton.gov.uk/health-social-care/children-family-health-social-care/safeguardingchildren/lscb/lscbprof/isa/mwbm/mwbm-key-integrated-working-processes.htm>

<sup>5</sup> Merton Agencies adopted the term 'Trigger Trio' to raise staff awareness of the increased risk of these dynamics either singly or in combination. 'Trigger Trio' was used instead of the term 'Toxic Trio' which had been used in research on

## understanding and implementation

Merton Agencies have adopted the term 'Trigger Trio' rather than 'Toxic Trio'<sup>6</sup> for cases where there is Mental Ill-Health, Substance Misuse and/or Domestic Violence. In this case, there was clear evidence of on-going mental ill-health, recovery, non-compliance and relapse and references are also made to Mother's drinking and smoking. On several occasions, there are references to domestic incidents and these become noted as 'domestic abuse' by some agencies. The Police appropriately used the DASH Assessment Model<sup>7</sup> and recognised that these were not domestic abuse *per se*, but aspects of the symptoms of the Mother's mental ill-health. Allegations of abuse by Father to Mother were not substantiated by professionals (*but note B's comments about the arguments between her parents*).

The work undertaken suggests that staff across services were aware of the safeguarding implications of the 'Trigger Trio' where parental mental ill-health, alcohol use and / or domestic violence increase the risk and impact to children. This suggests that there was a general awareness in the local safeguarding system of the risks associated with these factors.

### 8.4 Risk assessments and decision-making

There were several occasions when risk assessments were undertaken or required in this case. These were mainly in relation to Mother's mental ill-health, but on some occasions, when Police were called, they were manifested as alleged domestic abuse; but were probably because of Mother's mental state.

In 2009, on a second occasion a section 47 enquiry was undertaken, which was appropriate; this followed procedures and led to a child protection conference and B was made the subject of a child protection plan. The risk assessment did not take full account of the parental history and dynamics, or cultural beliefs about mental health. There was clearly a physical risk to B; the Panel's view is that B should have been made subject of a child protection plan for risk of physical abuse as well as emotional abuse.

Although reference was made to Mother's drinking, this was not the subject of a risk assessment when it should have been. On some occasions alcohol (or need for it) seemed to be a trigger to Mother's perceived aggressive behaviour.

Subsequent risk assessments did not look at significant psycho-social history or take fully into consideration the emerging pattern of relapse, linked with non-compliance with medication – although this was a focus of some of the work. Views of the sustaining of Mother's mental well-being, when taking medication, were over-optimistic.

It is not clear from the records seen and the Agency Reviews undertaken that risk assessments and protection planning took into consideration when B or other family members, or Agencies supporting them, could see that Mother was becoming ill. There were no contingency plans built in to recognise or deal with possible relapse.

Father and Maternal Grand Mother were seen as protectors to B but no assessments were done of their ability to be consistent and recognise the risk that B may be at. We have learned that Father was assessed to have insight into B's needs and the risk but he was unable to follow through his agreements. At times, they allowed B to be prematurely reunited with her Mother; and although there was a written

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themes and patterns arising from serious case reviews; it was seen to be a more helpful term for those with mental health issues.

<sup>6</sup> The term toxic trio was used in the summary analysis of serious cases reviews by Brandon et al, 2012, to describe cases where there was co-morbidity of parental mental ill-health, substance misuse and or domestic violence. The presence of one or more of these factors was seen an indicator of the need to undertake a risk assessment. **New Learning from Serious Case Reviews: A two year report for 2009-2011; Brandon et al, 2012**

<sup>7</sup> National Domestic Abuse, Stalking and Harassment and Honour Based Violence Protocol 2009.  
<http://www.dashriskchecklist.co.uk/uploads/pdfs/DASH%202009.pdf>

agreement in place this was breached on more than one occasion.

In May 2012 when Mother came into B's bedroom at night, and assaulted B, no proper risk assessment was done. This was seen as a mental health issue but there was no analysis of what the trigger had been for Mother or what the behaviour signified so that it could be guarded against in the future. It was not appropriate for the Police and Children's Social Care to see this as a single agency assessment. This was an assault and as such should have triggered a Children Act 1989 section 47 enquiry and a consideration of a child protection conference.

When it came to light in January 2014, that B had cut her arms two months previously no risk assessment was done and agencies which should have been informed were not informed of the potential risk and of her need for help. There was intention to refer her to Child and Adolescent Mental Health Services but this did not happen and it was not appropriate to expect her Parents to do this, given the evidence to date.

Overall, it must be noted that B was seen to be at risk in late 2009 and early 2010 but in September 2010 she was removed from a Child Protection Plan with no Contingency Plan in place as Mother's mental health was said to be improved, and Father would be able to protect her. However, when Mother's health later deteriorated, the case was not stepped up again to child protection. Feedback from Practitioners suggested that there was Agency reluctance to have cases 're-registered' on a second Child Protection Plan as this was a key performance indicator, with a message that this needed to be kept low.

When, later, the risk to B was worse than it was in 2009 / 2010, with relapse and actual physical assault rather than a risk of B becoming inadvertently involved in parental disputes and harmed as a result, the response was at a lower level and remained as Child in Need. The failure of the written agreement was not seen as evidence to revert to a Child Protection Plan. There was a failure to recognise the renewed and greater risk to B.

On two occasions, there was a recommendation that legal proceedings and a Public Law Outline Process should be considered, to take B into care. No evidence has been found that this was followed up or what led to the decision that it was no longer appropriate; Partner agencies were not informed that Children's Social Care had decided not pursue the Public Law Outline or of the rationale for that decision.

## **8.5 Use of written agreements**

The London Child Protection Procedures (3<sup>rd</sup> edition. 2007) set out the requirement for a written agreement which incorporates the Child Protection Plan. It should be signed by all agencies in the Core Group and the parents: it did not include the requirement for a contingency plan if the Parents did not keep to the agreed actions. All agencies, including Adult Mental Health, were to sign (possibly electronically) the CP Plan/Agreement and store a copy on the Agency Records.

The Written Agreement is referred to in the First Review Child Protection Conference as already having been breached. Partner agencies were not informed of the breach, at the time.

The Review Conference noted that the Core Group should draw up a (new?) written agreement with the parents and the maternal grandmother within 21 days of the Review Conference outlining exactly what needed to change before consideration could be given to B no longer being subject of a CP Plan. There is no evidence that the Core Group drew up a revised written agreement.

An undated and untitled copy of a written agreement, with no visible information to identify what it is, was stored on the Children's Social Care record. It was uploaded to the electronic record at the end of the Child Protection process. There is no evidence that a copy was shared with Partner Agencies or given to the Parents. The actions required were to monitor Mother's mental health, ensure B was supervised and not left alone with Mother and to consider legal action in the event of any domestic abuse.

The document was signed by mother, father, Social Worker and the Assistant Head of B's school.



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This indicates that, in this case, at that time there was a lack of understanding of the purpose of written agreements or how to draft and use them.

The Mental Health Trust has noted that there was no clear plan for how teams and practitioners should respond to non-compliance, which led to an inconsistent response.

### 8.6 B as a young carer

Several agencies recognised B as a young carer. The Primary School referred her to the Merton Young Carers' Project. The Initial Child Protection Plan noted that the school's referral to Young Carers should be followed up but it did not put it into the Child Protection Plan that a Young Carer's Assessment should be undertaken. It was not followed up.

At the latter stages with step down from mental health services in January 2015, B was recognised as a carer but appeared to have been given additional responsibilities to monitor the welfare of her Mother; with no recognition of her own age and vulnerability and that she was still a child. This did not adhere to the paramount welfare of the child principle.

The GP Practice was aware that B was a carer but did not recognise the significance of her status as a young carer.

Agencies seemed to think that B's needs as a carer were being met through the Young Carers' Project but this was not so, as there was very little take up of the service; and on the few occasions when B did engage in activities there had been no full assessment of what her needs were.

No evidence has been seen for this Review that a proper assessment of B's needs as a young carer was undertaken or acted upon. Appendix 4 of this review quotes the guidance on young carers from the **Merton Joint Mental Health Protocol**. B was under 16 and so **could** have been considered for a carer's assessment. (This is an interesting use of words in the Joint Protocol – the assessments are permissive not mandatory - 'can receive a carer's assessment' rather than 'should receive'). The 2014 Protocol lists the areas and support which should be considered/offered to Young Carers but there is no evidence that for B these were systematically considered. The 2010 edition of the Joint MH Protocol puts the responsibility for the assessment with the Local Authority – presumably Children's Services? The 2014 version paragraph 2.8 says that there is a duty on both the local authority and the mental health services to assess carers when requested to do so. B and her Mother were unlikely to request this – where was the imperative for the services to initiate such an assessment?

The assumption in this is that either Mental Health Services or Children's Services will undertake such an assessment; but neither did. For those agencies which were not signatories to the Protocol – although it was available to Partner Agencies – the London Child Protection Procedures applied. The assumption here is that if there is thought to be risk from the caring activities then Children's Services should undertake an assessment, but otherwise 'professionals in all agencies should enquire, from LA adult social care, whether the family is receiving all their entitlements under the provisions of the *Carers (Recognition and Services) Act 1995*.'

*The Children and Families Act 2014* became law in the latter part of the period under review. This amended section 17 of the Children Act 1989 and among other clauses stated that: 'A young carer's needs assessment must include an assessment of whether it is appropriate for the young carer to provide, or continue to provide, care for the person in question, in the light of the young carer's needs for support, other needs and wishes.' The onus is on the local authority to undertake the assessment.

The evidence of this review suggests that practitioners from Partner Agencies in Merton were unclear of what their responsibilities were for B as a young carer and that this need was overlooked as part of the assessments of risk and more general need.

**8.7 Multi-agency working and information sharing** – multi-agency processes - Section 47 enquiries, Child Protection Meetings, Children in Need Meetings, Care Programme Arrangements Meetings - as examples from this case of how the local safeguarding system was working

This section reviews the local safeguarding **system** through the operation of the agreed multi-agency processes, rather than through the actions of individuals.

**Strategy Meetings/Discussions** There were not any strategy meetings or discussions in relation to the risks to B in the early phases. It could be argued that they were not needed as B was not being pro-actively harmed and by implication, as there was no criminal case to be pursued, the work was bi-lateral between social care and the mental health services. In May 2012 following further Police involvement there was a Strategy Meeting which decided that Police did not need to be involved. It has been noted above that this was not appropriate and that a multi-agency section 47 enquiry should have taken place involving key agencies who supported B – in particular, her school.

**Information sharing** There was good, but partial, information sharing at times of crisis – usually when Mother was relapsing and her behaviour was of concern to family members or members of the community who alerted the Police. The Police were called to the home on several occasions and appropriately shared information with social care and/or mental health services, having noted B's welfare.

At other times the information sharing was not as good, when services were not clear what was happening and were asking social care for information, including when the next Child in Need Meeting was to be convened. In March 2010, it was noted that there was a twelve-day delay in social care being informed that Mother had been sectioned; although mental health services had informed social care that voluntary admission had been offered at the time.

The Practitioner's Learning Event undertaken for this review (see above) showed that some agencies did not have key information shared with them.

**Child protection conferences** There were three conferences. It was noted that B was at risk of significant harm from emotional abuse as a result of her Mother's illness and behaviour. It is not clear what assessment of risk of physical harm was considered given that there was evidence that B would seek to intervene in arguments between her parents. The Review Conference Minutes for April 2010 and September 2010 do not appear to note progress of the Action Plan. A key written agreement was due to be written up within 21 days of the Initial CP Conference by the Core Group. By March 2010 this had not been done and a further 21 days was given for it to be completed. It does not appear to have been completed until July 2010. When B moved to stay with her Grandmother outside the borough there should have been consideration of a Transfer Child Protection Conference in the new area, although it was noted that her placement with her Grandmother may be temporary. As a minimum the other borough should have been notified that B was living in their area.

**Core Group Meetings** The Child Protection Plan was completed and filed on the Children's Social Care Record two days after the last Child Protection Conference. There was to be multi-agency monitoring. A family group conference was to be convened and a legal planning meeting was to be convened.

The first Core Group Meeting was held at the Primary School a week after the CP Conference. It had 15 action points, including convening a Legal Planning Meeting (which did not happen).

A further core Group Meeting was held two weeks later at the school it is not clear who attended or why a meeting was held so quickly.

The Review CP Conference was held in March and no further Core Group appears to have been held until July (no minute/record of that meeting itself has been found). A record of a meeting with B herself says that the Core Group had decided that B could return to live with her Mother, just before the start of the school holidays, but that B should not be allowed to stay in the sole care of her Mother overnight until the Community Mental Health Team said that it was safe for her to do so.

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No further Core Group Meeting was recorded prior to B being removed from the Child Protection Plan in September.

The London Child Protection Procedures state that the first core group meeting must be within ten working days of the initial child protection conference. After that the core group should meet within six weeks of the first meeting and at a minimum frequency of once every two months following the first review conference. More regular meetings may be required according to the needs and age of the child. From the records available it seems that these standards were not met.

It appears that some Core Group Meetings were not written up and notes were not distributed; this is of concern. As there are significant gaps in the Children's Social Care records it is possible that some of the Meetings did in fact happen, but this cannot be established. This was in 2010, however. Can Children's Social Care assure the MSCB that this is not the case now?

**Child in Need (CiN) Meetings** At step-down from the Child Protection Plan in September 2010 a multi-agency Child in Need Plan was agreed. The Plan did not note which agencies were to form the core team (Team Around the Child) nor how frequently the group should meet.

There were CiN Meetings in October 2010, March 2011, June 2011, August 2011 (school holidays), November 2012 and August 2013 (school holidays). CiN Meetings were cancelled in December 2010 and December 2012. There was also a 'Professionals' Meeting' in July 2012 (school holidays).

Minutes do not appear to exist for the March 2011 meeting or the November 2012 meeting.

The minutes of the CiN meeting of October 2010 repeats the actions in the original September CIN Plan stating that they must be completed by the end of September, hence all actions were overdue. There is no accounting for the non-completion of the actions. The minutes appear to be a cut and paste of the CP Plan itself with no update on progress. The actions do note the possible impact of parental behaviour on B. Information on file suggests that the meeting was attended by parents, social care, school and school nurse; mental health services were not present. Young Carers Merton was never invited yet was thought to have a key role. The GP Practice was not informed.

There is no available record of the CiN Meeting of March 2011.

In March 2011, the Community Health Service/School Nurse escalated concern to the Social Care Management that the CiN Meeting had not been reconvened. It is not clear what the Social Care response to this was.

The CiN Meeting in June 2011 was attended by the parents, social worker and community psychiatric nurse. School was unable to attend. The minutes do not confirm if B was seen by the social worker as frequently as required. Relapses in Mother's mental health are noted. But it is noted that for the previous four weeks her health has been improved. Referral to the Family Centre had not been possible because of Mother's poor mental health. A question from Father was noted about traditional African spiritual beliefs and their significance in Mother's mental health but the social worker felt ill-equipped to deal with this. It was noted that B was being supported by the Young Carers Project. There was no report from the school.

The CiN Meeting in August 2011 (school holidays) was attended by the parents, social worker and community psychiatric nurse. B was not present but the meeting was held in the family home. The minutes do not confirm if B was seen (alone) by the social worker at the agreed frequency; but there is evidence that she had been seen and advised about what arrangements could be should her Mother's health deteriorate again. It seems as if B was seen with her Mother and Father when this was discussed which could have prevented her from properly giving her views. It was noted that Mother's mental health had improved and been stable and she was reported to be compliant with her medication. There had been a change of Community Psychiatric Nurse; and there was to be a further change as Mother's care was to transfer to yet another mental health team as her service need was being re-prioritised to a lower level. Other tasks had not been completed as Parents had not wished to be part of group

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processes on domestic abuse or on family relationships. The meeting noted that B had been resident with her Maternal Grand Mother in SE London from Dec 2009 to July 2011 (this was incorrect - the same meeting minutes show that B was living at home from at least May 2011, and possibly before; and Maternal Grand Mother was supervising contact with Mother at home between B arriving from school and Father getting home in the evening. The possibility of Mother's relapse is noted and a contingency plan was agreed that should Mother's health deteriorate again the Father who had been granted Parental Responsibility would become B's main carer in the family home. If necessary, he would possibly move to alternative accommodation and care for B; it was also agreed that if necessary B should return to live with her GrandMother in SE London. There was no report from B's old school.

Changes in key workers/managers raise questions about continuity of understanding of history and working relationships and risk.

There appears to be no culture of agreeing the timing and or date of the next CiN meeting. What is the expectation on frequency of CiN Meetings and the expectation when they do not happen? It is not clear that minutes of meetings were distributed to other parties, including those who were not present. At least two Partner Agencies requested information about the planning of future CiN Meetings.

### Care Programme Approach Meetings CPA

CPA Meetings are the formal multi-disciplinary process within mental health services where a patient's health and treatment are planned and reviewed. There were a number of formal CPA Meetings to monitor and manage Mother's health during the period under review. They reviewed progress, relapses and any associated risks, including alcohol use, and treatment; and on occasion adjusted medication. When the Mother did not attend her CPA Meeting in July 2014 the meeting was not re-scheduled and no further CPA was held until January 2015. Child B was present in the final CPA Meeting in January 2015 and when it was agreed that Mother should be discharged from mental health services to the care of her GP.

It seems that B's needs and vulnerability as a child were not considered in these meetings; and her status as a child and young carer was not properly recognised in the final CPA Meeting in January 2015. This seems to be contrary to Trust guidance – see Appendix 6.

Trust staff were involved appropriately, on occasions, in multi-agency child focused meetings at both child protection and child in need levels where B was discussed in her own right.

Professionals Meetings Two meetings were held which were described as 'Professionals' Meetings'. There appears to be no mandate for these in the London Child Protection Procedures. Their status is therefore unclear. The Practitioners' Learning Event gave information that such meetings could be used to meet without Parents present and that they were often not minuted; this was not a practice in this case only. It raises a question about their status and accountability and the principle of partnership with service users and probably needs to be clarified.

**A key question arises:** How do Partner Agencies and the MSCB monitor the operation and quality of CiN and Professionals Meetings?

## 8.8 Escalation of concerns

At times, there was concern about the scheduling of CiN meetings and practitioners made good effort to ask for these to be reconvened but when this did not happen in a timely way there was no escalation to a higher level.

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Similarly, when the school was concerned that Children's Social Care was planning to close the case this was challenged in the multi-agency meeting but was not escalated.

Given the increased levels of risk in the later stages of the case it is puzzling that Agencies did not have the confidence to push for it to be considered at the level of child protection by referring to senior management in their own agency or within Children's Social Care or referring the case to the Quality Assurance Sub Group of the Merton Safeguarding Children Board and asking it to review the decision-making.

This suggests that Agencies are not familiar with the escalation processes or perhaps feel powerless in the system in challenging Children's Social Care as the primary decision-maker of thresholds at the higher levels of the Well-Being Model.

See London Child Protection Procedures 2010: **Professional Conflict Resolution**.

### 8.9 Child and family views

Not all agencies have given information to this review about how the families' views were canvassed and taken into consideration. The school and Police sought B's views in a positive way and were observant of her distress at times. (B herself talks of the school seeking her views but of withholding some information from them. She did not think that the Police sought her view of the parental behaviour or accuracy of statements, although the Police were sympathetic and enquiring about her well-being).

Children's social care noted that the direct work with B was inconsistent. B often minimised her difficulties but was sometimes scared and on those occasions, might say something like 'no-one knows what my life is like'. There was little evidence of exploration with B about the quality of her life. Workers did not go back to B after a crisis when she had been scared or upset to explore that with her. Her positive statements were often taken at face value.

It was noted at one point that B may not share what was happening at home but it is not clear what was done about this challenge to work with her to help her understand her Mother's illness and the risk of any behaviour or relapse.

This aspect of the casework must be viewed alongside assessment and intervention planning and was central to the assessments of the Mother's insight and co-operation and to Father and Grand Mother's ability to protect B.

Was there disguised compliance?

The Child Protection Conference Chair who agreed that B should cease to be subject of a Child Protection Plan has told the Review that she asked the Father about his insight into Mother's illness and his ability to protect B. However, agreements were not kept to.

When Mother was discharged from the Mental Health Services in early 2014, B attended the Care Programme Arrangement Meeting and was treated more as an adult and a partner in her Mother's care, rather than as a child. This was not appropriate.

### 8.10 Race and culture

Little mention is made of the family's racial and cultural background and its significance in either parent. At one point the Father expressed concern to the children's social worker/core group that African spiritual beliefs may have had an impact on Mother's mental illness. The worker is reported to have answered honestly that they had no experience in this area, but did not seek advice, and so the matter

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was not followed up.

There should have been more curiosity here about why the Father raised it and what significance he thought there was in the possible link. There is growing research into understanding traditional belief systems from other parts of the world and how they have been imported into the United Kingdom. There was also guidance on this issue in the London Child Protection Procedures.

In some belief systems health and welfare are seen to have a direct causal link to spiritual beliefs. Some traditional beliefs about illness and healing have been incorporated into current faith systems through a process of syncretism.

It is right that the practitioner owned their inexperience in this area but it raised the question of where was supervision or seeking out of professional advice or literature? It would also have been appropriate to share the information and the Father's concern with the mental health services.

B commented on her Father's beliefs about traditional religious views. But this is in hindsight and was not shared with Practitioners at the time.

In a diverse demographic area like Merton it is important that workers can recognise where belief or cultural practices may be an important dynamic in the work and assessment; and where the worker does not feel competent or confident it is important that this is raised in case supervision.

In 2014 the MSCB supported a joint conference with Sutton LSCB, led by the Metropolitan Police, to promote awareness of cultural practices which may be harmful, this included awareness of beliefs in spirit possession (in children). 28 practitioners from across the Merton workforce attended. There had been no prior multi-agency training on faith or cultural practices.

The London Safeguarding Children Board<sup>8</sup> has undertaken research and development work in this area; more needs to be done to ensure that practitioners across the multi-disciplinary workforce are open to this possibility and know where to seek information when necessary.

### 8.11 Supervision / management

Within adult mental health services it has been acknowledged that, given the risk history and that the child had been subject of formal child protection procedures, that the case and the discharge plans should have been discussed with one of the mental health trust Named Safeguarding Children professionals; it was not.

The discharge from secondary mental health services to the GP may have been deemed appropriate but this plan should have been discussed with Children's Social Care before discharge was confirmed. All clinical teams have a Child Safeguarding Lead who can provide immediate advice and then can seek more specialist support from the CAMHS Borough Lead and the trust Named Professionals.

Children's social care has noted that there is a significant issue with the lack of proper case management and oversight. Agreed actions were not checked for progress or completion. In the early stages of the work when B was subject of the CP Plan casework supervision was noted on file. This is not the case in the latter stages. The issue of (serious) gaps in recording and the not following through of actions was not picked up by managers.

The failure of the transfer of the case to the Vulnerable Children's Team is of concern. There were no

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<sup>8</sup> [Local safeguarding children board strategy for engaging with minority ethnic culture and faith \(often socially excluded\) communities, groups and families to safeguard their children 2011](http://www.scie-socialcareonline.org.uk/search?q=subject_terms%3A%22multicultural+society%22&f_author_name_facet=LONDON+SAFEGUARDING+CHILDREN+BOARD&page=1) ://www.scie-socialcareonline.org.uk/search?q=subject\_terms%3A%22multicultural+society%22&f\_author\_name\_facet=LONDON+SAFEGUARDING+CHILDREN+BOARD&page=1  
[Final report of the pan-London safeguarding children culture and faith project](#)

management systems in place to monitor and track case transfers on stepping a case down.

### **8.12 Systems dynamics outside the case which may have impacted on the multi-agency case work**

In 2010 – 2011 Merton received Think Family Funding, for the Family Intervention Project and Parenting; but not for young carers pathfinders, family pathfinders or think family reforms. A Think Family steering group led this as a sub group of the Children’s Partnership. It successfully delivered the FIP with strong outcomes and a range of parenting support. The sub group met with a range of partner adult services (Primary Care Trust, Mental Health Trust, substance misuse providers, Housing and Voluntary sector) to look at how they might adopt the national guidance on Think Family, published in 2009; raising awareness of integrated offender management, adults’ alcohol services, and adult mental health services, and young carers. These sessions raised awareness across the whole sector of the children’s agenda; but had no link to safeguarding policy and did not affect policy or commissioning decisions.

### **8.13 Health Overview**

As well as the Individual Management Reviews provided by single agencies and incorporated into this Review, at the request of NHS England (London), the Merton Clinical Commissioning Group reviewed the overall health agencies’ work in this case. In summary, the findings from that Review are:

Areas for improvement in practice that require action across all partner agencies include:

The development and implementation of an escalation process where there is professional disagreement between professionals concerning the safeguarding of a child / young person.

Identification and assessment of young carers with particular focus on assessing risk and safety of the child / young person.

Responsiveness of agencies to self-harm in both assessment of risk and referral to specialist services including CAMHS and third sector services.

## **9 Lessons**

Only the most important priority lessons as agreed by the Panel are discussed in this section. Other lessons have been noted in the analysis and discussion above.

### **9.1 A holistic ‘Think Family’ Approach has not been embedded across multi-agency children’s and adults’ services in Merton.**

The work with B and her family shows that throughout the period under review the holistic principles of the Think Family approach had not been fully embedded in the local multi-agency systems at the front line. The Joint Mental Health Protocol and MSCB training provided over the period<sup>9</sup> promoted a holistic approach, understanding of the possible impact on children of parental mental ill-health and of the need to consider that children, or others may be carers.

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<sup>9</sup> Since 2012 the MSCB has run ‘impact of parental mental illness on children and young people’ training twice a year except for 2012-13 when the second event was cancelled. 96 staff across the sector attended 7 courses; only one of these has been from adult mental health services.

The work did not take into account the family dynamics of family history, relationships, impact of parental ill-health on parenting, different belief systems, or culture. Practitioners were ill-equipped to understand the possible significance of the cultural and religious dynamics.

There was little evidence of understanding of these **Think Family** principles in the work undertaken or in its clinical supervision or management.

There were some good examples of joint work in this case by children's social care services and adult mental health services but there was a need for more rigorous joint and holistic assessments of adult mental health, risk assessments, relapse and contingency plans in the context of the whole family and its diversity.

From a systemic perspective, the MSCB cannot provide evidence that policies or protocols are implemented. There is a lack of clarity about ownership and governance of strategies, policies, protocols and procedures. The MSCB had noted this in its own review in 2015 and clarified the governance of policies and their introduction. (See Appendix 5)

## **9.2 Young carers are not always recognised as such; and when they are their needs are not always understood or attended to by the whole multi-agency system.**

B's status as a carer was noted but not attended to with sufficient rigour. Neither Children's Social Care, the Mental Health Services or Primary Care took sufficient account of the impact of B's experience or of how much she was doing to support her Mother. Assumptions were made that this was being covered by Merton Young Carers but this was not properly checked. No proper assessment of B's needs as a young carer was done and at times Mental Health Services placed inappropriate responsibilities on B, given her age and vulnerability.

The Young Carer's Strategy was not clear about responsibility for the commissioning of young carer's assessments, looking more to the provision of services, rather than identifying individual need.

## **9.3 Analysing family history and dynamics, recognition of trends or patterns of risk, or changes in risk and when to 'step up' or 'step up' a case are not robust; and there is a lack of confidence to escalate concern.**

In the initial period the risks to B of emotional abuse were noted, although the risk of physical abuse was not fully assessed, nor was a thorough family history or analysis of family dynamics taken to inform the assessment. It was appropriate that B was made the subject of child protection plan but when this was stepped down there was no proper contingency plan. It is not clear why, when later incidents of harm occurred, these were not treated as child protection inquiries. There was no forensic review of the possible emerging pattern of maternal illness and behaviours, failure to take medication, relapse and prevention. Good progress, at times short-lived, or new episodes of concern were reviewed more in the here and now rather than as part of a possible emerging pattern. There was no in depth assessment of the previous incidents when Mother had assaulted B. The hand-over of Mother's care to primary care did not take sufficient notice of history, risk and the need for monitoring and contingency planning. This raises questions about supervision, management, operation of local thresholds and inter-agency escalation.

## **9.4 Negotiating, enabling and enforcing child protection plans, child in need plans and written agreements were not effective in this case – is that a wider pattern?**



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The review has noted that written agreements were ineffective and did not follow the Child Protection Procedures. It is not clear that parental capacity was considered to ensure that the adults were aware of the importance and able to commit to the agreements being made. The written agreement was not fully shared, or monitored, by the multi-agency meetings which were used to monitor B's welfare.

There is a question for the Review Panel as to whether there is a sufficient knowledge and skill base for practitioners and supervisors in drawing up such written agreements; Partner Agencies do not feel that they are fully engaged in this process, which is led by social care. It is not clear how the system ensures that there is always a contingency plan to address possible changes, relapse or non-compliance; and how this will be monitored.

Over the later part of this review period Merton has been introducing the Signs of Safety Model which has implemented a new approach to this. The use of multi-agency written agreements under the new system is yet to be evaluated locally.

### **9.5 There was insufficient leadership and quality assurance in the use of multi-agency safeguarding meetings and processes.**

After step-down from child protection the children in need process was not well planned or managed from a multi-agency perspective, with a lack of clarity about who should be involved, what the goals were and timing of meetings. They were permitted to drift and questions about them being re-convened were left unanswered. This raises questions about how practitioners are trained and supported to lead such processes and how these meetings are quality assured.

It is not clear that there is a recognition of the 'minimum sufficient network' for such meetings and that where a key professional, such as a GP or school representative, is not present that they will be informed of the progress, any changes and any actions. This is particularly important for Core Groups, Child in Need Meetings and informal Professionals Meetings where there is no formal minute-taker. It is puzzling that Child in Need Meetings were scheduled in school holidays rather than prior to school holidays to plan for periods when B would not have the school's support.

It would have been appropriate for Partner Agencies to have escalated their concern to a more senior level for action to be taken. It is not clear that the Care Programme Arrangement Meetings fully took account of Mother's role as a parent.

## **10 Recommendations**

The MSCB and its Partner Agencies are asked to consider these recommendations and, if endorsed, to agree an Action Plan to address them.

### **10.1 Think Family**

The MSCB and its Partner Agencies should review how the principles of the holistic **Think Child, Think Parents, Think Family** approach are operating in Merton and how they are embedded in commissioning and leadership of front-line practice and its management, with joint-working and understanding of mental ill-health and parenting. Consideration should be given to a revised multi-agency strategy to implement the Think Family principles, including the commissioning of services, staff awareness and skills – across adult mental health services, community health, primary health services and children's services; to include parenting assessments as integral to mental health assessments, and the understanding of risk and relapse.

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From this review, the MSCB should complete its revision of the **Joint Protocol for Safeguarding Children and Families with Mental Health and/or Drug and Alcohol Needs** and ensure that it is fully multi-agency.

The Board should ensure that the revised Strategy and Protocol are properly implemented through the MSCB Training Offer and within agencies as part of a commitment to the MSCB Annual Business Plan and that the implementation is monitored over the twelve months from launch of the revised Protocol. The MSCB Policy Sub Group should take the lead for this and then hand over to the Policy and the Learning and Development Sub Groups to implement and monitor.

### 10.2 Young Carers' Strategy and Protocol

The MSCB should recommend to the Children's Trust that it should review the **Merton Young Carers' Strategy** and draw up a clear multi-agency **Young Carers' Protocol**, for all sectors, to clarify the nature and arrangements for Young Carer's Assessments, following the duties set out in The Young Carers (Needs Assessments) Regulations 2015. It is recommended that there should be a separate set of guidance on Young Carers and that this section of the original Joint Mental Health Protocol should be removed to avoid duplication, but that the Joint Mental Health Protocol (and others like it) and the Merton Child and Young Person Well-Being Model should clearly note the need to recognise young carers and signpost the separate Young Carer's Protocol.

The Board should ensure that the revised strategy and Protocol are properly implemented through the MSCB Training Offer and within agencies as part of a commitment to the MSCB Annual Business Plan and that the implementation is monitored over the twelve months from launch of the revised Protocol.

### 10.3 Understanding of family history and current family dynamics, including cultural and belief systems in assessments

The MSCB and its Partner Agencies should review their processes for ensuring staff awareness in analysing family history and dynamics, including the understanding of how culture and belief systems impact on their understanding and (risk) assessments of mental health and parenting. This should include staff awareness of listening to family members.

If necessary Agencies and the MSCB should consider whether training should be provided for relevant staff or attention drawn to the **London Child Protection Procedures sections on Harmful Practices linked to faith or culture (Sections B3 23 – 27)**

### 10.4 Written agreements

Children's Social Care should review the competency of staff responsible for drafting written agreements and the detailed Child Protection Plans, in the light of relevant research, guidance and case law; to ensure that such staff and their supervisors are well-equipped to negotiate and draw up realistic and achievable agreements, based on thorough risk assessments.

All such agreements should include clauses on the possibility of recognising and dealing with relapse, non-compliance and contingencies.

Partner Agencies should confirm to the MSCB that all relevant staff are aware of their responsibilities to support such child protection or child in need plans and written agreements and to report any breaches under the guidance set out in the *London Child Protection Procedures Section A 5.3*

## 10.5 Effective multi-agency meetings

Children's Social Care and the SW London Mental Health Trust should seek to ensure that the staff (and their immediate line-managers) who have responsibility for chairing multi-agency meetings, particularly Core Groups, Child in Need and Care Programme Arrangements meetings are competent in the facilitation of meetings and have an understanding of the holistic Think Family approach and the principles set out in the London Child Protection Procedures for Core Groups *London Child Protection Procedures, Part B, section 9*. This should include agency monitoring and quality assurance of samples of such meetings; the findings of such audits should be shared with the MSCB.

The MSCB Quality Assurance Sub Group should commission an audit of a sample of multi-agency core groups and children in need meetings within six months of the review's publication; and review any local guidance or action which is taken to ensure that the meetings are effective. From this the MSCB should consider a skills audit and briefing or training for the chairs of multi-agency meetings with the authority for making decisions to step down a case to ensure that they are aware of the need to consider the fuller history, risk and future contingency. (see also 10.6)

## 10.6 'Step down' or closure from child protection or children in need, contingency plans – and inter-agency escalation

The MSCB Policy Sub Group should review guidance on 'step down' from child protection or child in need thresholds to ensure that it covers a review of the relevant case history, including the original risk and any other risks subsequently identified, not only recent progress; and an assessment of risk or need in the longer term, including the risk of relapse and contingency plans – including the recognition of potential breakdown or non-compliance; or future significant changes in the family composition.

Within twelve months of the publication of this review the MSCB Quality Assurance Sub Group should monitor a sample of cases where the threshold has been stepped down to ensure that the guidance has been adopted.

The MSCB Training Offer and Partner Agency Internal Guidance and Training should ensure that staff who attend Core Groups are aware of their responsibilities under the London Child Protection Procedures; *London Child Protection Procedures, Part B, section 9*.

All Agencies should confirm to the MSCB that they have issued guidance to ensure that relevant staff are made aware of the need to escalate concerns (to a more senior manager, if necessary) where they disagree with a decision made by another agency; using either the **London Child Protection Procedures for Professional Conflict Resolution (LCPP Part B1 11)** or the new **Merton Multi-Agency Escalation Policy**.<sup>10</sup>

## 10.7 Non-engagement or withdrawal from referred services by service users and closure of cases

Commissioners should ensure in their contracts that service providers have a duty to notify the referring agency when a service user does not take up a service, or withdraws from a service, for which they have been referred, **as an essential part of a child protection plan or child in need plan**. This will enable the risk assessment to be reviewed. (A Standard clause to be considered for such commissioning contracts).

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<sup>10</sup> The Merton Multi-Agency Escalation Policy 2015 is on the MSCB website. ([http://www.merton.gov.uk/mscb\\_escalation\\_procedure\\_june\\_2016.pdf](http://www.merton.gov.uk/mscb_escalation_procedure_june_2016.pdf))

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When closing a **child in need** or **child protection case**, Children's Social Care should put in place arrangements to notify all agencies which are still involved in the case, including universal services (e.g. GP, school and community health), that the case has been closed and what the contingency arrangements for re-referral are.

These arrangements will be subject to the consent of the service users and the principles of data protection and information sharing.

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Malcolm Ward

Independent Reviewer

December 2016

## Appendices

### Appendix 1 Terms of Reference

#### Agreed by the Business Implementation Group on 16 November 2015

In early September 2015 Child B (16) was seriously attacked by her Mother while she was asleep and sustained significant injuries, including by biting. The Mother had a history of mental ill-health and alcohol use; B had previously been subject of a CP Plan and patterns of relapse and non-engagement by Mother had been identified.

Following the injuries to Child B the Merton Safeguarding Children Board has agreed a SCR and notified the National Panel of Independent Experts in SCRs of this decision.

The purpose of a SCR is to learn from Agency and Multi-Agency work with children and their families. It must seek to understand why the serious harm occurred but it is not the role of the review to apportion blame. The MSCB is seeking accountability not culpability.

#### Methodology

The MSCB has agreed to use the Multi-Agency Child Practice Review methodology [www.wales.gov.uk/docs/dhss/publications/121221guidanceen.pdf](http://www.wales.gov.uk/docs/dhss/publications/121221guidanceen.pdf)

This includes the creation of a timeline of key events, analysis and a practitioners' learning workshop to identify the priority lessons from the work with the family. Although a number of working documents for the SCR Panel will be produced the published report will be an anonymised summary of the key events, the analysis, conclusions and lessons with a proposed action plan to embed any required changes and learn the lessons. National guidance requires that an SCR will review the working of local systems (single agency and joint work), not just actions undertaken by individuals.

B and her family will be advised of and invited to contribute to the review, as and when this is appropriate.

#### Scope:

The review will cover the period from late 2009 a key episode in Mother's mental health, to September 2015, when the injuries occurred. Agencies in preparing their reviews should consider if they have knowledge of any prior significant history or events which should be summarised – particularly in relation to B's care and parenting and to her Mother's previous mental health. The detailed analysis will cover the period 14 August 2013 (Child in Need Meeting) to the injuries on 8 Sept 2015. The rationale for this is that the review should concentrate in more detail on recent multi-agency practice and not historic practice. However, the work between late 2009 and August 2013 will also be considered as a foundation for the more detailed analysis.

A detailed chronology for the Panel's use only will be compiled indicating key agency contacts with B and her family members or inter-agency communications from November 2009; summarising the content and outcome of the contact or communication and who was involved from the agency by role e.g. SW1, HV1, GP2, etc. The chronology should be confidential and should not identify an individual by name – only role.

The chronology should be supplied confidentially and securely in electronic format using the attached proforma to Merton Safeguarding Children Board **by 4 January 2016**. Most agencies have completed a chronology but other agencies should now do so covering all contacts in the key period identified as being in scope.

### Independent Management Reviews (IMR) or Root Cause Analysis reviews for Health Agencies

Using the agency chronology, agency records and direct conversations with the relevant practitioners each agency which had contact with B or her family is asked to compile an IMR. This should be undertaken by a suitably qualified and independent senior practitioner who is able to analyse the agency involvement and provide a review which comments on the agency practice and any lessons arising from the agency review. The review should be formally endorsed by a senior manager of the agency at LSCB level and who did not have direct involvement in the management of the case.

The Agency IMRs should note and review:

- Any known significant prior history relating to B or her family members;
- The Agency's key and priority practice episodes (i.e. phases of work covering several contacts which relate to one another rather than single contacts or events; these will be drawn from the agency chronology);
- the Agency's comments on the use of relevant LSCB and agency policy and procedures or protocols, or accepted best clinical/professional practice, in use at the time, including the relevant NICE guidance; in particular reference to recognition, referral, assessment and intervention, multi-agency processes – such as information sharing and contribution to safeguarding meetings or processes;
- use of the agreed Joint Mental Health Protocol between SW London Mental Health Trust and the Merton Children's Social Care Service.
- the agency's and inter-agency assessment of B's needs, including her developmental needs, her emotional needs, and ethnic and cultural needs; and any risks identified, including signs or disclosures of neglect or abuse;
- how a child focus was ensured and prioritised;
- the direct work undertaken with B and her family members – how B's views and wishes were ascertained by the Agency and how her family's views and wishes were ascertained, at each stage of the process;
- the Agency decisions, actions taken and timescales, noting any gaps, errors and successes and why these occurred;
- any specialist advice/support that was required or sought;
- any regular management or supervisory oversight of the work,
- seeking to understand the work undertaken by what was known at the time, not through hindsight, but noting any gaps in action from information which was available at the time;
- the views of the Agency's practitioners who were involved should be actively sought as part of this review; and
- the wider agency systemic context in which the work was undertaken, and any factors intrinsic to the agency or external to the case which may have impacted on the work; e.g. pressures, agency challenges, staffing issues or agency cultural issues.

In summary the Agency IMR should note the key lessons, including good practice and any concerns, which have been learned as a result of the agency independent review and any recommendations to be taken as a result within the agency; and whether the agency has accepted such internal recommendations as formal actions.

The review should concentrate on the Agency's own work. If as part of that review the Agency wishes to signpost good practice or raise questions about any other agency's work this should be done in a separate section of the IMR. Similarly, if the Agency wishes to make recommendations to the MSCB or Partner Agencies these should be kept separate.

Health Agency IMRs will be undertaken using NHS England Guidance for SCRs, using Root Cause Analysis and will be overseen by the Designated Nurse and Doctor who will take responsibility for compiling an overall health agencies' overview report for this SCR and for NHS England.

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### IMRs will be requested from the following agencies:

Merton Children's Social Care

Merton Education

School

Royal Marsden and Sutton and Merton Community Health Trust

GP

SW London and St George's Health Trust

Merton Adult Social Care

Merton Young Carers

Metropolitan Police

### SCR Panel

Merton SCB has appointed a panel of senior and experienced practitioners in safeguarding to draw together the learning from the IMRs and Health Overview and to comment on the work undertaken. The SCR Panel members will be independent of the line-management for this case.

An independent reviewer has been appointed to work with the Panel and to author the final report

The Panel has been commissioned by the Merton SCB Chair

### The Panel members will be:

|                                   |                                      |
|-----------------------------------|--------------------------------------|
| SCR Panel Chair                   | Lynn Street, Merton CCG              |
| Lead Independent Reviewer         | Malcolm Ward, Independent Consultant |
| Designated Doctor                 | Dr Benedicta Ogeah, Merton CCG       |
| Designated Nurse                  | Liz Royle, Merton CCG                |
| Merton Children's Social Care     | Paul Angeli, Asst Director           |
| Merton Education                  | Keith Shipman,                       |
| SW London and St Georges MH Trust | Ian Higginson, Named Nurse           |
| Ursuline School                   | Julia Waters, Principal              |
| Merton Young Carers               | Melanie Monaghan, Chief Executive    |
| Metropolitan Police               | Sgt Helen Rendell                    |
| Named GP Wandsworth CCG           | Dr Helen Morgan                      |
| Merton LSCB Manager               | Paul Bailey                          |

None of the Panel Members should have had direct involvement in the management of the case –

The Panel should be able to co-opt specialist advice as needed; e.g. in relation to the management of mental health in the community or the significance of the injuries by biting. Legal advice, if required will be provided by the Council's Legal Team.

The Panel will have the authority to invite the agency IMR authors to further discuss their IMRs and findings.

**Participation by family members and carers**

B's mother and family will be advised of the review, its purpose, how it will be conducted and how they may be involved; including by direct conversation.

There is an on-going police investigation into the alleged assault; this may prevent the offer of interviews to the Mother or any family witnesses. The Police will advise the SCR Chair and Independent Reviewer on the progress of these. Any interviews for the SCR will be with Police agreement.

**Practitioners' Learning Event**

A key feature of the model is the Learning Event for those practitioners who were directly involved in the case within the review period. Its purpose is to enable them to share their perspective and provide a reality and systems check which may not be possible from a review of the records alone. Practitioners who were involved should be consulted by Agency IMR Authors at the stage of compiling the Agency IMR. When the Panel has agreed the priority lessons arising from the review the Learning Event will be convened to present the emerging finding to the Practitioners to comment on the Panel's findings for accuracy and interpretation.

The Learning Event will be facilitated by the SCR Chair and the Independent Reviewer.

**Governance**

The SCR Panel chair will hold responsibility for informing the LSCB Chair, Director of CSF, Agency CE or other relevant agency lead of any emerging findings which require attention before the SCR is completed. The emerging findings will remain confidential at this stage.

The SCR will be signed off by Merton SCB in a special LSCB meeting.



## Appendix 2 Case Practitioners' and Managers' Perspectives

The Practitioners were given a summary of the case timeline and there was discussion about the emerging lessons, as identified by the SCR Panel. The purpose of the Learning Event was to obtain the Practitioners' experience of the case and the operation of local systems at the time it was being managed to assist with understanding what happened and why.

### Practitioners noted the following:

#### Risk assessments and Thresholds for Intervention

- There was a lack of risk assessments.
- Missed opportunities. Some of the incidents should have been regarded as child protection not child in need.
- Although the Mother's history of compliance and non-compliance was known not enough account was taken of its impact on B.
- Was the Mother's alcohol use explored enough?
- There was no safety plan for how to note and respond if Mother's health deteriorated.
- How was Mother's health to be monitored when she transferred to community care under the GP Service?
- At the point when there was concern about B's school attendance there was no information to suggest that Mother's mental health may be a cause. *(Nor is there information in hindsight to suggest that)*
- Mother was overdue for a mental health review at the time of the critical incident. No monitoring of whether medication was being taken as prescriptions were issued on automatic repeat. The surgery has changed this practice as a result of this review.
- Other changes made in the GP Practice include – proactive reviewing of mental health patients including chasing those who do not attend for review; and clearer identification of children at risk
- Mother was overdue for a mental health review at the time of the critical incident. No monitoring of whether medication was being taken as prescriptions were issued on automatic repeat. The surgery has changed this practice as a result of this review.
- How was the decision to give Father the caring role decided?
- Was Mother's alcohol use checked and dealt with, and if not why not?
- Young Carers Service did not have a full history of risk.
- The Chair of the CP Conference in Sept 2010 recalled that reports to the conference were positive and that the Father understood the concerns in relation to Mother's illness and the risk of relapse and how to support B.
- Do all agencies understand the agreed thresholds? *(As set out in the Merton Child and Young Person Well-Being Model)*
- How are written agreements used and how are other agencies aware of them? If the agreement is done at an inter-agency meeting they will know. But often do not.
- Lack of contingency and safety planning.

#### The Child's Voice and Experience

- B had wanted to be like her friends.
- Not enough attention was paid to B's voice.
- There was no clear understanding of what B was experiencing at home.

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- What level of caring she was giving?

### B as a Young Carer

- Lack of a Young Carer's Assessment.
- Until 2013 Young Carers Merton did not have a holistic assessment tool based on needs and strengths.
- GPs (out of borough) did not recognise until after the critical event that B was a Young Carer. It was mentioned in the referral letter for Mother but not linked to B's own patient record and so no assessment of her vulnerability, risk or needs was done by the GPs.

### Information sharing

- Are assumptions made that other professionals will know what is happening rather than kept up-to-date properly? At times agencies did not know that B had returned home to her Mother.
- Young Merton Carers now ensure that the referring agency and or Children's Social Care will be informed if a case is closed to them. *(This was not the case with B, but has been put in place as a result of the Agency's review of this case)*
- Why was B's self-harm not referred to the GP?
- GP Surgery was unaware of B's physical symptoms or how this was referred to a specialist Clinic (out of borough).

### Networking and use of Meetings

- Thought needs to be given to when to hold Child in Need / Child Protection Meetings in school holidays as significant information may not be available.
- Schools should always be invited to and involved in CiN Meetings and Strategy Meetings.
- Young Carers Merton was only invited to one CiN Meeting or CP Conference and was unaware of the others.
- CiN Meetings were unsuccessful. Who has the responsibility to share information to those professionals who do not or cannot attend?
- CiN Meetings should be structured and consistent.
- Difficult for the social worker to convene CiN Meetings as some agencies are reluctant to attend.
- Consider ways that GPs can be more involved in CPA, CiN and CP Meetings – skype or conference calls at the end or beginning of the meetings?
- Should other services other than Children's Services have been involved in the Mental Health CPA Meetings?
- When a CiN Meeting has to be rescheduled it can be a big problem coordinating diaries and this falls on the social worker, with no assistance.
- When an Agency is not present in a meeting there must be realism about what they can be asked/expected to do.
- Meetings need to be more effective
- How do other agencies know what is agreed in CPA Meetings? *(Within bound of confidentiality)*
- 'Professionals Meetings are sometimes used when it is not appropriate to invite parents'.
- Professionals Meetings – have greater fluidity, may not have minutes and do not require Parental attendance.

### Systemic issues

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- Pressure from management within Children's Social Care to close the case and a strong belief that Maternal Grandmother would keep B safe.
- Changes in personnel within Children's Social Care and Adult Mental Health Services in the case created difficulties.
- Problems with incompatible electronic recording systems across services. History may be lost.
- Workloads, deadlines and data requests and other demands can detract from clinical practice. (Mental Health Services)
- Having familiarity with a school is important in good networking, where there is not a prior relationship between social worker and school this needs to be established to gain trust and good joint working.
- When a case is stepped down to another service there needs to be a system to ensure that the referral has been received and accepted.
- There has been improvement in Children's Social Care case recording since the early years of this case.
- Caseloads in Children's Social Care have improved in that social workers now have fewer cases than was the case in the early part of this period.
- This case was not seen as a priority by Management compared to other cases at the time.
- Why doesn't escalation work? Are Agencies aware of how and who to escalate to?
- In 2010 there were changes to the structure of the child protection process leaving one Independent Reviewing Officer to chair conferences on 100 – 140 children.

### Other factors and lessons as a result of the review

- Should B have been referred to CAMHS?
- Changes made in the GP Practice include – proactive reviewing of mental health patients including chasing those who do not attend for review; clearer identification of children at risk; family structures and carer duties being documented and assessed.
- The school worked well with B and the case but could have been more active in ensuring a Young Carer's assessment was undertaken and that a referral was made to the GP when it was learned that B had self-harmed.
- Lack of understanding of Faith as a dynamic in care and risk for children – no training for staff on this.
- Supervision and advice were not always available

### Appendix 3 Summary Timeline of Key Events and Key Practice Phases

|         |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Phase 1 | 1999 - 2009            | The work undertaken from 2009 did not take account of B's earlier life, care, upbringing or experiences.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 2       | Late 2009 – Early 2010 | Police being called to a domestic dispute led to a decision to undertake a Common Assessment Framework assessment, but Mother did not co-operate. The situation worsened over the next few months. Mental health services were asked to assess Mother, but were unable to meet with her. School referred B to the young carers project. In December, it was agreed to undertake a section 47 enquiry. B was made subject of a Child Protection Plan.                                                                                                                                                                                               |
| 3       | Jan – Mar 2010         | <b>Child Protection</b> Core groups noted continuing concern about Mother's mental state deteriorating, breach of the CP Plan; Mother was eventually sectioned under the Mental Health Act. B was living outside the borough<br>Review CP Conference noted little progress                                                                                                                                                                                                                                                                                                                                                                         |
| 4       | April – Sep 2010       | <b>Child Protection</b> Mother discharged from hospital and when B's temporary care arrangements could not continue B returned to live with Mother, but should not have been alone with her, other agencies were not aware of the change in the CP Plan.<br>Over the summer school holidays Mother was more stable and co-operating with treatment, but B was, at times, in sole care of Mother in contravention of the CP Plan. B was attending some young carers activities. B moved to secondary school. Based on, some small progress the CP Plan was ceased in September, no contingency plan put in place. B became a <b>child in need</b> . |
| 5       | Sep 2010 – Feb 2011    | B as a <b>child in need</b> , Mother initially non-compliant with treatment, no new risk assessment; a Child in Need Meeting (October) noted good progress but there is little evidence of this.<br>December CIN Meeting cancelled because of bad weather & not reconvened. In January Mother noted to be more stable.                                                                                                                                                                                                                                                                                                                             |
| 6       | Feb 2011 – Sep 2011    | <b>Child in need.</b> Mother's deterioration and recovery<br>In February there was an incident when Mother, in a disturbed state, woke B in the night. Mother was admitted as a voluntary patient and later sectioned. There should have been a section 47 enquiry, or at least an urgent Child in Need Meeting.<br>In Spring there was concern about a domestic dispute, although Mother was now compliant with medication. A child in need meeting was held in the school holidays and it was planned that social care would close the case if progress continued – other key agencies were not aware of this.                                   |
| 7       | Oct 2011 – April 2012  | Father had moved out of the house. The <b>Child in Need Plan</b> was no longer valid. Mother was not co-operating with treatment.<br>In January 2012, it was planned to undertake a Common Assessment Framework Assessment with a view to closing the case.<br>Social care advised Partner Agencies that the case was to be closed in February                                                                                                                                                                                                                                                                                                     |
| Phase 7 |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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|       |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| cont. |                      | (in March it was transferred to the Vulnerable Children Team unsuccessfully).<br>By March Mother was relapsing and her aggressive behaviour was increasing, including with strangers. There should have been a section 47 enquiry. Partner agencies were concerned about B but did not re-refer her to children's social care.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 8     | May – Sept 2012      | <p><b>Increased concern and new incident of assault but case not stepped up again to child protection.</b></p> <p>Mother was not engaging with mental health services.</p> <p>In Mid-May Mother again disturbed B in her bedroom at night and assaulted her. Police and Children's Social Care decided that there would be a 'single agency assessment' and other agencies were not told. School should have been involved. Social care closed the case after the assessment. B was showing that she was taking responsibility for her Mother's welfare.</p> <p>Mental health staff noted the emerging pattern of relapse and that B may not disclose her Mother's deterioration and, therefore, should not return home without a Child Protection Plan in place. No child protection conference was called.</p> <p>By September Mother was improving and consideration was being given to B returning to live with her.</p> |
| 9     | Sept 2012 – Jan 2014 | <p><b>A period of drift, improvement over time in Mother's mental health</b></p> <p>Mother making progress and then appearing to relapse, but unable to see when there is a risk of relapse, Children in Need Meetings held but not effective, use of Professionals Meeting without Mother</p> <p>B returned home in December 2012</p> <p>By Summer 2013 sufficient progress for Children's Social Care to close the case. Up to December 2013 continued improvement and Mother compliant with medication.</p> <p>In January 2014, it came to light that B had self-harmed in November 2013. Not assessed or followed up appropriately. Key agencies were not informed.</p>                                                                                                                                                                                                                                                  |
| 10    | Feb 2014 – Sept 2015 | <p><b>Mother stable, discharged from mental health services</b></p> <p>Monitoring by mental health services, Mother's mental health was settled and no signs of relapse.</p> <p>B was progressing at school</p> <p>February 2015 Mother was discharged to the care of her GP – 'supported by her daughter (B)'</p> <p>In July B left her secondary school age 16 to go to college</p> <p>September 2015 – B seriously assaulted by her Mother during the night</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

**Appendix 4** Extract from:

**Joint Protocol for Safeguarding Children and Families with Mental Health and /or Drug and Alcohol needs. October 2014**

First published January 2007, reviewed July 2010, and Sept 2013

**Section 1.4 All Services with respect to Young Carers**

When a child is under 16 they can receive a carer's assessment when the adult is being assessed or re-assessed, but when 16 or over they can request an assessment at any time. Young carers may be hidden and there is a need to develop pro-active practice to enable families to feel able to ask for support

All health and social care professionals in adult's and children's services should ensure that children and young carers are provided with information (appropriate to their age) which will help them understand the cared-for person's health issues, and the role of professionals visiting their home.

All professionals should ensure that

- Young carers are safeguarded appropriately and protected from any harm which may result from their caring role.
- Every young person who is a young carer receives adequate support to ensure that they do not take on an unduly heavy or inappropriate caring role. The reasons for their caring role may be complex and to resolve them may require a multifaceted approach.
- Every young carer has the opportunity to extend and fulfil their potential and receive sufficient support to enable them to attend school regularly and benefit from the opportunities offered to all young people at school, college or education provision.
- Every young carer has opportunity to access positive activities.
- Every young carer receives a range of timely, practical and emotional support to help them manage their caring role. Support and information will be readily accessible.
- Young Carers are entitled to be children first and ensure access to leisure activities and having fun.
- Young Carers should be included and consulted on all plans for the person they have caring responsibilities for, where this is appropriate.
- Young Carers are involved in the design, development and review of services to support them and their families.
- Young Carers should be given the contact details for care coordinators, or appropriate professionals in adult mental health and drug and alcohol teams, both for office hours and evening and weekends in case they have concerns to raise or in the event of a crisis or emergency.
- A whole-family approach to work with Young Carers is taken, in the context of an awareness of the individual and cultural identity of each family.

## Appendix 5

### Think child, think parent, think family *Extract from 'At a glance' summary*

- Think child, think parent, think family in order to develop new solutions to improve outcomes for parents with mental health problems and their families.
- Take a multi-agency approach, with senior level commitment to implement a think family strategy.
- Review whether criteria for access to adult mental health and to children's services take into account the individual and combined needs of children, parents and carers.
- Ensure screening systems in adult mental health and children's services routinely and reliably identify and record information about adults with mental health problems who are also parents.
- Listen to parents and children – most want support that is flexible, based on a relationship with a key worker and takes account of their practical priorities.
- Build resilience and manage risk – ensure ready access to specialist mental health and children's safeguarding services when needed and that staff know who makes what decision in what circumstances.
- Be creative – consider allocating an individual budget to provide flexibility and tackle stigma by developing non-traditional ways of providing services.
- Increase every family member's understanding of a parent's mental health problem – this can strengthen their ability to cope.

See <http://www.scie.org.uk/publications/atagance/atagance09.asp>

## Appendix 6

### Mental Health Trust Guidance on Carers and Families

#### Carers and Families

Staff should always share as much information as possible with carers, friends and families. Carers, friends and families should be involved throughout a service user's care and treatment, as long as the confidentiality and rights of the service user are protected. Even if details cannot be shared, staff should always consider what information would help a service user's carer, friend or family in their own right and in their supportive role with the service user.

Staff should discuss with service users whether and how to involve family, friends and carers in their treatment and support, how this could be beneficial and what information might be shared with them.

Staff should always be alert to the possible risks inherent in decisions to share or not share information with families, friends and carers. Staff should follow information sharing and confidentiality protocols when information needs to be shared with family, friends or carers against the express wishes of a service user in order to manage significant risks.

Carers form a vital part of the support required to aid a person's recovery. Their own needs should be recognised and supported. Providers of substantial informal care are entitled to 'an assessment of their own needs; and may be entitled to receive funded social care services in their own right. Carer's support or care plans should be developed, implemented and reviewed in collaboration between staff and carers as appropriate. The carers of service users on CPA should be identified and given information about available services and entitlements they may have access to.

#### **Information Sharing and Copying Correspondence to Relevant Professionals in Other Organisations**

Service users have a right to confidentiality. The presumption made is that of full disclosure of clinical information to all Trust professionals directly involved in a service user's care and relevant professionals in other organisations with which the Trust has an information sharing agreement is appropriate as long as it is in the interests of safety of the service user or others.

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Malcolm Ward  
Independent Reviewer

December 2016